UNITEDHEALTH GROUP INC
Form 10-Q
August 05, 2013

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

Form 10-Q

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x QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
FOR THE QUARTERLY PERIOD ENDED JUNE 30, 2013
or
o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
FOR THE TRANSITION PERIOD FROM _______ TO _______
Commission file number: 1-10864

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

Minnesota (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)

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

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No o
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No o
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act:

Large accelerated filer	x	Accelerated filer	o	Non-accelerated filer	o	Smaller reporting company	o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes o No x
As of August 2, 2013, there were 1,016,699,724 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

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PART I
ITEM 1. FINANCIAL STATEMENTS
UnitedHealth Group
Condensed Consolidated Balance Sheets
(Unaudited)

(in millions, except per share data)	June 30, 2013	December 31, 2012
Assets		
Current assets:		
Cash and cash equivalents	$7,654	$8,406
Short-term investments	2,443	3,031
Accounts receivable, net	3,674	2,709
Other current receivables, net	3,020	2,889
Assets under management	2,613	2,773
Deferred income taxes	366	463
Prepaid expenses and other current assets	848	781
Total current assets	20,618	21,052
Long-term investments	17,976	17,711
Property, equipment and capitalized software, net	3,785	3,939
Goodwill	31,427	31,286
Other intangible assets, net	4,079	4,682
Other assets	2,316	2,215
Total assets	$80,201	$80,885
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$11,855	$11,004
Accounts payable and accrued liabilities	7,046	6,984
Other policy liabilities	5,176	4,910
Commercial paper and current maturities of long-term debt	1,086	2,713
Unearned revenues	1,242	1,505
Total current liabilities	26,405	27,116
Long-term debt, less current maturities	15,543	14,041
Future policy benefits	2,451	2,444
Deferred income taxes	2,076	2,450
Other liabilities	1,576	1,535
Total liabilities	48,051	47,586
Commitments and contingencies (Note 9)		
Redeemable noncontrolling interest	769	2,121
Shareholders' equity:		
Preferred stock, $0.001 par value - 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value - 3,000 shares authorized; 1,006 and 1,019 issued and outstanding	10	10
Additional paid-in capital	—	66
Retained earnings	31,906	30,664
Accumulated other comprehensive (loss) income	(535)	438
Total shareholders' equity	31,381	31,178
Total liabilities and shareholders' equity	$80,201	$80,885

See Notes to the Condensed Consolidated Financial Statements

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UnitedHealth Group
Condensed Consolidated Statements of Operations
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
(in millions, except per share data)	2013	2012	2013	2012
Revenues:				
Premiums	$27,220	$24,609	$54,494	$49,240
Services	2,244	1,800	4,356	3,591
Products	749	678	1,500	1,366
Investment and other income	195	178	398	350
Total revenues	30,408	27,265	60,748	54,547
Operating costs:				
Medical costs	22,173	20,013	44,742	39,952
Operating costs	4,825	4,080	9,439	8,176
Cost of products sold	669	620	1,351	1,254
Depreciation and amortization	340	326	676	622
Total operating costs	28,007	25,039	56,208	50,004
Earnings from operations	2,401	2,226	4,540	4,543
Interest expense	(176)	(153)	(354)	(301)
Earnings before income taxes	2,225	2,073	4,186	4,242
Provision for income taxes	(789)	(736)	(1,510)	(1,517)
Net earnings	1,436	1,337	2,676	2,725
Less: earnings attributable to noncontrolling interest	—	—	(48)	—
Net earnings attributable to UnitedHealth Group common shareholders	$1,436	$1,337	$2,628	$2,725
Earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	$1.42	$1.30	$2.60	$2.64
Diluted	$1.40	$1.27	$2.56	$2.59
Basic weighted-average number of common shares outstanding	1,009	1,028	1,012	1,034
Dilutive effect of common stock equivalents	17	21	15	20
Diluted weighted-average number of common shares outstanding	1,026	1,049	1,027	1,054
Anti-dilutive shares excluded from the calculation of dilutive effect of common stock equivalents	9	10	13	17
Cash dividends declared per common share	$0.2800	$0.2125	$0.4925	$0.3750

See Notes to the Condensed Consolidated Financial Statements

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UnitedHealth Group
Condensed Consolidated Statements of Comprehensive Income
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
(in millions)	2013	2012	2013	2012
Net earnings	$1,436	$1,337	$2,676	$2,725
Other comprehensive (loss) income:				
Gross unrealized holding (losses) gains on investment securities during the period	(453)	81	(501)	111
Income tax effect	165	(35)	181	(46)
Total unrealized (losses) gains, net of tax	(288)	46	(320)	65
Gross reclassification adjustment for net realized gains included in net earnings	(49)	(50)	(106)	(89)
Income tax effect	18	19	39	33
Total reclassification adjustment, net of tax	(31)	(31)	(67)	(56)
Total foreign currency translation losses	(604)	(4)	(586)	(1)
Other comprehensive (loss) income	(923)	11	(973)	8
Comprehensive income	513	1,348	1,703	2,733
Less: comprehensive income attributable to noncontrolling interests	—	—	(48)	—
Comprehensive income attributable to UnitedHealth Group common shareholders	$513	$1,348	$1,655	$2,733

See Notes to the Condensed Consolidated Financial Statements

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UnitedHealth Group
Condensed Consolidated Statements of Changes in Shareholders' Equity
(Unaudited)

(in millions)	Common Stock		Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)		Total Shareholders' Equity
	Shares	Amount			Net Unrealized Gains (Losses) on Investments	Foreign Currency Translation Losses	
Balance at January 1, 2013	1,019	$10	$ 66	$30,664	$516	$ (78)	$ 31,178
Net earnings attributable to UnitedHealth Group common shareholders				2,628			2,628
Other comprehensive loss					(387)	(586)	(973)
Issuances of common stock, and related tax effects	10	—	228				228
Share-based compensation, and related tax benefits			207				207
Common stock repurchases	(23)	—	(445)	(889)			(1,334)
Acquisition of noncontrolling interest			(56)				(56)
Cash dividends paid on common stock				(497)			(497)
Balance at June 30, 2013	1,006	$10	$—	$31,906	$129	$ (664)	$ 31,381
Balance at January 1, 2012	1,039	$10	$—	$27,821	$476	$ (15)	$ 28,292
Net earnings				2,725			2,725
Other comprehensive income (loss)					9	(1)	8
Issuances of common stock, and related tax effects	18	—	194				194
Share-based compensation, and related tax benefits			351				351
Common stock repurchases	(33)	—	(545)	(1,264)			(1,809)
Cash dividends paid on common stock				(386)			(386)
Balance at June 30, 2012	1,024	$10	$—	$28,896	$485	$ (16)	$ 29,375

See Notes to the Condensed Consolidated Financial Statements

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UnitedHealth Group
Condensed Consolidated Statements of Cash Flows
(Unaudited)

