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

Form 10-K

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

For the fiscal year ended December 31, 1999

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 1-5975

HUMANA INC.
(Exact Name of registrant as specified in its charter)

Delaware	**61-0647538**
(State of incorporation)	**(I.R.S. Employer Identification Number)**
500 West Main Street Louisville, Kentucky	**40202**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: 502-580-1000

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

Title of each class	Name of each exchange on which registered
Common Stock, $0.16 2/3 par value	New York Stock Exchange

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

None

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

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

The aggregate market value of voting stock held by non-affiliates of the Registrant as of March 1, 2000 was $1,145,376,612 calculated using the average price on such date of $7.25. The number of shares outstanding of the Registrant's Common Stock as of March 1, 2000 was 167,752,710.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of Part II and Part IV incorporate herein by reference the Registrant's 1999 Annual Report to Stockholders; Part III incorporates herein by reference portions of the Registrant's Proxy Statement filed pursuant to Regulation 14A covering the Annual Meeting of Stockholders scheduled to be held May 18, 2000.

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PART I

ITEM 1. BUSINESS

General

Humana Inc. is a Delaware corporation organized in 1961. Its principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202 and its telephone number at that address is (502) 580-1000. As used herein, the terms the "Company" or "Humana" include Humana Inc. and its subsidiaries. This Annual Report on Form 10-K contains both historical and forward-looking information. The forward-looking statements may be significantly impacted by risks and uncertainties and are made pursuant to the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. There can be no assurance that anticipated future results will be achieved because actual results may differ materially from those projected in the forward-looking statements. Readers are cautioned that a number of factors, which are described herein, could adversely affect the Company 's ability to obtain these results. These include the effects of either federal or state health care reform or other legislation, including the *Patients' Bill of Rights Act*, any changes in the Medicare reimbursement system, the ability of health care providers (including physician practice management companies) to comply with current contract terms, renewal of the Company's Medicare contracts with the federal government, renewal of the Company's contract with the federal government to administer the TRICARE program and renewal of the Company 's Medicaid contracts with various state governments and the Health Insurance Administration in Puerto Rico. Such factors also include the effects of other general business conditions, including but not limited to, the success of the Company's improvement initiatives including its electronic business strategies, premium rate and yield changes, retrospective premium adjustments relating to federal government contracts, changes in commercial and Medicare HMO membership, medical and pharmacy cost trends, compliance with debt covenants, changes in the Company's debt rating and its ability to borrow under its commercial paper program, operating subsidiary capital requirements, competition, general economic conditions and the retention of key employees. In addition, the Company and the managed care industry as a whole are experiencing increased litigation, including alleged class action suits challenging various managed care practices and suits seeking significant punitive damages awards. (See *Legal Proceedings* section for a description of the Company's significant litigation.) Past financial performance is not necessarily a reliable indicator of future performance and investors should not use historical performance to anticipate results or future period trends.

Since 1983, the Company has been a health services company that facilitates the delivery of health care services through networks of providers to its approximately 5.9 million medical members. The Company's products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracted providers. HMOs and PPOs control health care costs by various means, including pre-admission approval for hospital inpatient services, pre-authorization of outpatient surgical procedures and risk-sharing arrangements with providers. These providers may share medical cost risk or have incentives to deliver quality medical services in a cost-effective manner. The Company also offers various specialty products to employers, including dental, group life and workers' compensation, and administrative services ("ASO") to those who self-insure their employee health plans. The Company has entered into a definitive agreement to sell its workers' compensation business. In total, the Company 's products are licensed in 49 states, the District of Columbia and Puerto Rico, with approximately 20 percent of its membership in the state of Florida.

Acquisitions and Dispositions

Between December 30, 1999 and February 4, 2000, the Company entered into definitive agreements to sell its workers' compensation, Medicare supplement and North Florida Medicaid businesses for proceeds of approximately $115 million. The Company recorded a $118 million loss in 1999 related to these sale transactions.

On January 31, 2000, the Company acquired the Memorial Sisters of Charity Health Network ("MSCHN"), a Houston based health plan for approximately $50 million in cash.

On June 1, 1999, the Company reached an agreement with FPA Medical Management, Inc. ("FPA"), FPA 's lenders and a federal bankruptcy court under which the Company acquired the operations of 50 medical centers from FPA for approximately $14 million in cash. The Company has subsequently reached agreements with 14 provider groups to assume operating responsibility for 38 of the 50 acquired FPA medical centers under long-term provider agreements with the Company.

On October 17, 1997, the Company acquired ChoiceCare Corporation ("ChoiceCare") for approximately $250 million in cash. The purchase was funded with borrowings under the Company's commercial paper program. ChoiceCare provided health services products to members in the Greater Cincinnati, Ohio, area.

On September 8, 1997, the Company acquired Physician Corporation of America ("PCA") for total consideration of $411 million in cash, consisting primarily of $7 per share for PCA's outstanding common stock and the assumption of $121 million in debt. The purchase was funded with borrowings under the Company's commercial paper program. PCA provided comprehensive health services through its HMOs in Florida, Texas and Puerto Rico. In addition, PCA provided workers ' compensation third-party administrative management services. Prior to November 1996, PCA also was a direct writer of workers' compensation insurance in Florida. Long-term medical and other expenses payable in the accompanying Consolidated Balance Sheets includes the long-term portion of workers' compensation liabilities related to this business.

On February 28, 1997, the Company acquired Health Direct, Inc. ("Health Direct") from Advocate Health Care for approximately $23 million in cash.

Business Segments

During 1999, the Company realigned its organization to achieve greater accountability in its lines of business. As a result of this realignment, the Company organized into two business units: the Health Plan segment and the Small Group segment. The Health Plan segment includes the Company's large group commercial (100 employees and over), Medicare, Medicaid, ASO, workers' compensation and military or TRICARE business. The Company has entered into a definitive agreement to sell its workers' compensation business. The Small Group segment includes small group commercial (under 100 employees) and specialty benefit lines, including dental, life and short-term disability. Results of each segment are measured based upon results of operations before income taxes. The Company allocates administrative expenses, interest income and interest expense, but no assets, to the segments. Members served by the two segments generally utilize the same medical provider networks, enabling the Company to obtain more favorable contract terms with providers. As a result, the profitability of each segment is somewhat interdependent. In addition, premium revenue pricing to large group commercial employers has historically been more competitive than that to small group commercial employers, resulting in less favorable underwriting margins for the large group commercial line of business. Costs to distribute and administer products to small group commercial employers are higher compared to large group commercial employers resulting in small group's higher administrative expense ratio.

The following table presents the Company's segment membership and premium revenues by product for the year ended December 31, 1999:

(Dollars in millions)	Ending Medical Membership	Ending Specialty Membership	Premium Revenues	Percent of Total Premium Revenues
Health Plan:				
Large group commercial	1,420,500		$2,348	23.6%
Medicare HMO	488,500		2,920	29.3
Medicaid	616,600		603	6.1
TRICARE	1,058,000	29,800	866	8.7
ASO, workers' compensation and Medicare supplement	692,500	447,100	90	0.9
Total Health Plan	4,276,100	476,900	6,827	68.6
Small Group:				
Small group commercial	1,663,100		2,882	28.9
Specialty		2,484,400	250	2.5
Total Small Group	1,663,100	2,484,400	3,132	31.4
Total	5,939,200	2,961,300	$9,959	100.0%

Large and Small Group Commercial HMO and PPO Products

HMO

An HMO facilitates the delivery of prepaid health care services to its members through a network of independent primary care physicians, specialty physicians and other health care providers who contract with the HMO to furnish such services. Primary care physicians generally include internists, family practitioners and pediatricians. Generally, access to specialty physicians and other health care providers must be approved by the member's primary care physician. These other health care providers include, among others, hospitals, nursing homes, home health agencies, pharmacies, mental health and substance abuse centers, diagnostic centers, optometrists, outpatient surgery centers, dentists, urgent care centers and durable medical equipment suppliers. Because access to these specialty physicians and other health care providers must generally be approved by the primary care physician, the HMO product is the most restrictive form of managed care.

As of March 1, 2000, the Company owned and operated 13 licensed and active HMOs, which contracted with approximately 62,600 physicians (including approximately 21,100 primary care physicians) and approximately 940 hospitals. In addition, the Company had approximately 5,100 contracts with other health care providers to provide services to HMO members.

An HMO member, typically through the member's employer, pays a monthly fee which generally covers, with minimal co-payments, health care services received from or approved by the member's primary care physician. For the year ended December 31, 1999, commercial HMO premium revenues totaled approximately $2.2 billion or 23 percent of the Company's total premium revenues. Approximately $234 million of the Company's commercial HMO premium revenues for the year ended December 31, 1999 were derived from contracts with the United States Office of Personnel Management ("OPM"), under which the Company facilitates the delivery of health care services through the Federal Employee Health Benefit Plan ("FEHBP") to approximately 135,200 federal civilian employees and their dependents. Pursuant to these contracts, payments made by OPM may be retrospectively adjusted downward by OPM if an audit discloses that a comparable product was offered by the Company to a similar size subscriber group at a lower premium rate than that offered to OPM.

Management believes that any retrospective adjustments as a result of OPM audits will not have a material impact on the Company's financial position, results of operations or cash flows.

PPO

PPO products include many elements of managed health care. PPOs are also similar to traditional health insurance because they provide a member with the freedom to choose a physician or other health care provider. In a PPO, the member is encouraged, through financial incentives, to use participating health care providers which have contracted with the PPO to provide services at favorable rates. In the event a member chooses not to use a participating health care provider, the member may be required to pay a greater portion of the provider 's fees.

As of March 1, 2000, approximately 397,000 physicians and approximately 3,400 hospitals contracted directly with the Company to provide services to PPO members (including the ChoiceCare Network described below). The Company also had approximately 5,000 contracts (including certain contracts which also service the Company 's HMOs) with other providers to provide services to PPO members. In addition, the Company had access to 24 leased provider networks throughout the country. During 1999, the Company assumed the operational control of a previously leased provider network. This new provider network called the ChoiceCare Network added approximately 330,000 physicians and other providers as well as 2,500 hospitals to the Company's PPO networks.

For the year ended December 31, 1999, commercial PPO premium revenues totaled approximately $3.0 billion or 30 percent of the Company's total premium revenues.

The Company expects that 2000 commercial HMO and PPO premium rates will increase by approximately 10 to 12 percent. Over the last five years, changes in the Company's commercial HMO and PPO premium rates have ranged between an approximate two percent decrease for the year ended December 31, 1995, to an approximate six percent increase for the year ended December 31, 1999, with an average increase of approximately three percent.

Medicare Products

Medicare is a federal program that provides persons age 65 and over and some disabled persons certain hospital and medical insurance benefits, which include hospitalization benefits for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Each Medicare-eligible individual is entitled to receive inpatient hospital care ("Part A") without the payment of any premium, but is required to pay a premium to the federal government, which is adjusted annually, to be eligible for physician care and other services ("Part B ").

Even though participating in both Part A and Part B of the traditional Medicare program, beneficiaries are still required to pay certain deductible and coinsurance amounts. They may, if they choose, supplement their Medicare coverage by purchasing Medicare supplement policies which pay these deductibles and coinsurance amounts. Many of these policies also cover other services (such as prescription drugs) which are not included in Medicare coverage.

Medicare HMO

Humana contracts with the federal government's Health Care Financing Administration ("HCFA") under the Medicare+Choice ("M+C") program, to facilitate the delivery of medical benefits in exchange for a fixed monthly payment per member for Medicare-eligible individuals residing in the geographic areas in which its HMOs operate. Individuals who elect to participate in these Medicare programs are relieved of the obligation to pay some or all of the deductible or coinsurance amounts but are generally required to use exclusively the services provided by the HMO and are required to pay a Part B premium to the Medicare program. Generally, the enrollee pays the HMO a premium only in cases where the HMO provides additional benefits and where competitive market conditions permit. At December 31, 1999, approximately 48,000 members in six markets were paying premiums, which totaled approximately $30 million for the year ended December 31, 1999. In January 2000, the Company instituted member premiums in additional markets to offset the effect of lower HCFA reimbursement rates. During 2000, approximately 229,000 Medicare HMO members in ten markets, or approximately one-half of the Company's entire Medicare HMO membership, will be paying premiums totaling approximately $73 million.

A Medicare HMO product involves a contract between an HMO and HCFA pursuant to which HCFA makes a fixed monthly payment to the HMO on behalf of each Medicare-eligible individual who chooses to enroll for coverage in the HMO. Membership may be terminated by the member at any time during the month. The fixed monthly payment is determined by formula established by federal law.

As of March 1, 2000, the Company facilitates the delivery of Medicare HMO services under eight contracts with HCFA in nine states. HCFA contracts covered approximately 488,500 Medicare HMO members for which the Company received premium revenues of approximately $2.9 billion or 29 percent of the Company's total premium revenues for 1999. At December 31, 1999, one such HCFA contract covered approximately 250,000 members in Florida and accounted for premium revenues of approximately $1.5 billion, which represented 51 percent of the Company 's HCFA premium revenues or 15 percent of the Company's total premium revenues for the year ended December 31, 1999. HCFA contracts are renewed for a one-year term each January 1 unless terminated 90 days prior thereto. Management believes termination of the HCFA contract covering the members in Florida would have a material adverse effect on the Company 's financial position, results of operations or cash flows.

