UNITEDHEALTH GROUP INC
Form 10-K
February 12, 2019

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

Form 10-K

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

For the fiscal year ended December 31, 2018

or

[ ] 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)

Delaware	41-1321939
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
UnitedHealth Group Center 9900 Bren Road East Minnetonka, Minnesota	55343
(Address of principal executive offices)	(Zip Code)

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

_____

Securities registered pursuant to Section 12(b) of the Act:	
COMMON STOCK, $.01 PAR VALUE	NEW YORK STOCK EXCHANGE, INC.
(Title of each class)	(Name of each exchange on which registered)

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

_____

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes [X] No [ ]
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes [ ] No [X]
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes [X] No [ ]

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes [X] No [ ]

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

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

Large accelerated filer [X] Accelerated filer [ ] Non-accelerated filer [ ]

Smaller reporting company [ ] Emerging growth company [ ]

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. [ ]

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

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2018 was $234,490,429,732 (based on the last reported sale price of $245.34 per share on June 30, 2018, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2019, there were 959,538,515 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2019 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

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

Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes the provision of health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

Through UnitedHealthcare and Optum, in 2018, we processed more than three-quarters of a trillion dollars in gross billed charges and we managed more than $250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

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

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

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

UnitedHealthcare utilizes Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1.3 million physicians and other health care professionals and more than 6,000 hospitals and other facilities.

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UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. UnitedHealthcare Employer & Individual provides access to medical services for 27 million people on behalf of our customers and alliance partners, including employer customers serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options, and offer a spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs, consumer education and other digital offerings.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products, which complement its service offerings by improving quality of care, engaging

consumers and providing cost-saving options. Consumers served by UnitedHealthcare Employer & Individual can access clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

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

- wellness programs;
- decision support;

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

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. Through its broad network, UnitedHealthcare Employer & Individual delivers dental, vision, hearing, life, transportation, critical illness and disability product offerings using an integrated approach in private and retail settings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 4.9 million people through its Medicare Advantage products as of December 31, 2018.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below that of traditional Medicare, while helping seniors live healthier lives. Through our HouseCalls program, nurse practitioners performed 1.5 million in-home preventive care visits in 2018 to address unmet care opportunities and close gaps in care. Our Navigate4Me program provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams

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to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2018, UnitedHealthcare enrolled 9.0 million people in the Medicare Part D programs, including 4.7 million individuals in the stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.9 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

Premium revenues from CMS represented 30% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2018, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and people without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families (TANF), Children's Health Insurance Programs (CHIP), Dual SNPs (DSNPs), Aged, Blind and Disabled and other federal, state and community health care programs. As of December 31, 2018, UnitedHealthcare Community & State participated in programs in 30 states and the District of Columbia, and served 6.5 million people; including 1 million people through Medicaid expansion programs in 15 states under the Patient Protection and Affordable Care Act (ACA).

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

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants that can affect people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only 50% of total Medicaid spending. UnitedHealthcare Community & State's business development

opportunities include entering fee-for-service markets converting to managed care, which represents a population of nearly 8 million people; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care. This expansion includes integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care; typically, the 5% who are most at risk drive over 50% of states' medical costs.

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UnitedHealthcare Global

UnitedHealthcare Global serves 6.2 million people with medical benefits, residing principally in Brazil, Chile, Colombia and Peru but also in more than 130 other countries. UnitedHealthcare Global owns and operates more than 300 hospitals, specialty centers, primary care and emergency services clinics in South America and Portugal. UnitedHealthcare Global provides a comprehensive range of health and mobilization capabilities and supports the health systems of individual nations with support for improving health care financing and delivery. Clients include multi-national and local businesses, governments and individual consumers around the world.

Global Markets. UnitedHealthcare Global serves local populations in select markets around the world, primarily in Brazil; Chile; Colombia; Peru; and Portugal, by touching nearly every aspect of health care and leveraging expertise in clinical care management and health care data to improve outcomes, raise quality and constrain costs.

In Brazil, Amil provides health benefits to 4.1 million people through a broad network of owned and affiliated clinics, hospitals and care providers. Dental benefits are also provided to 2.2 million people. Amil's members have access to a provider network of physicians and other health care professionals, hospitals, laboratories and diagnostic imaging centers. Americas Serviços Médicos offers health care delivery in Brazil through hospitals, ambulatory clinics and surgery centers to Amil members and consumers served by the external payer market.