(in millions)	Six Months Ended June 30, 2013	2012
Operating activities		
Net earnings	$2,676	$2,725
Non-cash items:		
Depreciation and amortization	676	622
Deferred income taxes	100	108
Share-based compensation	176	242
Other, net	(86)	(163)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:		
Accounts receivable	(952)	(188)
Other assets	(661)	(27)
Medical costs payable	792	298
Accounts payable and other liabilities	107	23
Other policy liabilities	(41)	(365)
Unearned revenues	(260)	2,496
Cash flows from operating activities	2,527	5,771
Investing activities		
Purchases of investments	(5,942)	(4,946)
Sales of investments	2,924	2,090
Maturities of investments	2,718	2,322
Cash paid for acquisitions, net of cash assumed	(284)	(2,404)
Cash received from dispositions	45	—
Purchases of property, equipment and capitalized software	(625)	(465)
Proceeds from disposal of property, equipment and capitalized software	146	—
Cash flows used for investing activities	(1,018)	(3,403)
Financing activities		
Acquisition of noncontrolling interest shares	(1,474)	—
Common stock repurchases	(1,334)	(1,809)
Proceeds from issuance of long-term debt	2,235	995
Repayments of long-term debt	(1,560)	—
Repayments of commercial paper, net	(688)	—
Cash dividends paid	(497)	(386)
Customer funds administered	855	1,108
Proceeds from common stock issuances	314	410
Checks outstanding	37	(290)
Other, net	(55)	(247)
Cash flows used for financing activities	(2,167)	(219)
Effect of exchange rate changes on cash and cash equivalents	(94)	—
(Decrease) increase in cash and cash equivalents	(752)	2,149
Cash and cash equivalents, beginning of period	8,406	9,429
Cash and cash equivalents, end of period	$7,654	$11,578

See Notes to the Condensed Consolidated Financial Statements

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UnitedHealth Group
Notes to the Condensed Consolidated Financial Statements
(Unaudited)

1.Basis of Presentation

UnitedHealth Group Incorporated (both individually and together with its consolidated subsidiaries referred to as "UnitedHealth Group" and the "Company") is a diversified health and well-being company whose mission is to help people live healthier lives and to make the health system work better for everyone. The Company offers a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services.

The Company has prepared the Condensed Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The Company has eliminated intercompany balances and transactions. The year-end condensed consolidated balance sheet data was derived from audited financial statements, but does not include all disclosures required by GAAP. In accordance with the rules and regulations of the U.S. Securities and Exchange Commission (SEC), the Company has omitted certain footnote disclosures that would substantially duplicate the disclosures contained in its annual audited Consolidated Financial Statements. Therefore, these Condensed Consolidated Financial Statements should be read together with the Consolidated Financial Statements and the Notes included in the Company's Annual Report on Form 10-K for the year ended December 31, 2012 as filed with the SEC (2012 10-K). The accompanying Condensed Consolidated Financial Statements include all normal recurring adjustments necessary to present the interim financial statements fairly.

Use of Estimates

These Condensed Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to medical costs payable, premium rebates and risk-adjusted and risk-sharing provisions related to revenues, valuation and impairment analysis of goodwill and other intangible assets, estimates of other policy liabilities and other current receivables, valuations of investments, and estimates and judgments related to income taxes and contingent liabilities. These estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any changes in estimates is included in earnings in the period in which the estimate is adjusted.

Recently Adopted Accounting Standards

In February 2013, the Financial Accounting Standards Board (FASB) issued Accounting Standards Updated (ASU) No. 2013-02, "Comprehensive Income (Topic 220): Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income" (ASU 2013-02). ASU 2013-02 requires companies to report the effect of significant reclassifications out of accumulated other comprehensive income, by component, either on the face of the financial statements or in the notes to the financial statements and is intended to help entities improve the transparency of changes in other comprehensive income. ASU 2013-02 does not amend any existing requirements for reporting net income or other comprehensive income in the financial statements. ASU 2013-02 became effective for the Company's fiscal year 2013 and the new disclosures have been included with the Company's investment disclosures in Note 2.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Condensed Consolidated Financial Statements.

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2.Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
June 30, 2013				
Debt securities - available-for-sale:				
U.S. government and agency obligations	$2,305	$13	$(13)	$2,305
State and municipal obligations	6,430	192	(67)	6,555
Corporate obligations	7,194	152	(61)	7,285
U.S. agency mortgage-backed securities	2,031	27	(40)	2,018
Non-U.S. agency mortgage-backed securities	656	18	(10)	664
Total debt securities - available-for-sale	18,616	402	(191)	18,827
Equity securities - available-for-sale	770	4	(6)	768
Debt securities - held-to-maturity:				
U.S. government and agency obligations	180	3	—	183
State and municipal obligations	28	—	—	28
Corporate obligations	616	—	—	616
Total debt securities - held-to-maturity	824	3	—	827
Total investments	$20,210	$409	$(197)	$20,422
December 31, 2012				
Debt securities - available-for-sale:				
U.S. government and agency obligations	$2,501	$38	$(1)	$2,538
State and municipal obligations	6,282	388	(3)	6,667
Corporate obligations	6,930	283	(4)	7,209
U.S. agency mortgage-backed securities	2,168	70	—	2,238
Non-U.S. agency mortgage-backed securities	538	36	—	574
Total debt securities - available-for-sale	18,419	815	(8)	19,226
Equity securities - available-for-sale	668	10	(1)	677
Debt securities - held-to-maturity:				
U.S. government and agency obligations	168	6	—	174
State and municipal obligations	30	—	—	30
Corporate obligations	641	2	—	643
Total debt securities - held-to-maturity	839	8	—	847
Total investments	$19,926	$833	$(9)	$20,750

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The fair values of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination as of June 30, 2013 were as follows:

(in millions)	AAA	AA	A	Non-Investment Grade	Total Fair Value
2013	$71	$—	$—	$ —	$71
2012	110	—	—	—	110
2011	20	—	—	—	20
2010	20	2	—	—	22
2009	2	—	—	—	2
2007	74	—	—	3	77
Pre - 2007	337	4	11	10	362
U.S. agency mortgage-backed securities	2,017	—	1	—	2,018
Total	$2,651	$6	$12	$ 13	$2,682

The Company includes any securities backed by Alt-A or sub-prime mortgages and any commercial mortgage loans in default in the non-investment grade column in the table above.

The amortized cost and fair value of available-for-sale debt securities as of June 30, 2013, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$2,529	$2,542
Due after one year through five years	6,811	6,939
Due after five years through ten years	4,818	4,887
Due after ten years	1,771	1,777
U.S. agency mortgage-backed securities	2,031	2,018
Non-U.S. agency mortgage-backed securities	656	664
Total debt securities - available-for-sale	$18,616	$18,827

The amortized cost and fair value of held-to-maturity debt securities as of June 30, 2013, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$399	$400
Due after one year through five years	159	159
Due after five years through ten years	141	143
Due after ten years	125	125
Total debt securities - held-to-maturity	$824	$827

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The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months and in Total	
	Fair Value	Gross Unrealized Losses
June 30, 2013		
Debt securities - available-for-sale:		
U.S. government and agency obligations	$818	$(13)
State and municipal obligations	2,177	(67)
Corporate obligations	3,103	(61)
U.S. agency mortgage-backed securities	1,117	(40)
Non-U.S. agency mortgage-backed securities	337	(10)
Total debt securities - available-for-sale	$7,552	$(191)
Equity securities - available-for-sale	$134	$(6)
December 31, 2012		
Debt securities - available-for-sale:		
U.S. government and agency obligations	$183	$(1)
State and municipal obligations	362	(3)
Corporate obligations	695	(4)
Total debt securities - available-for-sale	$1,240	$(8)
Equity securities - available-for-sale	$13	$(1)

The unrealized losses from all securities as of June 30, 2013 were generated from approximately 6,500 positions out of a total of 19,000 positions. The Company believes that it will collect the principal and interest due on its investments that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). Therefore, the Company believes these losses to be temporary. As of June 30, 2013, the Company did not have the intent to sell any of the securities in an unrealized loss position.