Future premiums from HCFA will be impacted by new payment methods being developed by HCFA as more fully discussed in the *Health Care Reform —National* section. The Company 's 2000 average rate of statutory increase under the HCFA contracts is approximately two percent. Over the last five years, annual increases have ranged from as low as the January 1999 increase of two percent to as high as nine percent in January 1996, with an average of approximately five percent. On January 1, 2000, the Company exited 31 counties affecting approximately 46,000 members resulting, in part, from lower HCFA reimbursement rates. The Company intends to offset the effect of lower HCFA reimbursement rates with the introduction of member premiums, benefit changes and pursue expansion opportunities only in markets that meet the Company's long-term growth strategies.

The loss of the Company's HCFA contracts or significant changes in the Medicare HMO program as a result of legislative action, including reductions in payments or increases in benefits without corresponding increases in payments, would have a material adverse effect on the Company's financial position, results of operations or cash flows.

Medicare Supplement

On December 30, 1999, the Company reached agreement, subject to regulatory approvals, to transfer substantially all of the Company's 44,500 Medicare supplement policies to United Teachers Associates Insurance Company. These policies paid for hospital deductibles, co-payments and coinsurance for which an individual enrolled in the traditional Medicare program is responsible. For the year ended December 31, 1999, Medicare supplement premium revenues totaled approximately $60 million or 1 percent of the Company's total premium revenues.

Medicaid Product

Medicaid is a federal program that is state-operated to facilitate the delivery of health care services to low-income residents. Each state which chooses to do so develops, through a state specific regulatory agency, a Medicaid managed care initiative which must be approved by HCFA. HCFA requires that Medicaid managed care plans meet federal standards and cost no more than the amount that would have been spent on a comparable fee-for-service basis. States currently use either a formal proposal process reviewing many bidders or award individual contracts to qualified bidders, which apply for entry to the program. In either case, the contractual relationship with the state is generally for a one-year period. Management believes that the risks associated with participation in a state Medicaid managed care program are similar to the risks associated with the Medicare HMO product discussed previously. In both instances, the Company receives a fixed monthly payment from a government agency for which it is required to facilitate the delivery of managed health care services to enrolled members. Due to the increased emphasis on state health care reform and budgetary constraints, more states are utilizing a managed care product in their Medicaid programs.

In 1999, the Company renewed a two-year contract with the Health Insurance Administration of Puerto Rico to facilitate the delivery of health care to Medicaid-eligible individuals. On February 4, 2000, the Company entered into a definitive agreement, subject to regulatory approvals, to sell its North Florida Medicaid business covering approximately 94,000 Medicaid members to Well Care HMO, Inc. For the year ended December 31, 1999, premium revenues from the Company's Medicaid products totaled approximately $603 million or 6 percent of the Company's total premium revenues. At December 31, 1999, the Company had approximately 410,400 and 206,200 Medicaid members in the Commonwealth of Puerto Rico and in four states, respectively.

TRICARE

In 1993, the Company established Humana Military Healthcare Services, Inc. (a wholly owned subsidiary of the Company), to enter into contracts to facilitate the delivery of managed care services to the dependents of active duty military personnel and retired military personnel and their dependents. In November 1995, the United States Department of Defense awarded the Company its first TRICARE contract covering approximately 1.1 million eligible beneficiaries in Florida, Georgia, South Carolina, Mississippi, Alabama, Tennessee and Eastern Louisiana.

On July 1, 1996, the Company began facilitating the delivery of managed health care services to these approximate 1.1 million eligible beneficiaries under a potential five-year contract (a one-year contract renewable annually for one additional year). The government exercised its option to renew the contract for the year beginning July 1, 1999. The Company anticipates the government exercising its option for the year beginning July 1, 2000 which will be the fifth year of the five-year contract period. The Company is in discussion with the government concerning two additional one-year renewal periods, however, the Company is unable to predict if such an extension will be granted. The Company has subcontracted with third parties to provide certain administration and specialty services under the contract. Three health benefit options are available to TRICARE beneficiaries. In addition to a traditional indemnity option, participants may enroll in an HMO-like plan with a point-of-service option or take advantage of reduced co-payments by using a network of preferred providers. TRICARE premium revenues were approximately $866 million or 9 percent of the Company's total premium revenues for the year ended December 31, 1999.

The Company will actively seek opportunities to facilitate the delivery of managed care services to beneficiaries of federal and state programs, including other TRICARE contracts.

Other Related Products

The Company offers various specialty products to employers, including dental, group life and workers ' compensation, and administrative services ("ASO") to those who self-insure their employee health plans. The Company has entered into a definitive agreement to sell its workers' compensation business. Specialty and ASO membership at December 31, 1999 totaled approximately 3.0 million members and 648,100 members, respectively. Specialty product premium revenues were approximately $277 million or 3 percent of the Company's total premiums for the year ended December 31, 1999.

Provider Arrangements

In certain situations, the Company 's HMOs contract with individual or groups of primary care physicians, generally for an actuarially determined, fixed, per-member-per-month fee referred to as a "capitation" payment. Under these arrangements, physicians are paid a fixed amount to provide services to their members. These contracts typically obligate primary care physicians to provide or make referrals to specialty physicians and other providers for the provision of all covered managed health care services to HMO members. The capitation payment does not vary with the nature or extent of services to the member and is generally designed to shift a portion of the HMOs financial risk to the primary care physician. The degree to which the Company uses capitation arrangements varies by provider.

The Company also contracts with medical specialists and other providers to which a primary care physician may refer a member. The contracts with specialists may be capitation arrangements or may provide for payment on a fee-for-service basis based on negotiated fees. Typically, payments by the Company to these specialists and other providers reduce the ultimate payment that otherwise would be made to primary care physicians. The Company's HMOs also have arrangements under which physicians can earn bonuses when certain target goals relating to quality and cost effectiveness in the provision of patient care are met. The Company's contracts with capitated physicians generally provide for stop-loss coverage so that a physician's financial risk for any single member is limited to a certain amount on an annual basis.

The focal point for cost control in the Company's HMOs is the primary care physician who, under contract, provides services and controls utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. In addition, the Company's Hospital Inpatient Management System ("HIMS") controls costs by allowing specially trained physicians to manage the entire range of medical care while an HMO member is in the hospital, and coordinate the member's discharge and care after discharge. Cost control is further achieved by directly negotiating provider discounts. Cost control in the Company's PPOs is achieved primarily by establishing a cost-effective network of participating health care providers and providing incentives for members to use such providers. These providers are generally paid on a negotiated fee-for-service basis. With respect to both HMO and PPO

products, cost control is further achieved through the use of a utilization review system designed to allow only necessary hospital admissions, lengths of stay and necessary or appropriate medical procedures. The Company's HMOs and PPOs generally contract for hospital services under per-diem arrangements for inpatient hospital services and discounted fee-for-service arrangements for outpatient services. During the year ended December 31, 1999, approximately 41 percent of the Company's total medical costs were for services provided to its members in hospitals or related facilities.

The Company has certain risk-sharing contracts whereby providers also assume a specified level of risk for covered managed care services to its members. Under these risk-sharing arrangements, referred to as global capitation contracts, providers are paid a monthly capitation payment per covered member to assume risk for all managed care services including professional and institutional (i.e. hospital) costs. The capitation payments are based on a specified percentage of premiums (typically 78 to 88 percent). The Company continually monitors the financial viability and/or effectiveness of these risk-sharing arrangements. At December 31, 1999, approximately 30 percent and 45 percent of the Company's commercial and Medicare HMO membership, respectively, were under some form of risk-sharing arrangement deemed financially viable and/or effective. Under all of its arrangements, the Company remains financially responsible for the provision of covered medical services if its contractors fail to perform their obligations under the contract.

The Company continually contracts and seeks to renew contracts with providers at rates designed to ensure adequate profitability. To the extent the Company is unable to obtain such rates, its financial position, results of operations and cash flows could be adversely impacted.

The Company continues to implement several disease management programs in various markets. Under these arrangements, the Company provides financial incentives for contractors to provide the full range of care to members with respect to a particular high risk or chronic disease in a quality, cost-effective manner. These programs include congestive heart failure, prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes and breast cancer screening.

Quality Assessment

The Company's quality assessment program under its managed care products consists of several internal programs such as those that credential providers, and those designed to meet the standards of audits by federal and state agencies and external accreditation standards. The Company also offers quality and outcome measurement and improvement programs such as the Health Plan Employer Data Information Sets or HEDIS.

Physicians participating in the Company's HMO networks must satisfy specific criteria, including licensing, hospital admission privileges, patient access, office standards, after-hours coverage and many other factors. Participating hospitals must also meet accreditation criteria established by HCFA and/or the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO ").

Participating physicians are recredentialed regularly. Recredentialing of primary care physicians ("PCP") covers many aspects of patient care such as an analysis of member grievances filed with the Company, the transfer and termination rate of members from a physician practice, analysis of utilization patterns, and member surveys. Committees, each composed of a peer group of physicians, review participating PCPs being considered for credentialing and recredentialing.

The Company pursues accreditation for certain of its HMO plans from JCAHO, the National Committee for Quality Assurance ("NCQA") and the American Accreditation Healthcare Commission/URAC ("AAHC/URAC"). Accreditation or external review by an approved organization is mandatory in the states of Florida and Kansas for licensure as an HMO.

JCAHO performs reviews of standards for rights, responsibilities and ethics, continuum of care, education and communication, health promotion and disease prevention, management of human resource information and improving network performance. Humana Medical Plan, Inc. in Ft. Walton Beach, Florida received a three-year accreditation from JCAHO in 1998.

NCQA performs reviews for quality improvement, credentialing, utilization management, preventative health member rights and responsibilities and medical records. As of January 31, 2000, eight of Humana's markets have received commendable accreditation status from NCQA for all HMO product lines. Humana Medical Plan, Inc. in Central Florida (which includes Daytona Beach and Orlando), Humana Medical Plan, Inc. in North Florida (Jacksonville), Humana Medical Plan, Inc. in South Florida, Humana Medical Plan, Inc. in Tampa Bay, Florida, Humana Health Plan, Inc. in Chicago, Illinois, Humana Health Plan, Inc. and Humana Kansas City, Inc. in Kansas City, Missouri, Humana Health Plan, Inc. in Louisville, Kentucky and Humana Health Plan of Ohio, Inc. d/b/a ChoiceCare in Cincinnati, Ohio.

AAHC/URAC performs reviews of standards for confidentiality, staff qualifications and credentials, program qualifications, quality improvement programs, accessibility and on site review procedures, information requirements, utilization review procedures and appeals. AAHC/URAC accreditation was received for all Humana HMO markets which have utilization management functions performed in the Green Bay, Wisconsin or Louisville, Kentucky service centers.

The Company's Year 2000 Disclosure Statement

The Company commenced its assessment of Year 2000 exposures in early 1996. In December 1998, the Company was 100 percent complete with the remediation of its core business systems and by December 1999 had remediated 100 percent of its business application systems. As of December 31, 1999, the Company had completed all Year 2000 initiatives.

To date, the Company has experienced no outages or problems related to the Year 2000 date rollover. All business systems are functioning normally and the Company has not experienced any disruptions in service with third party organizations with which it interacts related to the century change.

The Company's application systems are largely developed and maintained in-house by a staff of 400 application programmers who are versed in the utilization of state-of-the-art technology. All application systems are fully integrated and automatically pass data through various system processes. The Company 's primary data center and the majority of its programming and support staff are located at the Company's corporate offices in Louisville, Kentucky. In order to create the necessary internal focus surrounding the Year 2000 issue, the Company established a centralized Year 2000 Program Management Office ("PMO") which is charged with overall coordination of enterprise wide Year 2000 initiatives and regular progress reporting to the Company's senior management.

The Year 2000 project is currently estimated to have a minimum total cost of approximately $30 million of which approximately $10 million was spent during 1999. Year 2000 expenses represented less than ten percent of the Information Systems budget during 1999. Year 2000 costs are expensed as incurred

and funded with cash flows from operations. The Company does not expect to incur significant Year 2000 project costs in the year 2000.

The extent and magnitude of the Year 2000 project, as it will affect the Company for some period after January 1, 2000, is difficult to predict or quantify. In order to mitigate these risks, the Company developed business continuity and contingency plans which were finalized in the second quarter of 1999. These plans would be enacted if Year 2000 problems were to occur within the Company, or if third party constituents have failures due to the millennium change. Contingency plans were developed for six major functional areas encompassing 22 operational subdivisions that require contingency plan development. The six major functional areas are: providers, service centers, suppliers and vendors, customers and brokers, banking and finance and legal services.

While the Company presently believes that the timely completion of its Year 2000 project limited the exposure, so that the Year 2000 issue has not posed material operational problems, the Company recognizes that it does not control third party constituents. If these third party organizations have failures related to the Year 2000 century change and/or fail to properly implement appropriate contingency plans, Year 2000 failures may result. These failures could potentially have a material adverse impact on the Company's financial position, results of operations and cash flows.

Sales and Marketing

Individuals become members of the Company's commercial HMOs and PPOs through their employer or other groups which typically offer employees or members a selection of managed health care products, pay for all or part of the premiums and make payroll deductions for any premiums payable by the employees. The Company attempts to become an employer's or group's exclusive source of managed health care benefits by offering HMO and PPO products that facilitate the delivery of cost-effective quality care consistent with the needs and expectations of the employees or members.