Empresas Banmédica provides health benefits and health care services to 2.1 million people in Chile, Colombia and Peru through a network of owned and affiliated clinics, hospitals and care providers. Empresas Banmédica owns and operates hospitals, clinics and outpatient centers.

Lusíadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

Global Solutions. UnitedHealthcare Global includes other diversified global health services with a variety of offerings for international customers.

Optum

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

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers, health plans, and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight specializes in data and analytics and other health care information technology services, and delivers operational services and support; and
- OptumRx provides pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of 93 million unique individuals. OptumHealth enables population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health and by coordinating care for the most medically complex patients.

OptumHealth serves patients and care providers through its local ambulatory care services business and delivers care through a physician-led, patient-centric and data-driven organization comprised of more than 35,000 employed,

managed or contracted physicians. OptumHealth also enables care providers' transition from traditional, fee-for-service care delivery to performance-based delivery and payment models that improve the focus on patient health and outcomes, such as those emerging through

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accountable care organizations (ACOs) and local care provider partnerships. Through strategic partnerships, alliances and ownership arrangements, OptumHealth helps care providers adopt new approaches and technologies that improve the coordination of care across all providers involved in patient care. MedExpress' neighborhood care centers provide urgent and walk-in care services with a consumer-friendly approach and Surgical Care Affiliates' independent ambulatory surgical centers and surgical hospitals provide high-value surgical services at a substantially lower cost than a traditional in-patient hospital setting.

OptumServe provides a wide range of health services specifically tailored to active military and veterans and the agencies that support them.

OptumHealth serves people through population health services that meet both the preventive care and health intervention needs of consumers across the care continuum - physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OptumHealth engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.

Optum Financial Services, through Optum Bank, a wholly-owned subsidiary, serves consumers through 5.2 million health savings and other accounts approaching $10 billion in assets under management as of December 31, 2018. During 2018, Optum Bank processed nearly $160 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, digital payment systems.

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

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, the Department of Defense, the Veterans Administration and other federal procurement agencies).

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on technology, research and consulting and managed services that help improve the quality of care and drive greater efficiency in the health care system. Technology includes population health and risk analytics, administrative and clinical technology for claims editing, risk adjustment and payment integrity, health information and electronic data exchange and technology strategy and management. Research and consulting helps organizations reduce administrative costs and implement best practices to improve clinical performance. Managed services provides solutions such as revenue cycle management, risk analytics, payment integrity outsourcing and state Medicaid data and technology management. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2018 was $17.0 billion, of which $8.6 billion is expected to be realized within the next 12 months. The aggregate backlog includes $6.2 billion related to intersegment agreements. OptumInsight's aggregate backlog at December 31, 2017, was $15.0 billion. OptumInsight cannot provide any

assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

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

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OptumInsight believes it is well positioned to address the needs of four primary market segments: care providers (e.g., physicians and hospital systems), health plans, governments and life sciences companies.

Care Providers. Serving more than four out of five U.S. hospitals and more than 100,000 physicians, OptumInsight assists care providers in meeting their challenge to improve patient outcomes and care amid changing payment models and pressures. OptumInsight brings a broad array of solutions to help care providers meet these challenges, with particular focus on clinical performance and quality improvement, population health, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Health Plans. OptumInsight serves three out of four U.S. health plans through cost-effective, technology-enabled solutions that help them improve efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals, and build and manage strong networks of care.

Governments. OptumInsight provides services tailored to government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting.

Life Sciences. OptumInsight provides services to global life sciences companies. These companies look to OptumInsight for data, analytics and expertise in core areas of health economics and outcomes research, market access consulting, integrated clinical and health care claims data and informatics services, epidemiology and drug safety, and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to 65 million people in the United States through its network of more than 67,000 retail pharmacies, multiple home delivery, specialty and compounding pharmacies and through the provision of home infusion services. In 2018, OptumRx added capabilities in managing limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology as well as capabilities to serve the growing pharmacy needs of people with behavioral health and substance use disorders, particularly Medicare and Medicaid beneficiaries.

OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individual consumers through enhanced services, elevated clinical quality and cost trend management.

In 2018, OptumRx managed $91 billion in pharmaceutical spending, including $40 billion in specialty pharmaceutical spending.

OptumRx provides pharmacy care services to a number of health plans, including a substantial majority of UnitedHealthcare members, large national employer plans, unions and trusts and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

OptumRx offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner, which are designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that affect member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care, using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and members.

As of December 31, 2018, OptumRx operated four home delivery pharmacies in the United States, which provide patients with access to maintenance medications and enables OptumRx to manage clients' drug costs through operating efficiencies and economies of scale. As of December 31, 2018, OptumRx's specialty pharmacy operations included more than 70 specialty and infusion pharmacies located throughout the United States that are used for delivery of advanced medications to people with chronic or genetic diseases and disorders. OptumRx also operates community mental health facility pharmacies, which help align benefits, care management and pharmacy services for those living with complex, chronic medical and behavioral health issues.

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GOVERNMENT REGULATION

Our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

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

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust compliance.

The Tax Cuts and Jobs Act. In December 2017, the U.S. federal government enacted a tax bill (Tax Cuts and Jobs Act or Tax Reform). The Tax Cuts and Jobs Act changed existing United States tax law and included numerous provisions that affected our results of operations, financial position and cash flows. For instance, Tax Reform reduced the U.S. corporate income tax rate and changed business-related exclusions and deductions and credits.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposed requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extended parts of HIPAA privacy and security provisions to business associates; added federal data breach notification requirements for covered entities and business associates and reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthened enforcement and imposed higher financial penalties for HIPAA violations and, in certain cases, imposed criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

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ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by that state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

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

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and protected health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply

to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices that involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation.

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The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

OptumRx's businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery, specialty and compounding pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our home delivery, specialty and compounding pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery, specialty and compounding pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. Additionally, certain of our pharmacies that participate in programs for Medicare and state Medicaid providers are required to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affect both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards that impact PBM pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic

examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

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International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve, which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; sales, marketing and pricing. See Part I, Item 1A, “Risk Factors” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

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

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

EMPLOYEES

As of December 31, 2018, we employed 300,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 12, 2019, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	66	Executive Chair of the Board
David S. Wichmann	56	Chief Executive Officer
Steven H. Nelson	59	Executive Vice President; Chief Executive Officer of UnitedHealthcare
Andrew P. Witty	54	Executive Vice President; Chief Executive Officer of Optum
John F. Rex	56	Executive Vice President; Chief Financial Officer
Thomas E. Roos	46	Senior Vice President; Chief Accounting Officer
Marianne D. Short	67	Executive Vice President; Chief Legal Officer
D. Ellen Wilson	61	Executive Vice President; Chief Human Resources Officer

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Executive Chair of the Board of UnitedHealth Group and has served in that capacity since September 2017. Mr. Hemsley previously served as Chief Executive Officer from 2006 to August 2017. He has been a member of the Board of Directors since 2000.

Mr. Wichmann is Chief Executive Officer of UnitedHealth Group and a member of the Board of Directors and has served in that capacity since September 2017. Mr. Wichmann previously served as President of UnitedHealth Group from November 2014 to August 2017. Mr. Wichmann also served as Chief Financial Officer of UnitedHealth Group from January 2011 to June

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2016. From April 2008 to November 2014, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Nelson is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since August 2017. Mr. Nelson served as Chief Executive Officer of UnitedHealthcare's Medicare & Retirement, from March 2014 to August 2017. He served as Chief Executive Officer of UnitedHealthcare Community & State from August 2012 to March 2014. From January 2008 to July 2012 he served as President of UnitedHealthcare Community & State and then as Chief Executive Officer of UnitedHealthcare Employer & Individual's West Region business.