A portion of the Company’s investments in equity securities and venture capital funds consists of investments held in various public and nonpublic companies concentrated in the areas of health care services and related information technologies. Market conditions that affect the value of health care and related technology stocks will likewise impact the value of the Company’s equity portfolio. The equity securities and venture capital funds were evaluated for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

(in millions)	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
Total OTTI	$(1)	$(1)	$(4)	$(4)
Portion of loss recognized in other comprehensive income	—	—	—	—
Net OTTI recognized in earnings	(1)	(1)	(4)	(4)
Gross realized losses from sales	(2)	(2)	(3)	(3)
Gross realized gains from sales	52	53	113	96
Net realized gains (included in Investment and Other Income on the Condensed Consolidated Statements of Operations)	49	50	106	89

Income tax effect (included in Provision for Income Taxes on the Condensed Consolidated Statements of Operations)	(18)	(19)	(39)	(33)
Realized gains, net of taxes	$31	$31	$67	$56

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3. Fair Value

Certain assets and liabilities are measured at fair value in the Condensed Consolidated Financial Statements or have fair values disclosed in the Notes to the Condensed Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in non-active markets (e.g., few transactions, limited information, non-current prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs; there were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during 2013 or 2012.

Non-financial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the three and six months ended June 30, 2013 or 2012.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and non-binding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The Company’s Level 3 equity securities are primarily investments in venture capital securities. The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company’s various venture capital

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investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries and having similar revenue and growth characteristics; and similar preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair value of certain of the Company's venture capital securities are based off of recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

AARP Program-related Investments. The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (AARP Program). AARP Program-related investments consist of debt and equity securities held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's debt and equity securities.

Interest Rate and Currency Swaps. Fair values of the Company's swaps are estimated using the terms of the swaps and publicly available information including market yield curves. Because the swaps are unique and not actively traded but are valued using other observable inputs, the fair values are classified as Level 2.

Long-term Debt. The fair value of the Company's long-term debt is estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-related Other Liabilities. AARP Program-related other liabilities consist of liabilities that represent the amount of net investment gains and losses related to AARP Program-related investments that accrue to the benefit of the AARP policyholders.

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The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets excluding AARP Program-related assets and liabilities, which are presented in a separate table below:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
June 30, 2013				
Cash and cash equivalents	$7,224	$430	$—	$7,654
Debt securities - available-for-sale:				
U.S. government and agency obligations	1,669	636	—	2,305
State and municipal obligations	—	6,555	—	6,555
Corporate obligations	18	7,236	31	7,285
U.S. agency mortgage-backed securities	—	2,018	—	2,018
Non-U.S. agency mortgage-backed securities	—	657	7	664
Total debt securities - available-for-sale	1,687	17,102	38	18,827
Equity securities - available-for-sale	504	19	245	768
Currency swap assets	—	21	—	21
Total assets at fair value	$9,415	$17,572	$283	$27,270
Percentage of total assets at fair value	35 %	64 %	1 %	100 %
Interest rate swap liabilities	$—	$88	$—	$88
December 31, 2012				
Cash and cash equivalents	$7,615	$791	$—	$8,406
Debt securities - available-for-sale:				
U.S. government and agency obligations	1,752	786	—	2,538
State and municipal obligations	—	6,667	—	6,667
Corporate obligations	13	7,185	11	7,209
U.S. agency mortgage-backed securities	—	2,238	—	2,238
Non-U.S. agency mortgage-backed securities	—	568	6	574
Total debt securities - available-for-sale	1,765	17,444	17	19,226
Equity securities - available-for-sale	450	3	224	677
Interest rate swap assets	—	14	—	14
Total assets at fair value	$9,830	$18,252	$241	$28,323
Percentage of total assets at fair value	35 %	64 %	1 %	100 %
Interest rate and currency swap liabilities	$—	$14	$—	$14

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The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
June 30, 2013					
Debt securities - held-to-maturity:					
U.S. government and agency obligations	$ 183	$—	$—	$183	$180
State and municipal obligations	—	—	28	28	28
Corporate obligations	21	319	276	616	616
Total debt securities - held-to-maturity	$ 204	$319	$ 304	$827	$824
Long-term debt	$—	$16,621	$—	$16,621	$15,728
December 31, 2012					
Debt securities - held-to-maturity:					
U.S. government and agency obligations	$ 174	$—	$—	$174	$168
State and municipal obligations	—	1	29	30	30
Corporate obligations	10	346	287	643	641
Total debt securities - held-to-maturity	$ 184	$347	$ 316	$847	$839
Long-term debt	$—	$17,034	$—	$17,034	$15,167

The carrying amounts reported in the Condensed Consolidated Balance Sheets for accounts and other current receivables, unearned revenues, commercial paper, accounts payable and accrued liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

(in millions)	Three Months Ended			Six Months Ended		
	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
June 30, 2013						
Balance at beginning of period	$32	$239	$271	$17	$224	$241
Purchases	7	11	18	22	42	64
Sales	—	—	—	—	(21)	(21)
Net unrealized losses in accumulated other comprehensive income	(1)	(4)	(5)	(1)	(6)	(7)
Net realized (losses) gains in investment and other income	—	(1)	(1)	—	6	6
Balance at end of period	$38	$245	$283	$38	$245	$283
June 30, 2012						
Balance at beginning of period	$7	$204	$211	$208	$209	$417
Purchases	—	33	33	—	51	51
Sales	—	(7)	(7)	—	(9)	(9)
Net unrealized losses in accumulated other comprehensive income	—	(3)	(3)	—	(3)	(3)
Net realized gains in investment and other income	—	1	1	—	1	1
Transfers to held-to-maturity	—	—	—	(201)	(21)	(222)
Balance at end of period	$7	$228	$235	$7	$228	$235

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The following table presents quantitative information regarding unobservable inputs that were significant to the valuation of assets measured at fair value on a recurring basis using Level 3 inputs:

(in millions)	Fair Value	Valuation Technique	Unobservable Input	Range	
				Low	High
June 30, 2013					
Equity securities - available-for-sale					
Venture capital portfolios	$226	Market approach - comparable companies	Revenue multiple	1.0	10.0
			EBITDA multiple	7.0	10.0
	19	Market approach - recent transactions	Inactive market transactions	N/A	N/A
Total equity securities available-for-sale	$245				

Also included in the Company's assets measured at fair value on a recurring basis using Level 3 inputs were $38 million of available-for-sale debt securities at June 30, 2013, which were not significant.

The Company elected to measure the entirety of the AARP Assets Under Management at fair value pursuant to the fair value option. See Note 2 of Notes to the Consolidated Financial Statements in the Company's 2012 10-K for further detail on AARP. The following table presents fair value information about the AARP Program-related financial assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Total Fair and Carrying Value
June 30, 2013			
Cash and cash equivalents	$169	$4	$173
Debt securities:			
U.S. government and agency obligations	488	251	739
State and municipal obligations	—	61	61
Corporate obligations	—	1,081	1,081
U.S. agency mortgage-backed securities	—	411	411
Non-U.S. agency mortgage-backed securities	—	145	145
Total debt securities	488	1,949	2,437
Equity securities - available-for-sale	—	3	3
Total assets at fair value	$657	$1,956	$2,613
Other liabilities	$10	$16	$26
December 31, 2012			
Cash and cash equivalents	$230	$—	$230
Debt securities:			
U.S. government and agency obligations	545	244	789
State and municipal obligations	—	51	51
Corporate obligations	—	1,118	1,118
U.S. agency mortgage-backed securities	—	427	427
Non-U.S. agency mortgage-backed securities	—	155	155
Total debt securities	545	1,995	2,540
Equity securities - available-for-sale	—	3	3
Total assets at fair value	$775	$1,998	$2,773

Other liabilities	$23	$58	$81

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4. Medicare Part D Pharmacy Benefits

The Condensed Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	June 30, 2013			December 31, 2012		
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Drug Discount	Risk-Share
Other current receivables	$141	$ 220	$—	$461	$ 314	$—
Other policy liabilities	—	232	411	—	319	438

The Catastrophic Reinsurance and Low-Income Member Cost Sharing Subsidies (Subsidies) and drug discounts represent cost reimbursements under the Medicare Part D program. The Company is fully reimbursed by the Centers for Medicare and Medicaid Services (CMS) for costs incurred for these contract elements and, accordingly, there is no insurance risk to the Company. Amounts received for these contract elements are not reflected as premium revenues, but rather are accounted for as a reduction of receivables and/or increase in deposit liabilities. CMS provides prospective payments for the drug discounts, which the Company records as liabilities when received. The drug discounts are ultimately funded by the pharmaceutical manufacturers. The Company bills them for claims under the program and records those bills as receivables. Related cash flows are presented as customer funds administered within financing activities in the Condensed Consolidated Statements of Cash Flows.