The Company uses various methods to market its commercial, Medicare HMO and Medicaid products, including television, radio, the Internet, telemarketing and mailings. At December 31, 1999, the Company used approximately 40,300 licensed independent brokers and agents and approximately 510 licensed employees to sell the Company's commercial products. Many of the Company's employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. The Company generally pays brokers a commission based on premiums, with commissions varying by market and premium volume.

At December 31, 1999, the Company used approximately 950 employed sales representatives, who are each paid a salary and/or per member commission, to market the Company's Medicare HMO and Medicaid products. The Company also used approximately 370 telemarketing representatives who assisted in the marketing of Medicare HMO and Medicaid products by making appointments for sales representatives with prospective members.

The following table lists the Company's medical membership at December 31, 1999, by market and product:

MEDICAL MEMBERSHIP
(In thousands)

	Commercial								
	HMO	PPO	Medicaid	Medicare HMO	Medicare Supplement	ASO	TRICARE	Total	Percent of Total
Florida	219.3	151.7	138.6	250.5	4.0	7.3	404.8	1,176.2	19.8%
Texas	258.1	319.4	29.3	68.9	3.8	11.2		690.7	11.6
Illinois	294.0	239.7	15.2	82.6		89.4		720.9	12.1
Puerto Rico	20.8	33.4	410.4					464.6	7.8
Wisconsin	110.4	66.6	23.1	3.3		310.6		514.0	8.7
Kentucky	99.4	177.3		19.8	22.9	55.2		374.6	6.3
Georgia	9.1	88.9			3.0	2.9	252.9	356.8	6.0
Ohio	206.1	104.4		11.2		50.2		371.9	6.3
Missouri/Kansas	75.3	37.3		24.3	4.5	14.6		156.0	2.6
Indiana	16.1	94.3		3.5	1.1	33.8		148.8	2.5
South Carolina		16.4				0.4	129.6	146.4	2.5
Tennessee		55.9				18.3	70.9	145.1	2.4
Colorado		147.4			0.9	0.2		148.5	2.5
Other		242.3		24.4	4.3	53.9	199.8	524.7	8.9
Total	1,308.6	1,775.0	616.6	488.5	44.5	648.0	1,058.0	5,939.2	100.0%

Risk Management

Through the use of internally developed underwriting criteria, the Company determines the risk it is willing to assume and the amount of premium to charge for its commercial products. In most instances, employer and other groups must meet the Company 's underwriting standards in order to qualify to contract with the Company for coverage. Small group reform laws in some states have imposed regulations which provide for guaranteed issue of certain health insurance products and prescribe certain limitations on the variation in rates charged based upon assessment of health conditions.

Underwriting techniques are not employed in connection with Medicare HMO products because HCFA regulations require the Company to accept all eligible Medicare applicants regardless of their health or prior medical history. The Company also is not permitted to employ underwriting criteria for the Medicaid product but rather follows HCFA and state requirements. In addition, with respect to the TRICARE contract, no underwriting techniques are employed because the Company must accept all eligible beneficiaries who choose to participate.

Competition

The managed health care industry is highly competitive and contracts for the sale of commercial products are generally bid or renewed annually. The

Company's competitors vary by local market and include other publicly traded managed care companies, national insurance companies and other HMOs and PPOs, including HMOs and PPOs owned by Blue Cross/Blue Shield plans. Many of the Company's competitors have more membership and/or greater financial resources than the Company's health plans in those markets. The Company's ability to sell its products and to retain customers is or may be influenced by such factors as benefits, pricing, contract terms, number and quality of participating physicians and other managed health care providers, utilization review, claims processing, administrative efficiency, relationships with agents, quality of customer service and accreditation results.

Government Regulation

Government regulation of health care products and services is a changing area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have broad discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and regulations are continually being considered, and the interpretation of existing laws and rules also may change periodically. These regulatory revisions could affect the Company's operations and financial results. Also, it may become increasingly difficult to control medical costs if federal and state bodies continue to consider and enact significant and sometimes onerous managed care laws and regulations.

Enforcement of health care fraud and abuse laws has become a top priority for the nation's law enforcement entities. The funding of such law enforcement efforts has increased dramatically in the past few years and is expected to continue. The focus of these efforts has been directed at participants in federal government health care programs such as Medicare, Medicaid and FEHBP. The Company participates extensively in these programs and has enhanced its regulatory compliance efforts for these programs. The programs are subject to very technical rules. When combined with law enforcement intolerance for any level of noncompliance, these rules mean that compliance efforts in this area continue to be challenging.

The Company is subject to various governmental audits, investigations and enforcement actions. These include possible government actions relating to the Employee Retirement Income Security Act ("ERISA"), FEHBP, federal and state fraud and abuse laws, and laws relating to Medicare, including adjusted community rating development, special payment status, payments for emergency room visits, and various other areas. Any such government actions could result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including exclusion from participation in government programs. The Company is currently involved in various government investigations, audits and reviews, some of which are under ERISA, and the authority of state departments of insurance. The Company does not believe the results of current audits or investigations, individually or in the aggregate, will have a material adverse effect on its financial position and results of operations.

Of the Company's 13 licensed and active HMO subsidiaries as of March 1, 2000, nine are qualified under the Federal Health Maintenance Organization Act of 1973, as amended. To obtain federal qualification, an HMO must meet certain requirements, including conformance with benefit, rating and financial reporting standards. In certain markets, and for certain products, the Company operates HMOs that are not federally qualified because this provides greater flexibility with respect to product design and pricing than is possible for federally qualified HMOs.

Six subsidiaries (Humana Medical Plan, Inc., Humana Health Plan of Texas, Inc., Humana Health Plan, Inc., Humana Kansas City, Inc., Humana Health Plan of Ohio, Inc., and Memorial Sisters of Charity HMO, L.L.C.) hold HCFA contracts under the M+C program to sell Medicare HMO products in nine states.

HCFA conducts audits of HMOs qualified under its M+C program at least biannually and may perform other reviews more frequently to determine compliance with federal regulations and contractual obligations. These audits include review of the HMOs administration and management (including management information and data collection systems), fiscal stability, utilization management and physician incentive arrangements, health services delivery, quality assurance, marketing, enrollment and disenrollment activity, claims processing, and complaint systems.

HCFA regulations require quarterly and annual submission of financial statements. In addition, HCFA requires certain disclosures to HCFA and to Medicare beneficiaries concerning operations of a health plan qualified under the M+C program. HCFA's rules require disclosure to members upon request of information concerning financial arrangements and incentive plans between an HMO and physicians in the HMO's networks. These rules also require certain levels of stop-loss coverage to protect contracted physicians against major losses relating to patient care, depending on the amount of financial risk they assume. The reporting of certain health care data contained in HEDIS is another important HCFA disclosure requirement.

The Company's Medicaid products are regulated by the applicable state agency in the state in which the Company sells a Medicaid product and the Health Insurance Administration in Puerto Rico, in conformance with federal approval of the applicable state plan, and are subject to periodic reviews by these agencies. The reviews are similar in nature to those performed by HCFA.

Laws in each of the states and the Commonwealth of Puerto Rico in which the Company operates its HMOs, PPOs and other health insurance-related services regulate the Company's operations, including the scope of benefits, rate formulas, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing and advertising. The HMO, PPO and other health insurance-related products offered by the Company are sold under licenses issued by the applicable insurance regulators and the entities selling these products are required to be in compliance with certain minimum capital requirements. These requirements must be satisfied by investing in approved investments that generally cannot be used for other purposes. Under state laws, the Company's HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance, and its HMOs are audited for compliance with health services standards by respective state departments of health. Most states' laws require such audits to be performed at least triennially.

The Company and its licensed subsidiaries are subject to regulation under state insurance holding company and Commonwealth of Puerto Rico regulations. These regulations require, among other things, prior approval and/or notice of certain material transactions, including dividend payments, intercompany agreements and the filing of various financial and operational reports.

The National Association of Insurance Commissioners has recommended that states adopt a risk-based capital ("RBC") formula for companies established as HMO entities, similar to the current requirement for insurance companies. The RBC provisions may require new minimum capital and surplus levels for some of the Company's HMO subsidiaries. Many states have not yet determined when they will adopt the RBC formula or if they will allow a phase-in to the required levels of capital and surplus.

The Company currently maintains approximately $768 million of capital and surplus in its health insurance and HMO entities, compared to the minimum statutory required capital and surplus levels of approximately $569 million. If the states in which the Company conducts business adopt the proposed RBC formula, without a phase-in provision, the Company estimates it would be required to fund additional capital into certain of its subsidiaries of approximately $45 million. After this capital infusion, the Company would have $138 million of capital and surplus above the required RBC level in its entities as a whole.

Management works proactively to ensure compliance with all governmental laws and regulations affecting the Company's business.

Health Care Reform

There continue to be diverse legislative and regulatory initiatives at both the federal and state levels to address aspects of the nation's health care system.

National

In 1999, Congress passed the Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 ("BBRA") amending certain provisions of the Balanced Budget Act of 1997 ("BBA"). The BBA revised the structure of and payment for private health plan options for Medicare enrollees under the M+C program. The BBRA improved reimbursement to M+C contracting organizations, made certain other technical corrections to ease administrative burdens and required that the Medicare Payment Advisory Commission issue a report on the impact of risk-adjusted payment.

Under the health risk-adjusted payment mechanism for M+C plans, health plan payments are adjusted based on the likelihood (or risk) that enrollees will use health care services. The BBRA slowed the phase-in period of the risk-adjustment payment mechanism to 10 percent in 2000, 10 percent in 2001 and 20 percent in 2002. The Company believes that Congress may again consider modifications to the payment formula during the intervening years.

The BBRA also increased future health plan payments by reducing from 0.5 percent to 0.3 percent, the difference in the annual growth rate allowed for M+C plans and traditional Medicare in 2002. Further, effective January 1, 2001, Congress changed the formula by which health plans pay for the national Medicare education campaign from one where M+C plans pay the entire amount based on number of plan enrollees to one based on a ratio of plan enrollees to the total Medicare population. Organizations that offer M+C plans in areas without such plans since 1997 will receive bonus payments in their first two years.

While the Company believes that these adjustments modestly restore some Medicare reimbursement, pending legislative and regulatory initiatives could cause the Company to again consider increasing enrollee out-of-pocket costs, modifying benefits or exiting markets in 2001. On January 1, 2000, the Company exited 31 M+C counties and raised or established premiums and reduced benefits in others. The Company is working with HCFA on modifications to the risk adjuster payment method.

The Health Insurance Portability and Accountability Act ("HIPAA") was enacted in 1996. The provisions of HIPAA that have already been implemented govern rules related to portability and guarantee issue requirements. Final rules mandated by HIPAA on privacy standards, administrative simplification of employer, provider and health plan identification information, claims transaction codes, security and electronic signatures will be proposed or promulgated in 2000. The Company is taking administrative steps to be in full compliance with the rules once finalized.

There are several other legislative proposals under consideration that include, among other things, a patient bill of rights, expansion of a patient's right to sue, protecting patient medical information, greater access to health insurance for the uninsured, provisions that seek to reduce the number of uninsured by expanding medical savings accounts, the acceleration of the self-employed tax deduction, collective bargaining rights for independent physicians, and provisions to permit employers to pool at the federal or state level. Many of these proposals may require additional administrative costs to ensure compliance and the Company is currently assessing their cost and impact on premiums for the future.

State

A number of states continue to enact some form of managed care reform. Issues relating to managed care consumer protection standards, including increased plan information disclosure, expedited appeals and grievance procedures, third party review of certain medical decisions, health plan liability, access to specialists, clean claim payment timing, physician collective bargaining rights and confidentiality of medical records continue to be under discussion. Further, proposals that place restrictions on the selection and termination of participating health care providers also are receiving review. A few states are also expected to consider small group purchasing alliance and small group rating legislation.

Management believes that managed care and health care in general will continue to be scrutinized and may lead to additional legislative health care reform initiatives. Management is unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting the Company's businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on its financial position, results of operations or cash flows.

Other

Captive Insurance Company

The Company insures substantially all professional liability risks through a wholly owned subsidiary (the "Subsidiary"). The annual premiums paid to the Subsidiary are determined by independent actuaries. The Subsidiary reinsures levels of coverage for losses in excess of its retained limits with unrelated insurance carriers.

Centralized Management Services

Centralized management services are provided to each health plan from the Company's headquarters and service centers. These services include management information systems, product administration, financing, personnel, development, accounting, legal advice, public relations, marketing, insurance, purchasing, risk management, actuarial, underwriting and claims processing.

Employees

As of December 31, 1999, the Company had approximately 17,300 employees, including approximately 330 employees covered by collective

bargaining agreements. The Company has not experienced any work stoppages and believes it has good relations with its employees.

ITEM 2. PROPERTIES

The Company owns its principal executive office, which is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition, the Company owns buildings in Louisville, Kentucky, San Antonio, Texas and Green Bay, Wisconsin and Jacksonville, Florida and leases facilities in Madison, Wisconsin, all of which are used for customer service and claims processing. The Louisville and Green Bay facilities also perform enrollment processing and other corporate functions.