Mr. Witty is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2018. He previously served as a UnitedHealth Group director from August 2017 to March 2018. Prior to joining UnitedHealth Group, Mr. Witty was CEO and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex spent over a decade at JP Morgan, a global financial services firm, and its predecessors, concluding his tenure as a Managing Director.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

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

Ms. Wilson is Executive Vice President and Chief Human Resources Officer of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments, concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at www.unitedhealthgroup.com to learn more about our company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, on our website, 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 website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), 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: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words “believe,” “expect,”

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

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements 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 our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

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

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise nearly 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 products depends in large part on our ability to predict, price for and effectively manage medical costs. In addition, our OptumHealth business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer’s premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, or effectively price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts are typically based on a fixed monthly rate per individual served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2018 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2018 would have been reduced by approximately $305 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. Any such assessment could

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expose our insurance entities and other insurers to the risk that they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. For example, some of our UnitedHealthcare and Optum businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations that are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being considered, and we cannot predict if the ACA will be further modified or repealed or replaced. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part; and a federal district court struck down the ACA in its entirety as unconstitutional in 2018. That opinion has been stayed and appealed. Further, the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while the Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and enforcement of industry regulations that could differ from the

approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

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

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

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit. Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system that provides various quality bonus payments to Medicare Advantage plans that meet certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models that apply to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position

and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

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We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. For example, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and corporate integrity agreements. Additionally, such investigations, audits or reviews sometimes arise out of, or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

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

We routinely process, store and transmit large amounts of data in our operations, including protected personal information as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place that are intended to detect, contain and respond to data security incidents and that provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to anticipate these techniques or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause system shutdowns that could negatively affect our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise information security. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human error; malicious social engineering; or other events that could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

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

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

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information is regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA imposed further restrictions on our ability to collect, disclose and use protected personal information and imposed additional compliance requirements on our business.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect that there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union’s General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. The new regulation superseded

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prior European Union privacy and data protection legislation, imposed more stringent European Union data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, goes into effect in 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

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

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the FDA and Boards of Pharmacy. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine that fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

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

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger

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and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other health care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services that are useful and relevant to consumers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care usage, and we may face challenges from new technologies and market entrants that could affect our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

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

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

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a

reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

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

The success of some of our businesses, including OptumHealth and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or

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

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

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

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

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

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

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of

operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

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

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

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

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

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

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

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further,

unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

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

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2018. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could adversely affect our profitability and equity.

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There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

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

As of December 31, 2018, our goodwill and other intangible assets had a carrying value of $68 billion, representing 45% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the financial covenants in our bank credit facilities.

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

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

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

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

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

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

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information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

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

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

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

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Legal Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

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

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2019, there were 11,948 registered holders of record of our common stock.

DIVIDEND POLICY

In June 2018, our Board of Directors increased the Company's annual cash dividend rate to shareholders to $3.60 per share compared to $3.00 per share, which the Company had paid since June 2017. 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.

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ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2018, we repurchased 3.3 million shares at an average price of $256.15 per share. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock.

PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index, the S&P Health Care Index and the Dow Jones US Industrial Average Index for the five-year period ended December 31, 2018. We have also included the customized peer group of certain Fortune 50 companies that we have compared ourselves to in prior years. We believe that these indices provide a more meaningful comparison than the previous subset of the Fortune 50 given our diverse businesses. The comparisons assume the investment of $100 on December 31, 2013 in our common stock and in each index, and that dividends were reinvested when paid.

The Fortune 50 Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. We are not included in this Fortune 50 Group index. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the Fortune 50 Group companies are weighted according to the stock market capitalizations of the companies at January 1 of each year.

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	12/13	12/14	12/15	12/16	12/17	12/18
UnitedHealth Group	$100.00	$136.46	$161.37	$223.35	$312.29	$357.64
S&P Health Care Index	100.00	125.34	133.97	130.37	159.15	169.44
Dow Jones US Industrial Average	100.00	110.04	110.28	128.47	164.58	158.85
S&P 500 Index	100.00	113.69	115.26	129.05	157.22	150.33
Fortune 50 Group	100.00	105.33	108.75	123.33	126.45	103.96