Premiums from CMS are subject to risk-sharing provisions based on a comparison of the Company’s annual bid estimates of prescription drug costs and the actual costs incurred. Variances may result in CMS making additional payments to the Company or require the Company to remit funds to CMS subsequent to the end of the year. The Company records risk-share adjustments to premium revenue and to other current receivables or other policy liabilities in the Condensed Consolidated Balance Sheets.

5. Medical Cost Development

The following table provides details of the Company's net favorable medical cost development:

	Three Months Ended June 30,		Six Months Ended June 30,	
(in millions)	2013	2012	2013	2012
Related to Prior Years	$120	$90	$400	$620
Related to Current Year	190	120	N/A	N/A

The favorable development for the three and six months ended June 30, 2013 and June 30, 2012 was primarily driven by lower than expected health system utilization levels.

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6. Commercial Paper and Long-Term Debt

Commercial paper and long-term debt consisted of the following:

	June 30, 2013			December 31, 2012		
(in millions, except percentages)	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial Paper	$901	$901	$901	$1,587	$1,587	$1,587
4.875% senior unsecured notes due February 2013	—	—	—	534	534	536
4.875% senior unsecured notes due April 2013	—	—	—	409	411	413
4.750% senior unsecured notes due February 2014	172	176	176	172	178	180
5.000% senior unsecured notes due August 2014	389	404	408	389	411	414
Senior unsecured floating-rate notes due August 2014	250	250	250	—	—	—
4.875% senior unsecured notes due March 2015 (a)	416	437	444	416	444	453
0.850% senior unsecured notes due October 2015 (a)	625	622	626	625	623	627
5.375% senior unsecured notes due March 2016 (a)	601	647	665	601	660	682
1.875% senior unsecured notes due November 2016	400	398	407	400	397	412
5.360% senior unsecured notes due November 2016	95	95	108	95	95	110
6.000% senior unsecured notes due June 2017	441	484	508	441	489	528
1.400% senior unsecured notes due October 2017 (a)	625	609	614	625	622	626
6.000% senior unsecured notes due November 2017	156	169	179	156	170	191
6.000% senior unsecured notes due February 2018	1,100	1,118	1,292	1,100	1,120	1,339
1.625% senior unsecured notes due March 2019	500	498	483	—	—	—
3.875% senior unsecured notes due October 2020	450	443	473	450	442	499
4.700% senior unsecured notes due February 2021	400	417	438	400	417	466
3.375% senior unsecured notes due November 2021 (a)	500	481	498	500	512	533
2.875% senior unsecured notes due March 2022	1,100	1,003	1,049	1,100	998	1,128
0.000% senior unsecured notes due November 2022	15	9	10	15	9	11
2.750% senior unsecured notes due February 2023 (a)	625	576	582	625	619	631
2.875% senior unsecured notes due March 2023	750	747	705	—	—	—
5.800% senior unsecured notes due March 2036	850	845	954	850	845	1,025
6.500% senior unsecured notes due June 2037	500	495	599	500	495	659
6.625% senior unsecured notes due November 2037	650	645	791	650	645	860
6.875% senior unsecured notes due February 2038	1,100	1,084	1,374	1,100	1,084	1,510
5.700% senior unsecured notes due October 2040	300	298	330	300	298	364
5.950% senior unsecured notes due February 2041	350	348	396	350	348	440
4.625% senior unsecured notes due November 2041	600	593	576	600	593	641
4.375% senior unsecured notes due March 2042	502	486	464	502	486	521
3.950% senior unsecured notes due October 2042	625	611	538	625	611	622
4.250% senior unsecured notes due March 2043	750	740	684	—	—	—
Total U.S. dollar denominated debt	16,738	16,629	17,522	16,117	16,143	18,008
Cetip Interbank Deposit Rate (CDI) + 1.3% Subsidiary floating debt due October 2013	—	—	—	147	148	150
CDI + 1.45% Subsidiary floating debt due October 2014	—	—	—	147	149	150
110% CDI Subsidiary floating debt due December 2014	—	—	—	147	151	147

CDI + 1.6% Subsidiary floating debt due October 2015	—	—	—	74	76	76
Brazilian Extended National Consumer Price Index (IPCA) + 7.61% Subsidiary floating debt due October 2015	—	—	—	73	87	90
Total Brazilian real denominated debt (in U.S. dollars)	—	—	—	588	611	613
Total commercial paper and long-term debt	$16,738	$16,629	$17,522	$16,705	$16,754	$18,621

(a) Fixed-rate debt instruments hedged with interest rate swap contracts. See below for more information on the Company's interest rate swaps.

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Commercial Paper and Bank Credit Facilities
Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of June 30, 2013, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.3%.
The Company has $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facilities with 21 banks, which mature in November 2017 and November 2013, respectively. These facilities provide liquidity support for the Company's $4.0 billion commercial paper program and are available for general corporate purposes. There were no amounts outstanding under these facilities as of June 30, 2013. The interest rates on borrowings are variable based on term and are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. As of June 30, 2013, the annual interest rates on both bank credit facilities, had they been drawn, would have ranged from 1.0% to 1.2%.
Debt Covenants
The Company's bank credit facilities contain various covenants including requiring the Company to maintain a debt to debt-plus-equity ratio of not more than 50%. The Company was in compliance with its debt covenants as of June 30, 2013.
Interest Rate and Currency Swap Contracts
The Company uses interest rate swap contracts to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The floating rates are benchmarked to LIBOR. The swaps are designated as fair value hedges on the Company's fixed-rate debt. Since the critical terms of the swaps match those of the debt being hedged, they are assumed to be highly effective hedges and all changes in fair value of the swaps are recorded as an adjustment to the carrying value of the related debt with no net impact recorded in the Condensed Consolidated Statements of Operations.
The following table summarizes the location and fair value of the interest rate swap fair value hedges on the Company's Condensed Consolidated Balance Sheet:

Type of Fair Value Hedge	Notional Amount (in billions)	Fair Value (in millions)	Balance Sheet Location
June 30, 2013			
Interest rate swap contracts	$3.4	$88	Other liabilities
December 31, 2012			
Interest rate swap contracts	$2.8	$14	Other assets
		11	Other liabilities

The following table provides a summary of the effect of changes in fair value of fair value hedges on the Company's Condensed Consolidated Statements of Operations:

	Three Months Ended June 30,		Six Months Ended June 30,	
(in millions)	2013	2012	2013	2012
Hedge (interest rate swap) (loss) gain recognized in interest expense	$(104)	$22	$(91)	$12
Hedged item (long-term debt) gain (loss) recognized in interest expense	104	(22)	91	(12)
Net impact on the Company's Condensed Consolidated Statements of Operations	$—	$—	$—	$—

In December 2012, the Company entered into currency swap contracts to hedge the foreign currency exposure on the principal amount of intercompany borrowings denominated in Brazilian reais. The currency swaps have a notional amount of $256 million and mature on December 30, 2013. As of June 30, 2013, the fair value of the currency swap assets totaled $21 million, which was recorded in Other Current Assets in the Company's Condensed Consolidated Balance Sheets. As of December 31, 2012 the fair value of the currency swap liabilities totaled $3 million, which was recorded in Other Current Liabilities in the Company's Condensed Consolidated Balance Sheets.