The Company also owns or leases medical centers ranging in size from approximately 1,500 to 80,000 square feet. The Company's administrative market offices are generally leased, with square footage ranging from approximately 700 to 89,000. The following chart lists the location of properties used in the operation of the Company at December 31, 1999:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	6	78	3	49	136
Illinois	7	17		8	32
Texas	5	5	3	3	16
Puerto Rico				23	23
Kentucky	9	4	3	2	18
Missouri/Kansas	3	5		4	12
California				3	3
Wisconsin			1	11	12
Ohio				6	6
Other	1	3	1	48	53
Total	31	112	11	157	311

ITEM 3. LEGAL PROCEEDINGS

Securities Litigation

Six purported class action complaints have been filed in the United States District Court for the Western District of Kentucky at Louisville, by purported stockholders of the Company against the Company and certain of its current and former directors and officers. The six complaints contain the same or substantially similar allegations; namely, that the Company and the individual defendants knowingly or recklessly made false or misleading statements in press releases and public filings concerning the Company's financial condition, primarily with respect to the impact of the negotiations over renewal of the Company's contract with Columbia/HCA which took effect April 1, 1999. The complaints allege violations of Section 10(b) of the Securities Exchange Act of 1934 (the "1934 Act") and SEC Rule 10b-5, and Section 20(a) of the 1934 Act and seek certification of a class of stockholders who purchased shares of Humana common stock starting either (in four complaints) in late October 1998 or (in two complaints) on February 9, 1999 and ending (in all six complaints) on April 8, 1999. All seek money damages in unspecified amounts, plus (in certain of the complaints) pre-judgment and post-judgment interest, and costs and expenses including attorney and expert fees. Plaintiffs moved for consolidation of the actions, now styled *In re Humana Inc. Securities Litigation*, and have filed a Consolidated Complaint.

In late 1997, three purported class action complaints were filed in the United States District Court for the Southern District of Florida by former stockholders of Physician Corporation of America ("PCA") against PCA and certain of its former directors and officers. The three actions were consolidated into a single action entitled *In re Physician Corporation of America Securities Litigation*, Civil Action No. 97-3678 (S.D. Fla.). The Consolidated Complaint alleges that PCA and the individual defendants knowingly or recklessly made false and misleading statements in press releases and public filings with respect to the financial and regulatory difficulties of PCA 's workers' compensation business. Count I alleges violations of Section 10(b) of the 1934 Act and SEC Rule 10b-5, and Count II alleges violations of Section 20(a) of the 1934 Act. Plaintiffs have moved for certification of a class of stockholders who purchased shares of PCA common stock from March 31, 1996 through March 31, 1997, as well as money damages plus prejudgment interest in an unspecified amount, and costs and expenses including attorneys fees. On February 19, 1999, the U.S. District Court denied PCA's motion to dismiss. On May 5, 1999, plaintiffs moved for certification of the purported class. On June 28, 1999, defendants moved for partial summary judgment and filed papers opposing the motion for class certification. Both motions are currently pending. Discovery is proceeding and the action has been set for trial beginning January 2001.

The Company believes that the above allegations are without merit and intends to pursue the defense of the actions vigorously.

Managed Care Industry Litigation

Since October 1999, the Company has received twelve purported class action complaints filed on behalf of various named plaintiffs who seek to represent a class consisting of present and former Humana subscribers but excluding persons insured by Medicare or Medicaid. All of the cases have been filed in federal courts, ten in the Southern District of Florida, one in the Southern District of Mississippi and one in the Northern District of Alabama. In each case, the plaintiffs seek a recovery (including statutory treble damages) under the Racketeer Influenced and Corrupt Organizations Act ("RICO") for all persons who are or were Humana subscribers at any time during the four-year period prior to the filing of the complaints. In addition, plaintiffs seek to represent a subclass of policyholders who purchased their Humana coverage through their employers' health benefits plans governed by ERISA, and who are or were Humana subscribers at any time during the six-year period prior to filing the complaints.

The plaintiffs' complaints, which are generally the same, allege, among other things, that Humana intentionally concealed from its members information concerning the various ways Humana decides what claims will be paid, what procedures will be deemed medically necessary, and what criteria and procedures are used to determine the extent and type of their coverage. Plaintiffs also allege that Humana concealed from members the existence of direct

financial incentives to treating physicians and other health care providers to deny coverage. The plaintiffs generally do not allege that any of the alleged practices resulted in any named plaintiff, or any other specific member, being denied coverage for services that should have been covered but, instead, claim that Humana provided the purported class with health insurance benefits of lesser value than promised. Humana has asked the Federal Judicial Panel on Multidistrict Litigation ("MDL Panel") to consolidate the management of all of these cases in a single court.

Humana has also received a class action suit filed in state court in Louisville, Kentucky, by named plaintiffs who seek to represent a purported nationwide class of providers who allege that the Company has improperly paid them and has "downcoded" their claims by paying lesser amounts than they billed for. The Company has removed the case to federal court and has asked the MDL Panel to consolidate that case with the ones described above as well as with another case brought by a physician plaintiff in Alabama and two others brought by physicians in South Florida.

The Company believes these actions are without merit and intends to pursue the defense of these actions vigorously.

Mary Forsyth, et al. V. Humana Inc., et al.

A class action lawsuit styled *Mary Forsyth, et al. V. Humana Inc., et al.,* Case No. CV-5-89-249-PMP, was filed on March 29, 1989, in the United States District Court for the District of Nevada involving claims arising out of the method of calculation of coinsurance for Nevada insureds prior to 1988, and an antitrust claim. The District Court granted the Company's motion for summary judgment on most of the claims on July 22, 1993. The District Court granted summary judgment in favor of plaintiffs on the claims under ERISA. On appeal, the Court of Appeals for the Ninth Circuit reinstated certain claims, including the claim under RICO on behalf of a class of insureds who paid coinsurance at Humana hospitals (the "Co-Payer Class"), and the antitrust claim. On August 18, 1997, the Company filed a Petition for Writ of Certiorari in the United States Supreme Court requesting the Supreme Court to reverse the part of the Ninth Circuit ruling reinstating the RICO claim of the Co-Payer Class. In January 1999, the Supreme Court ruled that the plaintiffs could pursue their RICO claim. The parties subsequently entered into a settlement agreement on July 16, 1999 resolving all outstanding claims. The District Court entered its final approval of the settlement agreement on November 30, 1999. The Company's portion of the settlement which was paid in 1999 was $11.2 million and since it had previously established adequate liabilities for the resolution of this matter, the settlement did not have a material impact on the Company's financial position or its results of operations.

Chipps v. Humana Health Insurance Company of Florida, Inc.

On January 4, 2000, a jury in Palm Beach County, Florida issued a verdict against Humana Health Insurance Company of Florida, Inc., a subsidiary of the Company, awarding approximately $80 million to Mark Chipps, an insured who had sued individually and on behalf of his minor daughter. The claim arose from the removal of the child from a case management program which had provided her with benefits in excess of those available under her policy. The award included $78.5 million for punitive damages, $1 million for emotional distress and $29,000 for contractual benefits. On March 13, 2000, the Humana Health Insurance Company of Florida, Inc., filed its notice of appeal to the Fourth District Court of Appeals in Florida.

Government Audits and Other

During 1999, the Company reached agreement in principle with the United States Department of Justice and the Department of Health and Human Services ("HHS") on a $15 million settlement relating to Medicare premium overpayments. The overpayments resulted from the erroneous designation of certain Medicare enrollees as also eligible for Medicaid. In conjunction with the settlement, the Company is also negotiating with the Office of the Inspector General of HHS with respect to the terms of a corporate integrity agreement which is expected to be finalized during the second quarter of 2000. The settlement amount is expected to be paid sometime during 2000. The Company previously established adequate liabilities for the resolution of these issues and, therefore, the settlement will not have a material impact on the Company's financial position or results of operations.

Damages for claims for personal injuries and medical benefit denials are usual in the Company's business. Personal injury and medical benefit denial claims are covered by insurance from the Company's wholly-owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance if awarded in states in which insurance coverage for punitive damages is not permitted. In connection with the case of *Chipps v. Humana Health Insurance Company of Florida, Inc.,* the Company's insurance carriers have preliminarily indicated that they believe no coverage may be available for a punitive damages award. Other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future.

Due to the nature of its business, the Company is or may become subject to pending or threatened litigation or other legal actions relating to the failure to provide or pay for health care or other benefits, poor outcomes for care delivered or arranged under the Company's programs, nonacceptance or termination of providers, failure to return withheld amounts from provider compensation, and failure to disclose network discounts and various provider payment arrangements and claims relating to contract performance. Recent court decisions and legislative activity may increase our exposure for any of these types of claims.

Management does not believe that any pending or threatened legal actions against the Company or audits by agencies will have a material adverse effect on the Company's financial position or results of operations. However, the likelihood or outcome of current or future suits cannot be accurately predicted, and they could adversely affect the Company's financial position, results of operations or cash flows.

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

Not applicable.

EXECUTIVE OFFICERS OF THE COMPANY

Set forth below are names and ages of all of the current executive officers of the Company as of March 9, 2000, their positions, date of election to such position and the date first elected an officer of the Company:

Name	Age	Position	First Elected Officer
Michael B. McCallister	47	President and Chief Executive Officer	09/89(1)
Kenneth J. Fasola	40	Chief Operating Officer—Small Group Division	05/96(2)
James E. Murray	46	Chief Operating Officer—Health Plan Division and Chief Financial Officer	08/90(3)
John M. Bertko	50	Vice President —Actuarial Consulting	03/00(4)
Douglas R. Carlisle	49	Senior Vice President—Market Operations	05/86(5)
Bruce J. Goodman	58	Senior Vice President and Chief Information Officer	04/99(6)
Bonita C. Hathcock	51	Senior Vice President—Human Resources	05/99(7)
Arthur P. Hipwell	51	Senior Vice President and General Counsel	08/90(8)
Heidi S. Margulis	46	Senior Vice President—Government Affairs	12/95(9)
Sheri E. Mitchell	52	Senior Vice President and Chief Compliance Officer	09/94(10)
Thomas T. Noland, Jr.	46	Senior Vice President—Corporate Communications	01/92(11)
Bruce D. Perkins	46	Senior Vice President—National Networks	05/95(12)
L. Bryan Shaul	55	Vice President —Finance and Controller	03/00(13)
George W. Vieth, Jr.	44	Senior Vice President—Large Group Commercial	12/95(14)

(1) Mr. McCallister was elected President, Chief Executive Officer and a member of the Board of Directors in February 2000. Prior to that, Mr. McCallister served as Senior Vice President—Health System Management from January 1998 to February 2000. Prior to that, Mr. McCallister served as Division I President from July 1996 to January 1998. Mr. McCallister joined the Company in June 1974.

(2) Mr. Fasola currently serves as Chief Operating Officer—Small Group Division having held this position since February 2000. Prior to that, Mr. Fasola served as Senior Vice President—Sales, Marketing and Business Development from November 1998 to February 2000 and as Vice President —Sales & Marketing from May 1996 to November 1998. Mr. Fasola served in a similar capacity as Vice President and National Sales Manager of Employers Health Insurance Company since 1989.

(3) Mr. Murray currently serves as Chief Operating Officer—Health Plan Division having held this position since February 2000. Mr. Murray will continue to serve as Chief Financial Officer until his replacement is selected. Prior to that, Mr. Murray served as Senior Vice President and Chief Financial Officer from November 1998 to February 2000, Chief Financial Officer from January 1997 to November 1998 and Vice President—Finance from August 1990 to January 1997. Mr. Murray joined the Company as Controller in October 1989.

(4) Mr. Bertko joined the Company in October 1999 as Vice President—Actuarial Consulting. Prior to joining the Company, Mr. Bertko was a Principal with Reden & Anders/PM Squared in San Francisco, California from September 1996 to October 1999 and a consultant with Coopers & Lybrand in San Francisco, California from April 1980 to 1995, then a Principal with the firm through August 1996. From 1976 to 1980, Mr. Bertko served as an Actuarial Assistant with Metropolitan Life Insurance Company in San Francisco, California and New York, New York.

(5) Mr. Carlisle currently serves as Senior Vice President—Market Operations having held this position since February 2000. Prior to that, Mr. Carlisle served as Senior Vice President—Health System Management from September 1999 to February 2000. Mr. Carlisle also served as Regional Vice President —Health System Management (Central Region) from January 1998 to September 1999 and held various positions with the Company from May 1986 to December 1997.

(6) Mr. Goodman joined the Company in April 1999 as Senior Vice President and Chief Information Officer. Prior to joining the Company, Mr. Goodman served as Chief Executive Officer of C2K Technology Partners, Inc. in Livingston, New Jersey from 1998 to April 1999. From 1993 to 1998, Mr. Goodman served as Chief Executive Officer—Prudential Service Co. for Prudential Insurance Co. in Roseland, New Jersey, and as Senior Vice President, Chief Information Officer of Metropolitan Life Insurance Co. in New York, New York from 1970 to 1993.

(7) Ms. Hathcock joined the Company in May 1999 as Senior Vice President—Human Resources. Prior to joining the Company, Ms. Hathcock served as Vice President of Human Resources & Development for US Airways Group in Crystal City, Virginia from 1997 to 1999. From 1990 to 1997, Ms. Hathcock served as Vice President of Human Resources for Siemens AG/Siemens Rolm Communications, Inc. in Santa Clara, California.

(8) Mr. Hipwell was initially elected an officer of the Company in 1990 and served as Senior Vice President and General Counsel from July 1992 until the spinoff of Galen Health Care Inc. ("Galen"), when he became Senior Vice President and General Counsel of Galen. Mr. Hipwell returned to the Company in January 1994 and was named Senior Vice President and General Counsel of the Company in June 1994. Mr. Hipwell retired from the Company in January 1999. He returned as Senior Vice President and General Counsel in September 1999.