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

ITEM 6. SELECTED FINANCIAL DATA

	For the Years Ended December 31,				
(in millions, except percentages and per share data)	2018	2017 (a)	2016	2015 (b)	2014
Consolidated operating results					
Revenues	$226,247	$201,159	$184,840	$157,107	$130,474
Earnings from operations	17,344	15,209	12,930	11,021	10,274
Net earnings attributable to UnitedHealth Group common shareholders	11,986	10,558	7,017	5,813	5,619
Return on equity (c)	24.4 %	24.4 %	19.4 %	17.7 %	17.3 %
Basic earnings per share attributable to UnitedHealth Group common shareholders	$12.45	$10.95	$7.37	$6.10	$5.78
Diluted earnings per share attributable to UnitedHealth Group common shareholders	12.19	10.72	7.25	6.01	5.70
Cash dividends declared per common share	3.45	2.875	2.375	1.875	1.405
Consolidated cash flows from (used for)					
Operating activities	$15,713	$13,596	$9,795	$9,740	$8,051
Investing activities	(12,385)	(8,599)	(9,355)	(18,395)	(2,534)
Financing activities	(4,365)	(3,441)	(1,011)	12,239	(5,293)
Consolidated financial condition (as of December 31)					
Cash and investments	$46,834	$43,831	$37,143	$31,703	$28,063
Total assets	152,221	139,058	122,810	111,254	86,300
Total commercial paper and long-term debt	36,554	31,692	32,970	31,965	17,324
Redeemable noncontrolling interests	1,908	2,189	2,012	1,736	1,388
Total equity	54,319	49,833	38,177	33,725	32,454

(a) Includes the impact of the revaluation of our net deferred tax liabilities due to Tax Reform enacted in December 2017.

(b) Includes the effects of the July 2015 acquisition of Catamaran Corporation (Catamaran) and related debt issuances.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

This selected financial data should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 7.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements and Supplementary Data." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding

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financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in data analytics and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

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 Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). 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, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform changes. The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A provision in the 2018 federal budget imposed a one year moratorium for 2019 on the collection of the Health Insurance Industry Tax. Pricing for contracts that cover a portion of calendar year 2019 reflected the impact of the moratorium. The industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted the competitive pricing environment.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties." We expect continued Medicaid revenue growth due to anticipated changes in mix and increases in the number of people we serve; we also believe that the payment rate environment creates the risk of downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term

viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care.

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Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider payment models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2018, we served nearly 17 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2018, our contracts with value-based elements totaled $74 billion in annual spending, including $18 billion through risk-transfer agreements.

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

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 ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business - Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2019 Medicare Advantage rates resulted in an increase in industry base rates of 3.4%, short of the industry forward medical cost trend, which creates continued pressure in the Medicare Advantage program.

The ongoing pressure on Medicare Advantage funding places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums that supplement the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

As Medicare Advantage payments change, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products, such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

Tax Reform. Tax Reform was enacted by the U.S federal government in December 2017, changing existing United States tax law, including reducing the U.S. corporate income tax rate. In 2018, the impact of Tax Reform was partially offset by the return of the nondeductible Health Insurance Industry Tax.

Health Insurance Industry Tax. After a moratorium in 2017, the industry-wide amount of the Health Insurance Industry Tax in 2018 was $14.3 billion, with our portion being $2.6 billion. The return of the tax impacted year-over-year comparability of our financial results, including revenues, the medical care ratio (MCR), operating cost ratio and effective tax rate. A one year moratorium is imposed on the collection of the Health Insurance Industry Tax in 2019.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2018 year-over-year operating comparisons to 2017.

- Consolidated revenues increased by 12%, UnitedHealthcare revenues increased 12% and Optum revenues grew 11%.
- UnitedHealthcare's addition of 2.2 million people through acquisition and 250,000 through organic growth was offset by 2.9 million fewer people served as a result of completion of its commitment under the TRICARE military health

care program.

- Earnings from operations increased by 14%, including increases of 7% at UnitedHealthcare and 23% at Optum.
- Diluted earnings per common share increased 14% to $12.19.
- Cash flows from operations were $15.7 billion, an increase of 16%.