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7. Shareholders' Equity

Share Repurchase Program

Under its Board of Directors’ authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company’s capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2013, the Board renewed and expanded the Company’s share repurchase program with an authorization to repurchase up to 110 million shares of its common stock. During the six months ended June 30, 2013, the Company repurchased 23 million shares at an average price of $58.92 per share and an aggregate cost of $1.3 billion. As of June 30, 2013, the Company had Board authorization to purchase up to an additional 109 million shares of its common stock.

Dividends

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

The following table provides details of the Company’s 2013 dividend payments:

Payment Date	Amount per Share	Total Amount Paid (in millions)
March 26, 2013	$ 0.2125	$ 216
June 26, 2013	0.2800	281

8. Share-Based Compensation

The Company’s outstanding share-based awards consist mainly of non-qualified stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares). As of June 30, 2013, the Company had 35 million shares available for future grants of share-based awards under its share-based compensation plan, including, but not limited to, incentive or non-qualified stock options, SARs and up to 14 million of awards in restricted shares.

Stock Options and SARs

Stock option and SAR activity for the six months ended June 30, 2013 is summarized in the table below:

	Shares (in millions)	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life (in years)	Aggregate Intrinsic Value (in millions)
Outstanding at beginning of period	63	$45		
Granted	8	57		
Exercised	(18)	42		
Forfeited	(2)	56		
Outstanding at end of period	51	47	4.6	$926
Exercisable at end of period	40	46	3.4	777
Vested and expected to vest, end of period	51	47	4.5	918

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Restricted Shares

Restricted share activity for the six months ended June 30, 2013 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	9	$ 46
Granted	3	58
Nonvested at end of period	12	49

Other Share-Based Compensation Data

(in millions, except per share amounts)	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
Stock Options and SARs				
Weighted-average grant date fair value of shares granted, per share	$20	$19	$19	$19
Total intrinsic value of stock options and SARs exercised	242	178	325	398
Restricted Shares				
Weighted-average grant date fair value of shares granted, per share	62	56	58	52
Total fair value of restricted shares vested	—	61	—	352
Share-Based Compensation Items				
Share-based compensation expense, before tax	77	102	176	242
Share-based compensation expense, net of tax effects	18	72	107	160
Income tax benefit realized from share-based award exercises	83	87	116	274

(in millions, except years)	June 30, 2013
Unrecognized compensation expense related to share awards	$436
Weighted-average years to recognize compensation expense	1.4

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
Risk-free interest rate	1.1%	0.7%	1.0% - 1.1%	0.7% - 0.9%
Expected volatility	43.0%	44.0%	42.6% - 43.0%	43.4% - 44.0%
Expected dividend yield	1.4%	1.2%	1.4% - 1.5%	1.2% - 1.3%
Forfeiture rate	5.0%	5.0%	5.0%	5.0%
Expected life in years	5.3	5.3	5.3	5.3 - 5.6

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company’s common stock and the implied volatility from exchange-traded options on the Company’s common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

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9. Commitments and Contingencies

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims, and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

Out-of-Network Reimbursement Litigation. Since 1999, the Company has been involved in a number of lawsuits challenging reimbursement amounts for non-network health care services based on the Company's use of a database previously maintained by Ingenix, Inc. (now known as OptumInsight). These suits have alleged, among other things, that the database licensed to these companies by Ingenix was flawed and that Ingenix conspired with these companies to underpay their members' claims. In 2012, the Company was dismissed as a party from one of these lawsuits involving Cigna and its members. In July 2013, the Company was dismissed from a similar lawsuit involving WellPoint and its members. In light of these and other developments, the Company does not believe that the remaining out-of-network reimbursement litigation concerning the use of the Ingenix database presents a reasonable possibility of a material loss.

California Claims Processing Matter. On January 25, 2008, the California Department of Insurance (CDI) issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations related to an alleged failure to include certain language in standard claims correspondence, timeliness and accuracy of claims processing, interest payments, care provider contract implementation, care provider dispute resolution and other related matters. The matter has been the subject of an administrative hearing before a California administrative law judge since December 2009. Although the Company believes that CDI has never issued a penalty in excess of $8 million, CDI is seeking a penalty of approximately $325 million in this matter. The Company is vigorously defending against the claims in this matter and believes that the penalty requested by CDI is excessive and without merit. After the administrative law judge issues a ruling at the conclusion of the administrative proceeding, expected in 2013, the California Insurance Commissioner may accept, reject or modify the administrative law judge's ruling, issue his own decision, and impose a fine or penalty. The Commissioner's decision is subject to challenge in court. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given the procedural status of the dispute, the legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting regulatory fines and penalties, and the various remedies and levels of judicial review available to the Company in the event a fine or penalty is assessed.

Endoscopy Center of Southern Nevada Litigation. In April 2013, a Las Vegas jury awarded $24 million in compensatory damages and $500 million in punitive damages against a Company health plan and its parent corporation on the theory that they were negligent in their credentialing and monitoring of an in-network endoscopy center owned and operated by independent physicians who were subsequently linked by regulators to an outbreak of hepatitis C. Company plans are party to 41 additional individual lawsuits and 2 class actions relating to the outbreak. The Company cannot reasonably estimate the range of loss, if any, that may result from these matters given the

likelihood of reversal on appeal, the availability of statutory and other limits on damages, the novel legal theories being advanced by the plaintiffs, the various postures of the remaining cases, the availability in many cases of federal defenses under Medicare law and Employee Retirement Income Security Act, and the pendency of certain relevant legal questions before the Nevada Supreme Court. The Company is vigorously defending these lawsuits.

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Government Investigations, Audits and Reviews

The Company has been and is 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 Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the Brazilian securities regulator - Comissão de Valores Mobiliários, Internal Revenue Service, the Brazilian federal revenue service - the Secretaria da Receita Federal, the U.S. Department of Labor, the Federal Deposit Insurance Corporation and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

In February 2012, CMS announced a final Risk Adjustment Data Validation (RADV) audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

10. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information presented to the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics are combined. The Company's four reportable segments are UnitedHealthcare, OptumHealth, OptumInsight and OptumRx.

Since the Company's acquisition of Amil occurred in the fourth quarter of 2012, the purchase price allocation is subject to adjustment as valuation analyses, primarily related to intangibles and fixed assets and contingent and tax liabilities, are finalized. During 2013, the Company acquired all of Amil's remaining public shares for $1.5 billion, bringing the Company's ownership of Amil to 90%. For more information on the Company's investment in Amil, see Note 6 of the Notes of the Consolidated Financial Statements in the Company's 2012 10-K.

Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and integrated care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. For more information on the Company's segments see Note 13 of the Notes of the Consolidated Financial Statements in the Company's 2012 10-K.