(9) Ms. Margulis currently serves as Senior Vice President—Government Affairs and was elected to that position in January 2000. Prior to that, Ms. Margulis served as Vice President—Government Affairs from December 1995 to January 2000. Ms. Margulis has been with the Company since November 1985.

(10) Ms. Mitchell currently serves as Senior Vice President and Chief Compliance Officer and was elected to this position in July 1999. Prior to that, Ms. Mitchell served as Vice President—Accreditation & Compliance from January 1998 to July 1999 and Vice President—Quality & Service Excellence from September 1994 to January 1998. Ms. Mitchell joined the Company in 1972.

(11) Mr. Noland currently serves as Senior Vice President—Corporate Communications and was elected to this position in September 1999. Prior to that, Mr. Noland served as Vice President—Corporate Communications from July 1997 to September 1999. Mr. Noland previously worked for the Company from 1984 to 1993 in various Vice President and Director positions in the Communications, Public Affairs and Hospital Public Relations areas. Prior to returning to the Company, Mr. Noland was a Publisher for The Cobb Group in Louisville, Kentucky from 1993 to 1997.

(12) Mr. Perkins currently serves as Senior Vice President—National Networks having held this position since February 2000. Prior to that, Mr. Perkins served as Senior Vice President—National Contracting from May 1998 to February 2000; as Senior Vice President—Provider Affairs and Reengineering from December 1996 to May 1998; as Vice President —Operations—Region II during the month of May 1996, then elected to the position of President of the South/West Division from May 1996 to December 1996 and Vice President—Region II from May 1995 to May 1996. Mr. Perkins joined the Company in May 1976.

(13) Mr. Shaul currently serves as Vice President—Finance and Controller and has held that position since March 2000. Prior to that, Mr. Shaul served as Vice President—Mergers and Acquisitions from March 1999 to March 2000. Prior to joining the Company, Mr. Shaul was Chief Financial Officer of Primary Health, Inc. in Boise, Idaho from February 1997 to February 1999; Chief Financial Officer of Pacific EyeNet, Inc. in Los Angeles, California from August 1996 to February 1997; and Chief Financial Officer of Right CHOICE Managed Care, Inc. from March 1994 to December 1995.

(14) Mr. Vieth currently serves as Senior Vice President—Large Group Commercial having held this position since August 1999. Prior to that, Mr. Vieth served as Senior Vice President—Market Segment Management from November 1998 to August 1999 and as Vice President—Strategy and Systems Development from January 1998 through November 1998. Mr. Vieth also served as Vice President —Development and Planning from December 1995 through January 1998. Mr. Vieth joined the Company in November 1992 as Director of Development and Planning.

Executive officers are elected annually by the Company's Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of the executive officers of the Company.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

The Company's common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Tape:

	High	Low
Year Ended December 31, 1999		
First quarter	20-3/4	16-15/16
Second quarter	16-7/16	11
Third quarter	13-1/8	6-7/8
Fourth quarter	8-1/4	5-7/8
Year Ended December 31, 1998		
First quarter	26-3/8	19-1/2
Second quarter	31-11/16	24-15/16
Third quarter	31-7/8	12-7/8
Fourth quarter	21-9/16	14-3/8

As of March 1, 2000, there were approximately 7,700 holders of record of the Company's common stock.

Since 1992, the Company has historically not declared or paid any cash dividends on its common stock. The Company does not presently intend to pay dividends on its common stock in the future and will retain all of its earnings for future operations and growth of its businesses.

Information for Items 6 through 8 of this report, which appears in the 1999 Annual Report to Stockholders as indicated on the following table, is incorporated by reference herein in this report and filed as an exhibit hereto:

		Annual Report to Stockholders Page
ITEM 6.	**SELECTED FINANCIAL DATA**	23
ITEM 7.	**MANAGEMENT 'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS**	24
ITEM 7a.	**QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK**	32
ITEM 8.	**FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA**	
	Consolidated financial statements	35
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ITEM 9.	**CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE**	

Not applicable.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

The information required by this Item other than the information set forth in Part I under the Section entitled **"Executive Officers of the Company,"** is herein incorporated by reference from the Registrant's Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on May 18, 2000 appearing under the caption **"Election of Directors"** of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item is incorporated herein by reference from the Registrant's Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on May 18, 2000 appearing under the caption **"Executive Compensation of the Company"** of such Proxy Statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The information required by this Item is herein incorporated by reference from the Registrant's Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on May 18, 2000 appearing under the caption **"Security Ownership of Certain Beneficial Owners of Company Common Stock"** of such Proxy Statement.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

The information required by this Item is herein incorporated by reference from the Registrant's Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on May 18, 2000 appearing under the caption **"Certain Transactions with Management and Others"** of such Proxy Statement.

PART IV

ITEM 14. EXHIBITS, FINANCIAL STATEMENT SCHEDULES AND REPORTS ON FORM 8-K

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements—The response to this portion of Item 14 is submitted as Item 8 of this report.

(2) Index to Consolidated Financial Statement Schedules:

I Parent Company Financial Information

II Valuation and Qualifying Accounts

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

3(a)	Restated Certificate of Incorporation filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992. Exhibit 4(i) to the Company's Post-Effective Amendment to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994, is incorporated by reference herein.
(b)	By-laws, as amended. Exhibit 3(b) to the Company's Annual Report for the fiscal year ended December 31, 1997, is incorporated by reference herein.
4(a)	Form of Amended and Restated Rights Agreement dated February 14, 1996, between Humana Inc. and Mid-America Bank of Louisville and Trust Company. Exhibit 1.3 to the Registration Statement (File No. 1-5975) on Form 8-A/A dated February 14, 1996, is incorporated by reference herein.
(b)	Amendment No. 2 to the Amended and Restated Rights Agreement. Exhibit 4.3 to the Registration Statement (File No. 1-5975) on Form 8-A/A dated March 1, 1999, is incorporated by reference herein.
(c)	There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of the Company on a consolidated basis. Other long-term indebtedness of the Company is described in Note 6 of Notes to Consolidated Financial Statements in the Company's 1999 Annual Report to Stockholders. The Company agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness to the Commission upon request.
10(a)*	1989 Stock Option Plan for Employees. Exhibit A to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on January 11, 1990, is incorporated by reference herein.
(b)*	Amendment No. 1 to the 1989 Stock Option Plan for Employees. Annex B to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on February 18, 1993, is incorporated by reference herein.
(c)*	Amendment No. 2 to the 1989 Stock Option Plan for Employees. Exhibit 10(e) to the Company 's Annual Report on Form 10-K for the fiscal year ended December 31, 1993, is incorporated by reference herein.
(d)*	1989 Stock Option Plan for Non-Employee Directors. Exhibit B to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on January 11, 1990, is incorporated by reference herein.
(e)*	Amendment No. 1 to the 1989 Stock Option Plan for Non-Employee Directors. Annex C to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on February 18, 1993, is incorporated by reference herein.

* Exhibits 10(a) through and including 10(v) are compensatory plans or management contracts.

10(f)* Amendment No. 2 to the 1989 Stock Option Plan for Non-Employee Directors. Exhibit 10(h) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1993, is incorporated by reference herein.

(g)* 1989 Stock Option Plan for Non-Employee Directors, as amended and restated in 1998. Exhibit A to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on May 14, 1998, is incorporated by reference herein.

(h)* 1996 Stock Incentive Plan for Employees. Annex A to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on May 9, 1996, is incorporated by reference herein.

(i)* 1996 Stock Incentive Plan for Employees as amended in 1998. Exhibit C to the Company 's Proxy Statement covering the Annual Meeting of Stockholders held on May 14, 1998, is incorporated by reference herein.

(j)* Executive Management Incentive Compensation Plan—Group A, Corporate. Exhibit C to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on May 26, 1994, is incorporated by reference herein.

(k)* Humana Inc. 1998 Executive Management Incentive Compensation Plan. Exhibit B to the Company 's Proxy Statement covering the Annual Meeting of Stockholders held on May 14, 1998, is incorporated by reference herein.

(l)* Restated agreement providing for termination benefits in the event of a change of control. Exhibit 10(m) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1997, is incorporated by reference herein.

(m)* Humana Inc. 1998 Management Incentive Compensation Plan. Exhibit 10(n) to the Company 's Annual Report on Form 10-K for the fiscal year ended December 31, 1997, is incorporated by reference herein.

(n)* Employment Agreement—Gregory H. Wolf, dated December 1, 1998. Exhibit 10(q) to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, is incorporated by reference herein.

(o)* Employment Agreement—Kenneth J. Fasola, dated March 29, 1999. Exhibit 10 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1999, is incorporated by reference herein.

(p)* Trust under Humana Inc. Deferred Compensation Plans, filed herewith.

(q)* Severance policy. Exhibit 10 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 1999, is incorporated by reference herein.

(r)* Agreement —David A. Jones, dated December 15, 1999, filed herewith.

(s)* Humana Officers ' Target Retirement Plan, as amended. Exhibit 10(p) to the Company 's Annual Report on From 10-K for the fiscal year ended December 31, 1997, is incorporated by reference herein.

(t)* Humana Thrift Excess Plan as amended. Exhibit 10(s) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1994, is incorporated by reference herein.

(u)* Humana Supplemental Executive Retirement Plan as amended. Exhibit 10(t) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1994, is incorporated by reference herein.

(v)* Letter agreement with Company officers concerning health insurance availability. Exhibit 10(mm) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1994, is incorporated by reference herein.

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* Exhibits 10(a) through and including 10(v) are compensatory plans or management contracts.

10(w) Indemnity Agreement. Appendix B to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on January 8, 1987, is incorporated by reference herein.

(x) Agreement between the Secretary of the Department of Health and Human Services and Humana Medical Plan, Inc. Exhibit 10(w) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1993, is incorporated by reference herein.

(y) The $1.5 Billion Credit Facility between the Company and Chase Manhattan Bank and the First Amendment thereto ("Credit Agreement"). Exhibit 10 to the Company 's Current Report on Form 8-K filed on September 23, 1997, is incorporated by reference herein.

(z) Second Amendment to the Credit Agreement dated November 19, 1999, filed herewith.

(aa) The $1.5 Billion Commercial Paper Private Placement Memorandum between the Company and Chase Securities, Inc. Exhibit 4a to the Company's Current Report on Form 8-K filed on September 23, 1997, is incorporated by reference herein.

(bb) The $1.5 Billion Commercial Paper Private Placement Memorandum between the Company and Merrill Lynch Money Markets, Inc. Exhibit 4b to the Company's Current Report on Form 8-K filed on September 23, 1997, is incorporated by reference herein.

(cc) Assumption of Liabilities and Indemnification Agreement between the Company and Galen Health Care, Inc. ("Galen"). Exhibit 10(g) to the Company's Current Report on Form 8-K filed on March 5, 1993, is incorporated by reference herein.

(dd) Agreement between the United States Department of Defense and Humana Military Healthcare Services, Inc., a wholly owned subsidiary of the Company. Exhibit 10(dd) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1995, is incorporated by reference herein.

12 Statement re: Computation of Ratio of Earnings to Fixed Charges, filed herewith.

13 1999 Annual Report to Stockholders, filed herewith. The Annual Report shall not be deemed to be filed with the Commission except to the extent that information is specifically incorporated by reference herein.

21 List of Subsidiaries, filed herewith.

23 Consent of PricewaterhouseCoopers LLP, filed herewith.

27 Financial Data Schedule, filed herewith.

(b) Reports on Form 8-K:

For the quarter ended December 31, 1999, there were no reports filed on Form 8-K. As of the filing date, Humana Inc. filed the following reports on Form 8-K:

(1) On January 3, 2000, the Company filed a report on Form 8-K regarding a proposed charge in the range of $400 million to $500 million relating primarily to goodwill and the proposed sale of its workers' compensation and Medicare supplemental businesses.

(2) On February 3, 2000, the Company filed a report on Form 8-K regarding the appointment of Michael B. McCallister as President and Chief Executive Officer of the Company.

SIGNATURES

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

HUMANA INC .

By: /S / JAMES E. MURRAY

James E. Murray
Chief Operating Officer—Health Plan Division and Chief Financial Officer

Date: March 30, 2000

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

Signature	Title	Date
/S / JAMES E. MURRAY James E. Murray	Chief Operating Officer—Health Plan Division and Chief Financial Officer (Principal Accounting Officer)	March 30, 2000
/S / DAVID A. JONES David A. Jones	Chairman of the Board	March 30, 2000

/S/ DAVID A. JONES, JR. David A. Jones, Jr.	Vice Chairman of the Board	March 30, 2000
/S/ K. FRANK AUSTEN, M.D. K. Frank Austen, M.D.	Director	March 30, 2000
/S/ MICHAEL E. GELLERT Michael E. Gellert	Director	March 30, 2000
/S/ JOHN R. HALL John R. Hall	Director	March 30, 2000
/S/ IRWIN LERNER Irwin Lerner	Director	March 30, 2000
/S/ MICHAEL B. MC CALLISTER Michael B. McCallister	Director, President and Chief Executive Officer	March 30, 2000
/S/ W. ANN REYNOLDS, PH.D. W. Ann Reynolds, Ph.D.	Director	March 30, 2000

REPORT OF INDEPENDENT ACCOUNTANTS

To the Board of Directors
Humana Inc.