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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)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
Revenues:							
Premiums	$178,087	$158,453	$144,118	$19,634	12%	$14,335	10 %
Products	29,601	26,366	26,658	3,235	12	(292)	(1)
Services	17,183	15,317	13,236	1,866	12	2,081	16
Investment and other income	1,376	1,023	828	353	35	195	24
Total revenues	226,247	201,159	184,840	25,088	12	16,319	9
Operating costs:							
Medical costs	145,403	130,036	117,038	15,367	12	12,998	11
Operating costs	34,074	29,557	28,401	4,517	15	1,156	4
Cost of products sold	26,998	24,112	24,416	2,886	12	(304)	(1)
Depreciation and amortization	2,428	2,245	2,055	183	8	190	9
Total operating costs	208,903	185,950	171,910	22,953	12	14,040	8
Earnings from operations	17,344	15,209	12,930	2,135	14	2,279	18
Interest expense	(1,400)	(1,186)	(1,067)	(214)	18	(119)	11
Earnings before income taxes	15,944	14,023	11,863	1,921	14	2,160	18
Provision for income taxes	(3,562)	(3,200)	(4,790)	(362)	11	1,590	(33)
Net earnings	12,382	10,823	7,073	1,559	14	3,750	53
Earnings attributable to noncontrolling interests	(396)	(265)	(56)	(131)	49	(209)	373
Net earnings attributable to UnitedHealth Group common shareholders	$11,986	$10,558	$7,017	$1,428	14%	$3,541	50 %
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$12.19	$10.72	$7.25	$1.47	14%	$3.47	48 %
Medical care ratio (a)	81.6 %	82.1 %	81.2 %	(0.5)%		0.9 %	
Operating cost ratio	15.1	14.7	15.4	0.4		(0.7)	
Operating margin	7.7	7.6	7.0	0.1		0.6	
Tax rate	22.3	22.8	40.4	(0.5)		(17.6)	
Net earnings margin (b)	5.3	5.2	3.8	0.1		1.4	
Return on equity (c)	24.4 %	24.4 %	19.4 %	— %		5.0 %	

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

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2018 RESULTS OF OPERATIONS COMPARED TO 2017 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by the increase in the number of individuals served through risk-based products across our UnitedHealthcare benefits businesses; pricing trends, including the Health Insurance Industry Tax in 2018; and growth across the Optum business, primarily due to expansion and growth in care delivery, pharmacy

care services, managed services and advisory services.

Medical Costs and MCR

Medical costs increased due to growth in people served through risk-based products and medical cost trends. The MCR decreased due to the revenue effects of the Health Insurance Industry Tax, which more than offset business mix changes and a lower level of favorable reserve development.

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Reportable Segments

See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more information on our segments. The following table presents a summary of the reportable segment financial information:

	For the Years Ended December 31,			Change		Change	
(in millions, except percentages)	2018	2017	2016	2018 vs. 2017		2016 vs. 2015	
Revenues							
UnitedHealthcare	$183,476	$163,257	$148,581	$20,219	12%	$14,676	10%
OptumHealth	24,145	20,570	16,908	3,575	17	3,662	22
OptumInsight	9,008	8,087	7,333	921	11	754	10
OptumRx	69,536	63,755	60,440	5,781	9	3,315	5
Optum eliminations	(1,409)	(1,227)	(1,088)	(182)	15	(139)	13
Optum	101,280	91,185	83,593	10,095	11	7,592	9
Eliminations	(58,509)	(53,283)	(47,334)	(5,226)	10	(5,949)	13
Consolidated revenues	$226,247	$201,159	$184,840	$25,088	12%	$16,319	9 %
Earnings from operations							
UnitedHealthcare	$9,113	$8,498	$7,307	$615	7 %	$1,191	16%
OptumHealth	2,430	1,823	1,428	607	33	395	28
OptumInsight	2,243	1,770	1,513	473	27	257	17
OptumRx	3,558	3,118	2,682	440	14	436	16
Optum	8,231	6,711	5,623	1,520	23	1,088	19
Consolidated earnings from operations	$17,344	$15,209	$12,930	$2,135	14%	$2,279	18%
Operating margin							
UnitedHealthcare	5.0 %	5.2 %	4.9 %	(0.2)%		0.3 %	
OptumHealth	10.1	8.9	8.4	1.2		0.5	
OptumInsight	24.9	21.9	20.6	3.0		1.3	
OptumRx	5.1	4.9	4.4	0.2		0.5	
Optum	8.1	7.4	6.7	0.7		0.7	
Consolidated operating margin	7.7 %	7.6 %	7.0 %	0.1 %		0.6 %	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

	For the Years Ended December 31,			Change	Change
(in millions, except percentages)	2018	2017	2016	2018 vs. 2017	2017 vs. 2016