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Corporate and intersegment elimination amounts are presented to reconcile the reportable segment results to the consolidated results. The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Total Optum	Corporate and Intersegment Eliminations	Consolidated
		Optum					
Three Months Ended June 30, 2013							
Revenues - external customers:							
Premiums	$ 26,603	$617	$ —	$ —	$ 617	$ —	$ 27,220
Services	1,564	176	480	24	680	—	2,244
Products	2	5	14	728	747	—	749
Total revenues - external customers	28,169	798	494	752	2,044	—	30,213
Total revenues - intersegment	—	1,581	287	4,895	6,763	(6,763)	—
Investment and other income	163	32	—	—	32	—	195
Total revenues	$ 28,332	$2,411	$ 781	$ 5,647	$ 8,839	$ (6,763)	$ 30,408
Earnings from operations	$ 1,865	$225	$ 157	$ 154	$ 536	$ —	$ 2,401
Interest expense	—	—	—	—	—	(176)	(176)
Earnings before income taxes	$ 1,865	$225	$ 157	$ 154	$ 536	$ (176)	$ 2,225
Three Months Ended June 30, 2012							
Revenues - external customers:							
Premiums	$ 24,184	$425	$ —	$ —	$ 425	$ —	$ 24,609
Services	1,184	187	410	19	616	—	1,800
Products	—	6	10	662	678	—	678
Total revenues - external customers	25,368	618	420	681	1,719	—	27,087
Total revenues - intersegment	—	1,377	251	3,924	5,552	(5,552)	—
Investment and other income	148	30	—	—	30	—	178
Total revenues	$ 25,516	$2,025	$ 671	$ 4,605	$ 7,301	$ (5,552)	$ 27,265
Earnings from operations	$ 1,906	$123	$ 95	$ 102	$ 320	$ —	$ 2,226
Interest expense	—	—	—	—	—	(153)	(153)
Earnings before income taxes	$ 1,906	$123	$ 95	$ 102	$ 320	$ (153)	$ 2,073

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(in millions)	UnitedHealthcare	Optum OptumHealth	OptumInsight	OptumRx	Total Optum	Corporate and Intersegment Eliminations	Consolidated
Six Months Ended June 30, 2013							
Revenues - external customers:							
Premiums	$ 53,284	$1,210	$ —	$—	$ 1,210	$ —	$ 54,494
Services	2,987	383	939	47	1,369	—	4,356
Products	4	10	33	1,453	1,496	—	1,500
Total revenues - external customers	56,275	1,603	972	1,500	4,075	—	60,350
Total revenues - intersegment	—	3,188	582	9,343	13,113	(13,113)	—
Investment and other income	336	62	—	—	62	—	398
Total revenues	$ 56,611	$4,853	$ 1,554	$10,843	$ 17,250	$ (13,113)	$ 60,748
Earnings from operations	$ 3,509	$451	$ 306	$274	$ 1,031	$ —	$ 4,540
Interest expense	—	—	—	—	—	(354)	(354)
Earnings before income taxes	$ 3,509	$451	$ 306	$274	$ 1,031	$ (354)	$ 4,186
Six Months Ended June 30, 2012							
Revenues - external customers:							
Premiums	$ 48,395	$845	$ —	$—	$ 845	$ —	$ 49,240
Services	2,362	389	800	40	1,229	—	3,591
Products	—	13	27	1,326	1,366	—	1,366
Total revenues - external customers	50,757	1,247	827	1,366	3,440	—	54,197
Total revenues - intersegment	—	2,659	515	7,960	11,134	(11,134)	—
Investment and other income	292	58	—	—	58	—	350
Total revenues	$ 51,049	$3,964	$ 1,342	$9,326	$ 14,632	$ (11,134)	$ 54,547
Earnings from operations	$ 3,971	$215	$ 184	$173	$ 572	$ —	$ 4,543
Interest expense	—	—	—	—	—	(301)	(301)
Earnings before income taxes	$ 3,971	$215	$ 184	$173	$ 572	$ (301)	$ 4,242

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ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Condensed Consolidated Financial Statements and Notes and with our 2012 10-K, including the Consolidated Financial Statements and Notes in that report. References to the terms "UnitedHealth Group," "we," "our" or "us" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations refer to UnitedHealth Group Incorporated and its consolidated subsidiaries.

Readers are cautioned that the statements, estimates, projections or outlook contained in this Management's Discussion and Analysis of Financial Condition and Results of Operations, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 2, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below.

EXECUTIVE OVERVIEW

General

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

Further information on our business is included in Item 1, "Business" in our 2012 10-K and additional information on our segments can be found in this Item 2 and in Note 10 to the Condensed Consolidated Financial Statements in Item 1, "Financial Statements."

Business Trends

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

Pricing Trends. We seek to price our health care benefit products consistent with anticipated underlying medical trends, while balancing growth, margins, competitive dynamics, cost increases for the industry fees and tax provisions of The Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010, which we refer to together as the Health Reform Legislation, and premium rebates at the local market level. Changes in business mix and Health Reform Legislation may impact our premiums, medical costs and medical care ratio. We continue to expect premium rates to be under pressure through ongoing market competition in commercial products and through government payment rates. Aggregating UnitedHealthcare's businesses, we believe the medical care ratio will rise over time as we continue to grow in the senior and public markets and begin to participate in the emerging health benefit exchange market in 2014.

In the commercial market segment, we expect pricing to continue to be highly competitive throughout 2013. We endeavor to sustain a commercial medical care ratio in a stable range for an equivalent mix of business. We plan to hold to our pricing disciplines and, considering the competitive environment and persistently weak employment and new business formation rates, we expect continued pressure on our commercial risk-based product membership over the balance of 2013. Self-insured membership as a percentage of total commercial membership is expected to continue to increase at a modest pace in 2013 and beyond, due in part to the emerging interest from fully-insured mid-size employers in moving to self-funded arrangements. In the first quarter of 2013, we worked with our largest fully-insured customer to convert its coverage arrangements from risk-based to fee-based status. While this conversion

of 1.1 million risk-based members to a fee-based arrangement will reduce our 2013 consolidated revenues by $2.5 billion, the impact to our earnings from operations and cash flows will be negligible.

In government programs, we are seeing continuing rate pressures. Medicare Advantage funding has been cut in recent years, was further reduced in 2013 and additional reductions are expected in 2014, as discussed below in “Regulatory Trends and Uncertainties.” Rate changes for some Medicaid programs are slightly negative year-over-year. Unlike in prior years, recent Medicaid rate reductions have generally not been mitigated by corresponding benefit reductions or care provider fee schedule reductions by the state sponsor. We continue to take a prudent, market-sustainable posture for both new bids and maintenance of existing Medicaid contracts. We expect these factors to result in year-over-year pressure on gross margin percentages for our

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Medicare and Medicaid programs over the balance of 2013.

For 2013, UnitedHealthcare created a new affordable “Basic Plan” for Medicare Part D consumers and reclassified its large four million member Medicare Part D plan to an “Enhanced Plan” status with CMS. The Basic Plan achieves a lower price point principally through a narrower list of covered drugs. Under CMS regulations, Enhanced Plans are not deemed actuarially equivalent to the standard Part D plan design for risk-sharing purposes. The change to Enhanced Plan status therefore changes the seasonal pattern of revenue and earnings to later in the year with no material impact expected on full-year profitability.

Medical Cost Trends. We expect our 2013 commercial medical cost trend to be in the range of 5.5% plus or minus 50 basis points, with relatively consistent unit cost and utilization trends compared to 2012. We expect our total trend will be driven primarily by continued unit cost pressure from health care providers as they try to compensate for persistently lower government reimbursement levels. Health system utilization is increasing at a relatively consistent pace with the prior year, with utilization increases observed in outpatient services and offset by declining inpatient utilization. We expect full year 2013 pharmacy trends to be flat to slightly lower than in 2012. The primary drivers of prescription drug trends continue to be unit cost pressure and a shift towards expensive new specialty drugs. Overall, the recent weak economic environment, combined with our medical cost management, has had a favorable impact on utilization trends. We believe our alignment of progressive benefit designs, consumer engagement, clinical management, pay-for-performance reimbursement programs for care providers and network resources is favorably controlling medical and pharmacy costs, enhancing affordability and quality of health care for our customers and members.