Our audits of the consolidated financial statements referred to in our report February 9, 2000 appearing in the 1999 Annual Report of Stockholders of Humana Inc. which report and consolidated financial statements are incorporated by reference in this Annual Report on Form 10-K, also included an audit of the financial statement schedules listed in Item 14(a)(2) of this Form 10-K. In our opinion, these financial statement schedules present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements.

PRICEWATERHOUSECOOPERS LLP

Louisville, Kentucky
February 9, 2000

HUMANA INC.

SCHEDULE I —PARENT COMPANY FINANCIAL INFORMATION (a)
CONDENSED BALANCE SHEETS

December 31, 1999 and 1998
(In millions, except share amounts)

	1999	1998
ASSETS		
Receivables from operating subsidiaries (b)	$ 120	$ 168
Other current assets	51	57
Total current assets	171	225
Property and equipment, net	176	181
Investments in subsidiaries	1,886	2,380
Other	40	48
TOTAL ASSETS	$2,273	$2,834
LIABILITIES AND STOCKHOLDERS' EQUITY		
Book overdraft	$ 159	$ 175
Other current liabilities (b)	114	106
Commercial paper	686	730
Total current liabilities	959	1,011
Debt		93
Other	46	42
Total liabilities	1,005	1,146
Contingencies (b)		
Preferred stock, $1 par; authorized 10,000,000 shares, none issued		
Common stock, $0.16-2/3 par; authorized 300,000,000 shares; issued and outstanding 167,514,710—1999, 167,515,362 —1998	28	28
Other stockholders ' equity	1,240	1,660
Total stockholders' equity	1,268	1,688
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$2,273	$2,834

(a) Parent company financial information has been derived from the consolidated financial statements of the Company and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with the consolidated financial statements of the Company.

(b) In the normal course of business, the parent company indemnifies certain of its subsidiaries for health plan obligations its subsidiaries may be unable to meet.

HUMANA INC.

SCHEDULE I —PARENT COMPANY FINANCIAL INFORMATION (a)
CONDENSED STATEMENTS OF OPERATIONS
For the Years Ended December 31, 1999, 1998 and 1997
(In millions)

	1999	1998	1997 (b)
Revenues:			
Management fees charged to operating subsidiaries	$364	$297	$228
Interest and other income	14	1	5
	378	298	233
Expenses:			
Selling, general and administrative	331	293	201
Depreciation	36	33	26
Interest	30	40	17
	397	366	244
Loss before income taxes and equity in income of subsidiaries	(19)	(68)	(11)
Income tax benefit	6	38	9
Loss before equity in income of subsidiaries	(13)	(30)	(2)
(Loss) equity in income of subsidiaries	(369)	159	175
Net (loss) income	$(382)	$129	$173

(a) Parent company financial information has been derived from the consolidated financial statements of the Company and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with the consolidated financial statements of the Company.

(b) Includes the operations of Health Direct, Inc., Physician Corporation of America and ChoiceCare Corporation since their dates of acquisition, February 28, 1997, September 8, 1997 and October 17, 1997, respectively.

HUMANA INC.

SCHEDULE I —PARENT COMPANY FINANCIAL INFORMATION (a)
CONDENSED STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1999, 1998 and 1997
(In millions)

	1999	1998	1997
Net cash provided by operating activities (b)	$354	$105	$191
Cash flows from investing activities:			
Purchases of property and equipment	(11)	(43)	(38)
Purchases of marketable securities		(1)	(6)
Maturities and sales of marketable securities	7	7	1
Parent funding of operating subsidiaries	(191)	(59)	(209)
Acquisition of health plans			(656)
Other	(7)	(11)	17
Net cash used in investing activities	(202)	(107)	(891)
Cash flows from financing activities:			
Issuance of long-term debt		123	300
Repayment of long-term debt	(93)	(330)	
Net commercial paper (repayments) borrowings	(44)	141	367
Other	(15)	68	33
Net cash (used in) provided by financing activities	(152)	2	700
Change in cash and cash equivalents			
Cash and cash equivalents at beginning of period			
Cash and cash equivalents at end of period	$	$	$

(a) Parent company financial information has been derived from the consolidated financial statements of the Company and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with the consolidated financial statements of the Company.

(b) During the years ended December 31, 1999, 1998 and 1997, the Company received dividends from its operating subsidiaries totaling $276 million, $93 million and $146 million, respectively.

HUMANA INC.

SCHEDULE II —VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 1999, 1998 and 1997
(In millions)

			Additions			
	Balance at Beginning of Period	Acquired Balances	Charged to Costs and Expenses	Charged to Other Accounts	Deductions or Write-offs	Balance at End of Period
Allowance for loss on premiums receivable:						
Years ended December 31,:						
1999	$62		$12	$(11)	$(2)	$61
1998	48		11	14	(11)	62
1997	38	$9	10	3	(12)	48

EXHIBIT 10(P)

TRUST UNDER HUMANA INC.
DEFERRED COMPENSATION PLANS

This Trust Agreement ("Trust Agreement") is made this 15th day of April, 1998, by and between (i) Humana Inc., a Delaware corporation ("Company"), and (ii) National City Bank of Kentucky, a Kentucky corporation ("Trustee").

Recitals:

A. Company has adopted the Humana Officers' Target Retirement Plan, the Humana Supplemental Executive Retirement Plan and the Humana Thrift Excess Plan (hereinafter individually referred to as a "Plan" and collectively referred to as the "Plans"), all of which are nonqualified deferred compensation plans.

B. Company has incurred liability under the terms of such Plans with respect to the individuals participating in such Plans.

C. Company wishes to establish a trust (hereinafter called "Trust") and to contribute to the Trust assets that shall be held therein, subject to the claims of Company's creditors in the event of Company's Insolvency (as herein defined) until paid to the Plan participant whose name is set forth on Exhibit A attached hereto and made a part hereof ("Plan Participant") and his beneficiaries in such manner and at such times as specified in the Plans.

D. It is the intention of the parties that this Trust shall constitute an unfunded arrangement and shall not affect the status of the Plans as unfunded plans maintained for the purpose of providing deferred compensation for a select group of management or highly compensated employees for purposes of Title I of the Employee Retirement Income Security Act of 1974, as amended.

E. It is the intention of Company to make contributions to the Trust to provide itself with a source of funds to assist it in the meeting of its liabilities under the Plans to the Plan Participant.

Agreement:

Now, Therefore, the parties do hereby establish the Trust and agree that the Trust shall be comprised, held and disposed of as follows:

1. Establishment of Trust

(a) Company hereby deposits with Trustee in trust $7,370,571.73, which shall become the principal of the Trust to be held, administered and disposed of by Trustee as provided in this Trust Agreement.

(b) The Trust hereby established shall be irrevocable.

(c) The Trust is intended to be a grantor trust, of which Company is the grantor, within the meaning of subpart E, part I, subchapter J, chapter 1, subtitle A of the Internal Revenue Code of 1986, as amended, and shall be construed accordingly.

(d) The principal of the Trust, and any earnings thereon shall be held separate and apart from other funds of Company and shall be used exclusively for the uses and purposes of the Plan Participant and general creditors as herein set forth. The Plan Participant and his beneficiaries shall have no preferred claim on, or any beneficial ownership interest in, any assets of the Trust. Any rights created under the Plans and this Trust Agreement shall be mere unsecured contractual rights of the Plan Participant and his beneficiaries against Company. Any assets held by the Trust will be subject to the claims of Company's general creditors under federal and state law in the event of Insolvency.

(d) Company, in its sole discretion, may at any time, or from time to time, make additional deposits of cash or other property in trust with Trustee to augment the principal to be held, administered and disposed of by Trustee as provided in this Trust Agreement. Neither Trustee nor the Plan Participant or his beneficiaries shall have any right to compel such additional deposits.

2. Payments to Plan Participant and His Beneficiaries.

(a) Company shall deliver to Trustee a schedule (the "Payment Schedule") that indicates the amounts payable in respect of the Plan Participant (and his beneficiaries) covered hereby, that provides a formula or other instructions acceptable to Trustee for determining the amounts so payable, the form in which such amount is to be paid (as provided for or available under the Plans), and the time of commencement for payment of such amounts. Except as otherwise provided herein, Trustee shall make payments to the Plan Participant and his beneficiaries in accordance with such Payment Schedule. The Trustee shall make provision for the reporting and withholding of any federal, state or local taxes that may be required to be withheld with respect to the payment of benefits pursuant to the terms of the Plans and shall pay amounts withheld to the appropriate taxing authorities or determine that such amounts have been reported, withheld and paid by Company.

(b) The entitlement of the Plan Participant or his beneficiaries to benefits under the Plan shall be determined by Company or such party as it shall designate under the Plan, and any claim for such benefits shall be considered and reviewed under the procedures set out in the Plans.

(c) Company may make payment of benefits directly to the Plan Participant or his beneficiaries as they become due under the terms of the Plans. Company shall notify Trustee of its decision to make payment of benefits directly prior to the time amounts are payable to the Plan Participant or his beneficiaries. In addition, if the principal of the Trust, and any earnings thereon, are not sufficient to make payments of benefits in accordance with the terms of the Plans, Company shall make the balance of each such payment as it falls due. Trustee shall notify Company where principal and earnings are not sufficient.

3. Trustee Responsibility Regarding Payments to Trust Beneficiary When Company is Insolvent.

(a) Trustee shall cease payment of benefits to the Plan Participant and his beneficiaries if the Company is Insolvent. Company shall be considered "Insolvent" for purposes of this Trust Agreement if (i) Company is unable to pay its debts as they become due, or (ii) Company is subject to a pending proceeding as a debtor under the United States Bankruptcy Code.

(b) At all times during the continuance of this Trust, as provided in Section 1(d) hereof, the principal and income of the Trust shall be subject to claims of general creditors of Company under federal and state law as set forth below.

(1) The Board of Directors and the chief executive officer of the Company shall have the duty to inform Trustee in writing of Company's Insolvency. If a person claiming to be a creditor of Company alleges in writing to Trustee that Company has become Insolvent, Trustee shall determine whether Company is Insolvent and, pending such determination, Trustee shall discontinue payment of benefits to the Plan Participant or his beneficiaries.

(2) Unless Trustee has actual knowledge of Company's Insolvency, or has received notice from Company or a person claiming to be a creditor alleging that Company is Insolvent, Trustee shall have no duty to inquire whether Company is Insolvent. Trustee may in all events rely on such evidence concerning Company's solvency as may be furnished to Trustee and that provides Trustee with a reasonable basis for making a determination concerning Company's solvency.

(3) If at any time Trustee has determined that Company is Insolvent, Trustee shall discontinue payments to the Plan Participant or his beneficiaries and shall hold the assets of the Trust for the benefit of Company's general creditors. Nothing in this Trust Agreement shall in any way diminish any rights of the Plan Participant or his beneficiaries to pursue their rights as general creditors of Company with respect to benefits due under the Plans or otherwise.

(4) Trustee shall resume the payment of benefits to the Plan Participant or his beneficiaries in accordance with Section 2 of this Trust Agreement only after Trustee has determined that Company is not Insolvent (or is

no longer Insolvent).

(c) Provided that there are sufficient assets, if Trustee discontinues the payment of benefits from the Trust pursuant to Section 3(b) hereof and subsequently resumes such payments, the first payment following such discontinuance shall include the aggregate amount of all payments due to the Plan Participant or his beneficiaries under the terms of the Plans for the period of such discontinuance, less the aggregate amount of any payments made to the Plan Participant or his beneficiaries by Company in lieu of the payments provided for hereunder during any such period of discontinuance.

4. Payments to Company. Except as provided in Section 3 hereof, after the Trust has become irrevocable, Company shall have no right or power to direct Trustee to return to

Company or to divert to others any of the Trust assets before all payment of benefits have been made to the Plan Participant covered hereby and his beneficiaries pursuant to the terms of the Plans.

5. Investment Authority.

(a) Trustee may invest in securities (including stock or rights to acquire stock) or obligations issued by Company. All rights associated with assets of the Trust shall be exercised by Trustee or the person designated by Trustee, and shall in no event be exercisable by or rest with the Plan Participant.

(b) All amounts paid to Trustee by Company shall be held and administered by Trustee as a single trust.

(c) Neither Company, the Plan Participant nor his beneficiaries shall have any authority or control whatsoever over the investments of the Trust.

(d) Trustee shall have all the powers necessary to carry out the provisions hereunder. Trustee shall have the custody of all cash, securities and investments received or purchased in accordance with the terms hereof. Trustee may sell or exchange any property or asset of the Trust at public or private sale, with or without advertisement, upon terms acceptable to Trustee and in such manner as Trustee may deem wise and proper. The proceeds of any such sale or exchange may be reinvested as provided hereunder. The purchaser of any such property from Trustee shall not be required to look to the application of the proceeds of any such sale or exchange by Trustee. Trustee may participate in the reorganization, recapitalization, merger or consolidation of any corporation in which Trustee may own stock or securities and may exercise any subscription rights or conversion privileges, and generally may exercise any of the powers of any owner with respect to any stock or other securities or property comprising the Trust. Trustee may, through any duly authorized officer or proxy, vote or refrain from voting any shares of stock or securities which Trustee may own from time to time.

(e) Trust may retain in cash such funds as from time to time it may deem advisable.

(f) Trustee may hold stocks or other securities in its own name as Trustee, with or without the designation of the Trust, or in the name of a nominee selected by it for that purpose, and may deposit securities with a depository trust company, but the Trustee shall nevertheless be obligated to account for all securities owned by it as a part of the Trust, notwithstanding the name in which the same may be held.