Delivery System and Payment Modernization. The market is changing based on demographic shifts, new regulations, political forces and both payer and patient expectations. These factors are creating market pressures to change from fee-for-service delivery and payment arrangements to new delivery models focused on the holistic health of the consumer, integrated care across care providers and pay-for-performance payment structures. Health plans and care providers are being called upon to work together to close gaps in care and improve the overall care for people, improve the health of a population and reduce the cost of care. The focus on delivery system modernization and payment reform is critical and the alignment of incentives between key constituents remains an important theme. We are placing a greater emphasis on rewarding care providers for better care and lower costs. We have more than $20 billion of our reimbursements to hospitals, physicians, and ancillary care providers paid through contracts that link a portion of the reimbursement to quality and cost-efficiency measures; we expect the number of such contracts to increase significantly in the coming years as more care providers join the transition to accountable care contracts that reward quality and value-based health care.

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

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

States are struggling to balance budget pressures with increases in their Medicaid expenditures. At the same time, many states are expanding their interest in managed care with particular emphasis on consumers who have complex and expensive health care needs. Medicaid managed care is increasingly viewed as an effective method to improve quality and manage costs. There are more than nine million individuals eligible for both Medicare and Medicaid (known as dually eligible). Dually eligible beneficiaries typically have complex conditions, with costs of care that are far higher than those of a typical Medicare or Medicaid beneficiary. While these individuals’ health needs are more complex and more costly, they have historically been in unmanaged environments. This provides UnitedHealthcare an opportunity to work with governments to integrate Medicare and Medicaid financing to fund efforts to optimize the

health status of this frail population through close coordination of care. As of June 30, 2013, UnitedHealthcare served more than 250,000 members in legacy dually eligible programs through Medicare Advantage and Special Needs Plans. In the first half of 2014, UnitedHealthcare Community & State plans to help implement Integrated Medicare-Medicaid Eligible (MME) programs in two states.

Regulatory Trends and Uncertainties

Following is a summary of management’s view of the trends and uncertainties related to some of the key provisions of the Health Reform Legislation and other regulatory items; for additional information regarding the Health Reform Legislation and regulatory trends and uncertainties, see Item 1, “Business - Government Regulation” and Item 1A, “Risk Factors” in our 2012 10-K.

Medicare Advantage Rates and Minimum Loss Ratios. Medicare Advantage payment benchmarks have been cut over the last several years, including 2013, with additional funding reductions to be phased-in over the next two to four years. Further, on April 1, 2013, CMS released its final notice of 2014 Medicare Advantage benchmark rates and payment policies. The final notice includes significant reductions to 2014 Medicare Advantage payments, including the benchmark reductions described previously. These reductions and the Health Reform Legislation insurance industry tax described below result in revenue reductions and incremental assessments totaling more than 4% in 2014, against a typical industry forward medical cost trend outlook of 3%. Additionally, Congress passed the Budget Control Act of 2011, which as amended by the American Taxpayer Relief Act of 2012, triggered automatic across-the-board budget cuts (known as sequestration), including a 2% reduction in Medicare Advantage and Medicare Part D payments beginning April 1, 2013. The impact of sequestration cuts to our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service reimbursement rates. We estimate that sequestration, which began in April 2013, will result in a net decrease to our consolidated pre-tax earnings in the range of $250 million to $300 million for the full year 2013. These factors will likely affect our plan benefit designs, market participation, growth prospects and earnings potential for our Medicare Advantage plans in 2014. In addition, beginning in 2014, Medicare Advantage plans will be required to have a minimum medical loss ratio of 85%.

On-going reductions to Medicare Advantage funding place continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we can and are making to partially offset these rate reductions. These adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the composition of our care provider network and the terms of our contracts with care providers, adjust members' benefits and decide on a county-by-county basis in which geographies to participate. These changes will impact the level of value our offerings provide to seniors and are likely to reduce both retention levels and slow the rate of new member sign-ups in 2014. The depth of the underfunding of these benefits is also causing us to exit certain plans and market areas for 2014 in which we currently serve approximately 150,000 Medicare Advantage beneficiaries.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on a plan’s star rating. The level of star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses. In addition, star ratings affect the amount of savings a plan has to generate to offer supplemental benefits, which ultimately may affect the plan’s revenue. The expanded stars bonus program is set to expire after 2014. In 2015, quality bonus payments will only be paid to 4 and 5 star plans compared to current bonuses that are available to qualifying plans rated 3 stars or higher. For the 2014 payment year, based on scoring released by CMS in October 2012, approximately 60% of our current Medicare Advantage members are enrolled in plans that will be rated 3.5 stars or higher and approximately 10% are enrolled in plans that will be rated 4 stars or higher. Updated scores, to be released in October 2013, will determine what portion of our Medicare Advantage membership will reside in 4 or 5 star plans and qualify for quality bonus payments in 2015. Although we are dedicating substantial resources to improving our quality scores and star ratings, if we are unable to significantly increase the level of membership in plans with a rating of 4 stars or higher for the 2015 payment year, our 2015 results of operations and cash flows could be adversely impacted.

We also may be able to mitigate the effects of reduced funding by increasing enrollment due, in part, to the increasing number of people eligible for Medicare in coming years. Compared with the second quarter of 2012, our 2013 Medicare Advantage membership has increased by 415,000 consumers, or 17%. Longer term, market wide decreases in the availability or relative quality of Medicare Advantage products may increase demand for other senior health benefits products such as our Medicare Supplement and Medicare Part D insurance offerings.

Industry Fees and Taxes. The Health Reform Legislation includes an annual, non-deductible insurance industry tax to be levied proportionally across the insurance industry for risk-based products, beginning January 1, 2014. The industry-wide amount of the annual tax is $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. For 2019 and beyond, the amount will be equal to the annual tax for the preceding year increased by the rate of premium growth for the preceding year. The annual tax will be allocated to each market

participant based on the ratio of the entity’s net premiums written during the preceding calendar year to the total health insurance industry’s net premiums written for any U.S. health risk-based products during the preceding calendar year, subject to certain exceptions. This tax will first be expensed and paid in 2014. However, because our policies are annual with varying beginning dates throughout the calendar year, for those policies that include a portion of 2014 coverage periods, we have included the tax and other Health Reform Legislation cost factors, wherever possible, proportionally in our 2013 rate filings; any related premium increases will increase the amount of premium recognized in 2013. Our effective income tax rate will increase significantly in 2014 as a result of the non-deductibility of these taxes.

With the introduction of state health insurance exchanges in 2014, the Health Reform Legislation includes three programs designed to stabilize the health insurance markets. These programs are: a transitional reinsurance program; a temporary risk

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corridors program; and a permanent risk adjustment program. The transitional reinsurance program is a temporary program that will be funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements ($25 billion over a three-year period beginning in 2014 of which $20 billion, subject to increases based on state decisions, will fund the state reinsurance pools and $5 billion will fund the U.S. Treasury). While funding for the reinsurance program will come from all commercial lines of business, only non-grandfathered individual business will be eligible for reinsurance recoveries.

Commercial Rate Increase Review. The Health Reform Legislation requires the U.S. Department of Health and Human Services (HHS) to maintain an annual review of “unreasonable” increases in premium rates for commercial health plans. HHS established a review threshold of annual premium rate increases generally at or above 10% and enacted a new rule requiring the production of information regarding any proposed rate increase (whether or not in excess of 10% annually). HHS review does not supersede existing state review and approval procedures. Premium rate review legislation (ranging from new or enhanced rate filing requirements to prior approval requirements) has been introduced or passed in more than half of the states.