(g) Company shall have the right at anytime, and from time to time in its sole discretion, to substitute assets of equal fair market value for any asset held by the Trust. This right is exercisable by Company in a nonfiduciary capacity without the approval or consent of any person in a fiduciary capacity.

6. Disposition of Income. During the term of this Trust, all income received by the Trust, net of expenses and taxes, shall be accumulated and reinvested .

7. Accounting by Trustee. Trustee shall keep accurate and detailed records of all investments, receipts, disbursements and all other transactions required to be made, including such specific records as shall be agreed upon in writing between Company and Trustee. Within 45 days following the close of each calendar year, and within 45 days after the removal or resignation of Trustee, Trustee shall deliver to Company a written account of its administration of the Trust during such year or during the period from the close of the last preceding year to the date of such removal or resignation, setting forth all investments, receipts, disbursements and other transactions effected by it, including a description of all securities and investments purchased and sold with the cost or net proceeds of such purchases or sales (accrued interest paid or receivable being shown separately), and showing all cash, securities and other property held in the Trust at the end of such year or as of the date of such removal or resignation, as the case may be.

8. Responsibility of Trustee.

(a) Trustee shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; provided, however, that Trustee shall incur no liability to any person for any action taken pursuant to a direction, request or approval given by Company which is contemplated by, and in conformity with, the terms of the Plans or this Trust and is given in writing by Company. In the event of a dispute between Company and a party, Trustee may apply to a court of competent jurisdiction to resolve the dispute.

(b) If Trustee undertakes or defends any litigation arising in connection with this Trust, Company agrees to indemnify Trustee against Trustee's costs, expenses and liabilities (including, without limitation, reasonable attorneys' fees and expenses) relating thereto and to be primarily liable for such payments. If Company does not pay such costs, expenses and liabilities in a reasonably timely manner, Trustee may obtain payment from the Trust.

(c) Trustee may consult with legal counsel (who may also be counsel for Company) with respect to any of its duties or obligations hereunder.

(d) Trustee shall have, without exclusion, all powers conferred on trustees by applicable law, unless expressly provided otherwise herein; provided, however, that if an insurance policy is held as an asset of the Trust, Trustee shall have no power to name a beneficiary of the policy other than the Trust, to assign the policy (as distinct from conversion of the policy to a different form) other than to a successor Trustee, or to loan to any person the proceeds of any borrowing against such policy.

(e) Notwithstanding any powers granted to Trustee pursuant to this Trust Agreement or by applicable law, Trustee shall not have any power that could give this Trust the

objective of carrying on a business and dividing the gains therefrom within the meaning of Treas. Reg. (S) 301.7701-2.

9. Compensation and Expenses of Trustee. Company shall pay all administrative and Trustee's fees and expenses. If not so paid, the fees and expenses shall be paid from the Trust.

10. Resignation and Removal of Trustee.

(a) Trustee may resign at any time by written notice to Company, which shall be effective 30 days after receipt of such notice unless Company and Trustee agree otherwise.

(b) Trustee may be removed by Company on 10 days notice or upon shorter notice acceptable by Trustee.

(c) Upon resignation or removal of Trustee and appointment of a successor Trustee, all assets shall subsequently be transferred to the successor Trustee. The transfer shall be completed with 30 days after receipt of notice of resignation, removal or transfer, unless Company extends the time limit.

(d) If Trustee resigns or is removed, a successor shall be appointed,

in accordance with Section 11 hereof, by the effective date of resignation or removal under Sections 10(a) or 10(b) hereof. If no such appointment has been made, Trustee may apply to a court of competent jurisdiction for appointment of a successor or for instructions. All expenses of Trustee in connection with the proceeding shall be allowed as administrative expenses of the Trust.

11. Appointment of Successor.

(a) If Trustee resigns or is removed in accordance with Sections 10(a) or 10(b) hereof, Company may appoint any third party, such as a bank trust department or other party that may be granted corporate trustee powers under state law, as a successor to replace Trustee upon resignation or removal. The appointment shall be effective when accepted in writing by the new Trustee, who shall have all of the rights and powers of the former Trustee, including ownership rights in the Trust assets. The former Trustee shall execute any instrument necessary or reasonably requested by Company or the successor Trustee to evidence the transfer.

(b) The successor Trustee need not examine the records and acts of any prior Trustee and may retain or dispose of existing Trust assets, subject to Sections 7 and 8 hereof. The successor Trustee shall not be responsible for, and Company shall indemnify and defend the successor Trustee from, any claim or liability resulting from any action or inaction of any prior Trustee or from any other past event, or any condition existing at the time it becomes successor Trustee.

12. Amendment or Termination.

(a) This Trust Agreement may be amended by a written instrument executed by Trustee and Company. Notwithstanding the foregoing, no such amendment shall conflict with the terms of the Plans or shall make the Trust revocable after it has become irrevocable in accordance with Section 1(b) hereof.

(b) The Trust shall not terminate until the date on which the Plan Participant covered hereby and his beneficiaries are no longer entitled to benefits pursuant to the terms of the Plans.

13. Miscellaneous.

(a) Any provision of this Trust Agreement prohibited by law shall be ineffective to the extent of any such prohibition, without invalidating the remaining provisions hereof.

(b) Benefits payable to the Plan Participant and his beneficiaries under this Trust Agreement may not be anticipated, assigned (either at law or in equity), alienated, pledged, encumbered or subjected to attachment, garnishment, levy, execution or other legal or equitable process.

(c) This Trust Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflict of laws rules.

14. Effective Date. The effective date of this Trust Agreement shall be April 15, 1998

In Witness Whereof, the parties hereto have executed this Trust Agreement this 15th day of April, 1998.

Humana Inc.

/s/ JAMES W. DOUCETTE

By: James W. Doucette
Title: Vice President Investments & Treasurer
("Company")

National City Bank of Kentucky

/s/ STEVEN C. PRINCE

By: Steven C. Prince
Title: Vice President
("Trustee")

Exhibit 10(r)

AGREEMENT

This Agreement made this 15th day of December, 1999, by and between Humana Inc., a Delaware corporation ("Humana"), and David A. Jones, an individual ("Jones").

WHEREAS, Jones is one of the original founders of Humana and served as Chairman of the Board of Directors of Humana (the "Board") and/or Humana's Chief Executive Officer since 1961, and

WHEREAS, Jones retired as Chief Executive Officer in December 1997 while continuing to serve as Chairman of the Board, and

WHEREAS, Jones agreed to resume the duties of Chief Executive Officer on August 3, 1999, and is currently serving as Humana's Chairman of the Board and Chief Executive Officer, and

WHEREAS, in recognition and consideration of Jones' leadership and service since the inception of the Company, Humana desires to continue to provide to Jones the same benefits he currently enjoys as Chairman of the Board until he no longer occupies that position or until December 31, 2004, whichever is longer.

NOW, THEREFORE, in consideration of the foregoing and of the respective covenants and agreements of the parties contained herein, the parties agree as follows:

1. Should Jones relinquish or otherwise not continue to serve as the Chairman of the Board for any reason, other than death, from the date hereof until December 31, 2004, Humana hereby agrees to continue the benefits he currently receives as Chairman of the Board as set forth in the following paragraphs from that time until December 31, 2004. Should Jones continue to serve as Chairman of the Board beyond December 31, 2004, Humana shall continue to provide all such benefits until he no longer occupies that position. All such benefits shall be provided to Jones at no cost to Jones other than federal and state income taxes as applicable. During such period Humana agrees:

A. to pay Jones an annual cash retainer of Two Hundred Thousand Dollars ($200,000.00), payable bimonthly.

B. to provide Jones with office space (including relevant parking) comparable to that which he and his staff are currently being provided on the second floor of the Humana Building.

C. to provide Jones with administrative and secretarial support of three Humana employees as he now enjoys and further agrees to maintain

rates of pay and benefits for said staff comparable to those given to Humana senior executive administrative and support staff, including pay increases at least annually.

D. to provide Jones and his support staff with office furniture, equipment, supplies and services comparable to those which they now enjoy or as upgraded from time to time.

E. to provide Jones with life and accidental death insurance at the same benefit levels, terms and conditions as is now being provided and to make available to Jones insurance benefits available from time to time to Humana's outside directors.

F. to provide Jones with the use of Humana's airplanes and pilots for business or personal use under the same arrangements as currently exist, including the Aircraft Management and Pilot Exchange Agreement dated December 12, 1994 and the Aircraft Interchange Agreement dated April 13, 1998.

G. to provide Jones membership to the Humana fitness club.

H. to continue to pay for Jones all local occupational taxes based

on his retainer described above in subparagraph A and the cost of life and accidental death insurance described above in subparagraph E.

I. to grant Jones (for so long as he is a member of the Board) stock options equivalent to those for other outside Board members according to Humana's policy of granting such stock options and to pay Jones for any service on the Executive Committee of the Board for so long as he serves in such capacity.

2. Notwithstanding anything contained herein, both before and after December 31, 2004, Jones shall be entitled to receive, or continue to receive, as the case may be, all benefits otherwise due or accruing to Jones under all Humana company and/or employee benefit plans (qualified or non-qualified).

3. Jones agrees that in addition to serving faithfully as Chairman of the Board and Chief Executive Officer, as the case may be, following such service and until December 31, 2004, he shall make himself available, at the reasonable request of the Board, to assist in any management transition occasioned by the appointment of a new Chairman of the Board or Chief Executive Officer. Jones further agrees to be available during such period to assist Humana in matters of national health care reform, legislative or other strategic business matters as may be reasonably requested by the Board.

4. Jones agrees that so long as he receives benefits under this Agreement, he shall not directly or indirectly compete with Humana, shall not solicit then current Humana employees away from Humana, nor divulge any confidential or proprietary information of Humana to any other party.

5. This Agreement and any amendments hereto shall be binding upon and inure to the benefit of the parties hereto and their successors and assigns.

6. If any part of this Agreement or any amendments hereto should be determined to be invalid, unenforceable, or contrary to law or regulation, that part shall be amended, if possible, to conform to law or regulation, and if amendment is not possible, that part shall be deleted and the other parts of this Agreement shall remain in full force and effect.

7. This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Kentucky without regard to its rules of conflict of laws. The parties hereby irrevocable and unconditionally consent to submit to the exclusive jurisdiction of the courts of the Commonwealth of Kentucky and of the United States of America located in the Commonwealth of Kentucky for any litigation arising out of or relating to this Agreement and the transactions contemplated hereby; and agree not to commence any litigation relating thereto except in such courts.

IN WITNESS WHEREOF, the parties hereto have set their hands as of the day and year first above written.

Humana Inc.

By: /s/ Irwin Lerner	/s/ David A. Jones
Irwin Lerner, Director Chairman, Organization and Compensation Committee	David A. Jones

EXHIBIT 10(Z)

SECOND AMENDMENT

SECOND AMENDMENT, dated as of November 19, 1999 (this "Amendment"), to the Credit Agreement, dated as of August 13, 1997 (as heretofore amended or otherwise modified, the "Credit Agreement"), among HUMANA INC., a Delaware corporation (the "Company"), the several banks and other financial institutions from time to time parties to this Agreement (the "Banks"), BANK OF AMERICA, a national banking association, as documentation agent (in such capacity, the "Documentation Agent") and THE CHASE MANHATTAN BANK, a New York banking corporation, as administrative agent for the Banks thereunder (in such capacity, the "Agent") and as CAF Loan agent (in such capacity, the "CAF Loan Agent").

W I T N E S S E T H:

WHEREAS, pursuant to the Credit Agreement, the Banks have agreed to make, and have made, certain loans and other extensions of credit to the Company; and

WHEREAS, the Company has requested that certain provisions of the Credit Agreement be amended in the manner provided for in this Amendment;

NOW, THEREFORE, the parties hereto hereby agree as follows:

I. Defined Terms; Amendments to Section 1.1. (a) Terms defined in the Credit Agreement and used herein shall have the meanings given to them in the Credit Agreement.

(b) The following definition of "Second Amendment Effective Date" is hereby added to Section 1.1 of the Credit Agreement immediately after the definition of "Riverview Square":

"Second Amendment Effective Date": as defined in the Second Amendment, dated as of November 19, 1999."

(c) The definition of "Applicable Margin" set forth in Section 1.1 of the Credit Agreement is hereby deleted in its entirety and replaced with the following new definition:

""Applicable Margin": with respect to each day for each Type of Revolving Credit Loan, the higher of (a) the rate per annum determined in accordance with Schedule II and (b) the rate per annum determined in accordance with Schedule IIA."

(d) The definition of "Consolidated Net Worth" set forth in Section 1.1 of the Credit Agreement is hereby deleted in its entirety and replaced with the following new definition:

""Consolidated Net Worth": at any date, the stockholders' equity of the Company and its Subsidiaries at such date, determined in accordance with GAAP; provided, that up to $300,000,000 of goodwill written off after the Second Amendment Effective Date will be added back to Consolidated Net Worth."

(e) The definition of "Consolidated EBIT" set forth in Section 1.1 of the Credit Agreement is hereby amended by replacing the word "and" appearing immediately before clause (ii) with a comma and adding the following immediately after the parenthetical at the end:

"and (iii) for the purpose of calculating Consolidated EBIT for any period that includes the first fiscal quarter of 1999, the amount shall be adjusted by adding charges recorded in such fiscal quarter, in an amount not exceeding $90,000,000, relating to additional medical claims expense including $50,000,000 related to premium deficiencies, $35,000,000 to strengthen medical claims payable and $5,000,000 for a payment to Columbia/HCA, and for the purpose of calculating Consolidated EBIT for any period after the Second Amendment Effective Date, the amount shall be adjusted by adding back one time charges recorded in such period, in an aggregate amount not exceeding $50,000,000, related to the reduction in the work force of the Company and its Subsidiaries and an increase in the provisions for reserves in Managed Care Indemnity, Inc., the Company's wholly-owned professional liability insurance Subsidiary."