The competitive forces common in our markets do not support unjustifiable rate increases. We have experienced and expect to continue to experience a tight, competitive commercial pricing environment. Further, our rates and rate filings are developed using methods consistent with the standards of actuarial practices. We have requested rate increases above 10% in a number of markets due to the combination of medical cost trends and the incremental costs of health care reform. We have begun to experience greater regulatory challenges to appropriate premium rate increases in several states, including California and New York. Depending on the level of scrutiny of our proposed rate increases by the states and HHS, we may experience a broad range of potential business impacts. For example, it may become more difficult for us to price our commercial risk-based business consistent with expected underlying cost trends, leading to the risk of operating margin compression in the commercial health benefits business.

State-Based Exchanges and Coverage Expansion. Effective in 2014, state-based exchanges are required to be established for individuals and small employers, with enrollment processes scheduled to commence in October 2013. We expect to respond and participate selectively in exchanges as they are introduced to the market. Our level of participation in state-based exchanges will be driven by how we assess each local market’s current and future prospects, including how the exchange and its rules are set up state-by-state and our market position relative to others in the market. We currently expect to participate in about 12 exchanges between the individual and small group exchange categories in 2014. Our participation will likely evolve over time as the exchange markets mature. Exchanges will create new market dynamics that could impact our existing businesses, depending on the ultimate member migration patterns for each market, the pace of migration in the market and the impact of the migration on our established membership. For example, certain small employers may no longer offer health benefits to their employees and some employers purchasing full risk products could convert to self-funded programs.

The Health Reform Legislation also provides for expanded Medicaid coverage effective in January 2014. These measures remain subject to implementation at the state level.

Individual & Small Group Market Reforms. The Health Reform Legislation includes several provisions that will take effect on January 1, 2014 and are expected to alter the individual and small group marketplace. In early 2013, HHS released new rules implementing key provisions of the Health Reform Legislation that address, among other matters: (1) adjusted community rating requirements, which will change how individual and small group plans are rated in many states and are expected to result in significant adjustments in some policyholders' rates; (2) essential health benefit requirements, which will result in benefit changes for many individual and small group policyholders and will also impact rates; and (3) actuarial value requirements, which will significantly impact benefit designs in the individual market, such as member cost sharing requirements, and could also significantly impact rates for many individual and some small group policyholders. We are assessing the impact of these rules to the individual and small group marketplace and working with state regulators to complete rate filings and approvals as needed.

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RESULTS SUMMARY

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

(in millions, except percentages and per share data)	Three Months Ended June 30, 2013	Three Months Ended June 30, 2012	Increase/(Decrease) 2013 vs. 2012		Six Months Ended June 30, 2013	Six Months Ended June 30, 2012	Increase/(Decrease) 2013 vs. 2012	
Revenues:								
Premiums	$27,220	$24,609	$2,611	11 %	$54,494	$49,240	$5,254	11 %
Services	2,244	1,800	444	25	4,356	3,591	765	21
Products	749	678	71	10	1,500	1,366	134	10
Investment and other income	195	178	17	10	398	350	48	14
Total revenues	30,408	27,265	3,143	12	60,748	54,547	6,201	11
Operating costs:								
Medical costs	22,173	20,013	2,160	11	44,742	39,952	4,790	12
Operating costs	4,825	4,080	745	18	9,439	8,176	1,263	15
Cost of products sold	669	620	49	8	1,351	1,254	97	8
Depreciation and amortization	340	326	14	4	676	622	54	9
Total operating costs	28,007	25,039	2,968	12	56,208	50,004	6,204	12
Earnings from operations	2,401	2,226	175	8	4,540	4,543	(3)	—
Interest expense	(176)	(153)	23	15	(354)	(301)	53	18
Earnings before income taxes	2,225	2,073	152	7	4,186	4,242	(56)	(1)
Provision for income taxes	(789)	(736)	53	7	(1,510)	(1,517)	(7)	—
Net earnings	1,436	1,337	99	7	2,676	2,725	(49)	(2)
Less earnings attributable to noncontrolling interest	—	—	—	nm	(48)	—	(48)	nm
Net earnings attributable to UnitedHealth Group common shareholders	$1,436	$1,337	$99	7 %	$2,628	$2,725	$(97)	(4)%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$1.40	$1.27	$0.13	10 %	$2.56	$2.59	$(0.03)	(1)%
Medical care ratio (a)	81.5 %	81.3 %	0.2 %		82.1 %	81.1 %	1.0 %	
Operating cost ratio	15.9	15.0	0.9		15.5	15.0	0.5	
Operating margin	7.9	8.2	(0.3)		7.5	8.3	(0.8)	
Tax rate	35.5	35.5	—		36.1	35.8	0.3	
Net margin	4.7	4.9	(0.2)		4.4	5.0	(0.6)	
Return on equity (b)	18.2 %	18.4 %	(0.2)%		16.7 %	18.9 %	(2.2)%	

nm= not meaningful

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

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

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

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

- Consolidated revenues increased by 12%, UnitedHealthcare revenues increased by 11% and Optum revenues grew by 21%.
- UnitedHealthcare medical enrollment grew by 9.1 million people, including 4.7 million people served internationally, primarily in Brazil, and 2.9 million military beneficiaries through the TRICARE contract.
- Medicare Part D stand-alone membership increased by 570,000 people.
- The consolidated medical care ratio of 81.5% increased 20 basis points.
- Earnings from operations decreased 2% at UnitedHealthcare and increased 68% at Optum.
- We acquired all of Amil’s remaining public shares for $1.5 billion.
- As of June 30, 2013, there was $1.2 billion of cash available for general corporate use.
- The ratio of debt to debt-plus-equity decreased 160 basis points from March 31, 2013 to 34.6% at June 30, 2013.

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2013 RESULTS OF OPERATIONS COMPARED TO 2012 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues for the three and six months ended June 30, 2013 were primarily driven by 2012 acquisitions, growth in the number of individuals served through benefit products and overall growth in each of Optum's major businesses, partially offset by the conversion of 1.1 million risk-based members of our largest public sector client to a fee-based arrangement in the first quarter of 2013.

Medical Costs and Medical Care Ratio

Medical costs for the three and six months ended June 30, 2013 increased due to risk-based membership growth in our international and public and senior markets businesses, partially offset by the conversion of the large client discussed above. The medical care ratio for the six months ended June 30, 2013 increased primarily due to changes in business mix favoring governmental benefit programs, pressure in Medicare and Medicaid funding rates, decreased favorable medical cost development and the impact of favorable rebate true-ups in the first quarter of 2012.

Operating Costs

The increase in our operating costs for the three and six months ended June 30, 2013 was due to business growth, including an increase in fee-based benefits and fee-based service revenues, which carry comparatively higher operating costs, the impact of the Amil acquisition and investments in TRICARE, which were partially offset by the Company's on-going cost containment efforts.

Reportable Segments

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

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

See Note 10 of Notes to the Condensed Consolidated Financial Statements and Item 1, "Business" in our 2012 10-K for a description of how each of our reportable segments derives its revenues, including intersegment transactions.

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The following table presents reportable segment financial information:

	Three Months Ended June 30,		Increase/(Decrease)			Six Months Ended June 30,		Increase/(Decrease)		
(in millions, except percentages)	2013	2012	2013 vs. 2012			2013	2012	2013 vs. 2012		
Revenues										
UnitedHealthcare	$28,332	$25,516	$2,816	11	%	$56,611	$51,049	$5,562	11	%
OptumHealth	2,411	2,025	386	19		4,853	3,964	889	22	
OptumInsight	781	671	110	16		1,554	1,342	212	16	
OptumRx	5,647	4,605	1,042	23		10,843	9,326	1,517	16	
Total Optum	8,839	7,301	1,538	21		17,250	14,632	2,618		