II. Other Amendments to the Credit Agreement.

1 Amendment to Section 2.4. Section 2.4 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"2.4 Fees. (a) The Company agrees to pay to the Agent, for the account of each Bank, on the last day of each fiscal quarter, a facility fee in respect of the average daily amount of the Commitment of such Bank during such fiscal quarter (such amount, the "Average Quarterly Commitment"). Such fee shall be computed at the rate per annum equal to the higher of (i) the rate per annum determined in accordance with Schedule II and (ii) the rate per annum determined in accordance with Schedule IIA.

(b) The Company agrees to pay to the Agent the other fees in the amounts, and on the dates, agreed to by the Company and the Agent in the fee letter, dated June 4, 1997, between the Agent and the Company.

(c) For any day on which the Aggregate Outstanding Extensions of Credit of all Banks equals or exceeds an amount equal to one third of the aggregate Commitments of all the Banks, the Company agrees to pay to the Agent for the account of the Banks (ratably in accordance with their Commitments) a fee in an amount equal to 0.125% per annum on the Aggregate Outstanding Extensions of Credit of all Banks on such day. Any accrued fees payable in accordance with the immediately preceding sentence shall be payable on the last day of each fiscal quarter and on the earlier of the date the Commitments are terminated and the Termination Date."

2 Amendment to Section 3.3. Subsection 3.3(a) of the Credit Agreement is hereby amended and restated in its entirety as follows:

"(a) The Company shall pay to the Agent, for the account of the Issuing Bank and the L/C Participants, a letter of credit commission with respect to each Letter of Credit, computed at the rate per annum equal to the higher of (i) the rate per annum determined in accordance with Schedule II and (ii) the rate per annum determined in accordance with Schedule IIA, of which .100% per annum shall be payable to the Issuing Bank and the balance shall be payable to the L/C Participants and the Issuing Bank to be shared ratably among them in accordance with their respective Commitment Percentages. Such fee shall be payable on each L/C Fee Payment Date and shall be nonrefundable."

3 Amendment to Sections 4.3, 4.4, 4.7 and 4.9. Each of sections 4.3, 4.4, 4.7 and 4.9 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"4.3 Litigation. Except as disclosed in the Company's Annual Report on Form 10-K for its fiscal year ended December 31, 1996 and the Company's

Quarterly Report on Form 10-Q for its fiscal quarter ended March 31, 1997 filed with the Securities and Exchange Commission and previously distributed to the Banks or disclosed in writing to the Banks between the date thereof and November 19, 1999 (the "Updated Disclosure Letter"), as of the Second Amendment Effective Date there is no litigation, at law or in equity, or any proceeding before any federal, state, provincial or municipal board or other governmental or administrative agency, including without limitation, HMO Regulators and Insurance Regulators, pending or to the knowledge of the Company threatened which, after giving effect to any applicable insurance, may involve any material risk of a Material Adverse Effect or which seeks to enjoin the consummation of any of the transactions contemplated by this Agreement or any other Loan Document, and no judgment, decree, or order of any federal, state, provincial or municipal court, board or other governmental or administrative agency, including without limitation, HMO Regulators and Insurance Regulators, has been issued against the Company or any Subsidiary which has, or may involve, a material risk of a Material Adverse Effect. The Company does not believe that the final resolution of the matters disclosed in its Annual Report on Form 10-K for its fiscal year ended December 31, 1996 and the Company's Quarterly Report on Form 10-Q for its fiscal quarter ended March 31, 1997 filed with the Securities and Exchange

Commission and previously distributed to the Banks or the Updated Disclosure Letter, will have a Material Adverse Effect."

"4.4 Disclosure. Neither this Agreement nor any agreement, document, certificate or statement furnished to the Banks by the Company in connection herewith (including, without limitation, the information relating to the Company and its Subsidiaries included in the Confidential Information Memorandum dated July 1997 delivered in connection with the syndication of the credit facilities hereunder) contained at the time furnished to the Banks any untrue statement of material fact or, taken as a whole together with all other information furnished to the Banks by the Company, omitted to state a material fact necessary in order to make the statements contained herein or therein not misleading. All pro forma financial statements made available to the Banks have been prepared in good faith based upon reasonable assumptions. There is no fact known to the Company which materially adversely affects or could reasonably be expected to materially adversely affect the business, operations, affairs or condition of the Company and its Subsidiaries on a consolidated basis, except to the extent that they may be affected by future general economic conditions and except as set forth in paragraph 2 of the Updated Disclosure Letter."

"4.7 Changes in Condition. Since December 31, 1998, there has been no development or event nor any prospective development or event, which has had, or could reasonably be expected to have, a Material Adverse Effect."

"4.9 Tax Returns. The Company and each of its Subsidiaries have filed all tax returns which are required to be filed and have paid, or made adequate provision for the payment of, all taxes which have or may become due pursuant to said returns or to assessments received. All federal tax returns of the Company and its Subsidiaries through their fiscal years ended in 1993 have been audited by the Internal Revenue Service or are not subject to such audit by virtue of the expiration of the applicable period of limitations, and the results of such audits are fully reflected in the balance sheets referred to in subsection 4.6. The Company knows of no material additional assessments since said date for which adequate reserves have not been established."

4 Amendment to Section 7.5. Section 7.5 of the Credit Agreement is hereby amended by deleting the word "or" immediately before subsection 7.5(f) and deleting subsection 7.5(f) in its entirety and substituting the following in lieu thereof:

"(f) the sale or other disposition of any other property so long as no Default or Event of Default shall have occurred and be continuing; provided that the aggregate book value of all assets so sold or disposed of in any

fiscal year of the Company (disregarding the book value of any assets sold or disposed of in accordance with subsection 7.5(g) below in the fiscal year in which such sale or other disposition is completed) shall not exceed in the aggregate 12% of the Consolidated Assets of the Company and its Subsidiaries as at the end of the immediately preceding fiscal year of the Company; or

(g) the sale or other disposition of the Company's workers' compensation division and the Company's dental division, the aggregate book value of which assets shall not exceed $300,000,000"

III. Amendments to Schedules to the Credit Agreement.

1 Amendment to Schedule II. Schedule II to the Credit Agreement is hereby deleted in its entirety and replaced by Schedule II to this Amendment.

IV. Addition of Schedule IIA. The Credit Agreement is hereby amended by adding Schedule IIA, a copy which is attached hereto.

V. Notification of Commitment Reduction. The Agent hereby notifies the Banks that the Company has, in accordance with Section 2.5(a) of the Credit Agreement, reduced the amount of the Commitments in an aggregate amount such that the aggregate amount of the remaining Commitments is $1,000,000,000.

VI. Substitution of New Schedule 1. Schedule 1 to the Credit Agreement is hereby revised and restated by reducing the stated amount of each Bank's Commitment's by an amount equal to one third of the amount presently listed as such Bank's Commitment.

VII. Effective Date. This Amendment shall become effective on the date (the "Second Amendment Effective Date") on which the Agent receives (i) counterparts of this Amendment executed by each of the Company, the Agent and the Required Banks and (ii) an amendment fee from the Company for the account of each Bank delivering an executed counterpart of this Amendment on or before November 19, 1999 in an amount agreed to between the Company and the Agent.

VIII. General.

1 Representation and Warranties. To induce the Agent and CAF Loan Agent and the Banks parties hereto to enter into this Amendment, the Company hereby represents and warrants to the Agent and CAF Loan Agent and all of the Banks as of the Second Amendment Effective Date that (a) this Amendment constitutes the legal, valid and binding obligation of the Company, enforceable against it in accordance with its terms, except as such enforcement may be limited by bankruptcy, insolvency, fraudulent conveyances, reorganization, moratorium or similar laws affecting creditors' rights generally, by general equitable principles (whether enforcement is sought by proceedings in equity or at law) and by an implied covenant of good faith and fair dealing, (b) the representations and warranties made by the Company in the Credit

Agreement (as modified hereby) are true and correct in all material respects on and as of the date hereof (except to the extent that such representations and warranties are expressly stated to relate to an earlier date, in which case such representations and warranties shall have been true and correct in all material respects on and as of such earlier date), (c) the representation and warranty set forth in subsection 4.7 of the Credit Agreement (without giving effect to the modifications effected hereby except that the phrase 'could reasonably be expected to" shall be used in lieu of the word "may") is true and correct in all material respects as of the Second Amendment Effective Date and (d) no Default or Event of Default has occurred and is continuing.

2 Payment of Expenses. The Company agrees to pay or reimburse the Agent and CAF Loan Agent for all of its out-of-pocket costs and reasonable expenses incurred in connection with this Amendment, any other documents prepared in connection herewith and the transactions contemplated hereby, including, without limitation, the reasonable fees and disbursements of counsel to the Agent and CAF Loan Agent.

3 No Other Amendments; Confirmation. Except as expressly amended, modified and supplemented hereby, the provisions of the Credit Agreement and the Notes are and shall remain in full force and effect.

4 GOVERNING LAW. THIS AMENDMENT AND THE RIGHTS AND OBLIGATIONS OF THE PARTIES HERETO SHALL BE GOVERNED BY, AND CONSTRUED AND INTERPRETED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK.

5 Counterparts. This Amendment may be executed by one or more of the parties to this Agreement on any number of separate counterparts, and all of said counterparts taken together shall be deemed to constitute one and the same instrument. A set of the copies of this Amendment signed by all the parties shall be lodged with the Company and the Agent and CAF Loan Agent. This Amendment may be delivered by facsimile transmission of the relevant signature pages hereof.

SCHEDULE II

Applied Margins

REVOLVING CREDIT LOANS

Consolidated Capitalization Ratio	Alternate Base Rate Loans	Eurodollar Loans	Facility Fee (Rate Per Annum)	L/C Commission (Rate Per Annum)
less than .20	.000%	.1200%	.0650%	.2200%
at least .20 but less than .30	.000%	.1300%	.0700%	.2300%
at least .30 but less than .35	.000%	.1600%	.0900%	.2600%
at least .35 but less than .40	.000%	.2000%	.1000%	.3000%
at least .40	.000%	.3000%	.1500%	.4000%

Any change of the Applicable Margin or Facility Fee rate resulting from a change in the Consolidated Capitalization Ratio shall become effective on the first Business Day following the date to which the Consolidated Capitalization Ratio Certificate reflecting such change is applicable.

SCHEDULE IIA

Applied Margins

REVOLVING CREDIT LOANS

Rating	Alternate Base Rate Loans	Eurodollar Loans	Facility Fee (Rate Per Annum)	L/C Commission (Rate Per Annum)
Rating I	.000%	.350%	.100%	.450%
Rating II	.000%	.375%	.125%	.475%
Rating III	.000%	.475%	.150%	.575%
Rating IV	.000%	.575%	.175%	.675%
Rating V	.000%	.800%	.200%	.900%

For purposes of this Schedule the following terms shall have the following meanings:

"Rating": the respective rating of each of the Rating Agencies applicable to the long-term senior unsecured non-credit enhanced debt of the Company, as announced by the Rating Agencies from time to time.

"Rating Agencies": collectively, S&P and Moody's.

"Rating Category": each of Rating I, Rating II, Rating III, Rating IV and Rating V.

"Rating I, Rating II, Rating III, Rating IV and Rating V": the respective Ratings set forth below:

Rating Category	S&P	Moody's
Rating I	greater than or equal to BBB+	greater than or equal to Baa1
Rating II	lower than BBB+ and greater than or equal to BBB	lower than Baa1 and greater than or equal to Baa2
Rating III	lower than BBB and greater than or equal to BBB-	lower than Baa2 and greater than or equal to Baa3
Rating IV	lower than BBB- and greater than or equal to BB+	lower than Baa3 and greater than or equal to Ba1
Rating V	lower than BB+	lower than Ba1

; provided, that (i) if on any day the Ratings of the Rating Agencies do not fall in the same Rating Category, then the Rating Category of the lower of such Ratings shall be applicable for such day, (ii) if on any day the Rating of only one of the Rating Agencies is available, then the Rating Category of such Rating shall be applicable for such day and (iii) if on any day a Rating is available from neither of the Rating Agencies, then Rating V shall be applicable for such day. Any change in the applicable Rating Category resulting from a change in the Rating of a Rating Agency shall become effective on the date such change is publicly announced by such Rating Agency.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be duly executed and delivered by their respective proper and duly authorized officers as of the day and year first above written.

HUMANA INC.

By:_____
Name:_____
Title:_____

THE CHASE MANHATTAN BANK, as Agent, as CAF Loan Agent and as a Bank

By:_____
Name:_____
Title:_____

BANK OF AMERICA NATIONAL ASSOCIATION (formerly known as BANK OF AMERICA NATIONAL TRUST & SAVINGS ASSOCIATION), as Documentation Agent and as a Bank

By:_____
Name:_____
Title:_____

ASAHI BANK, LIMITED, CHICAGO BRANCH

By:_____
Name:_____
Title:_____

BANCA NAZIONALE DEL LAVORO S.P.A.

By:_____
Name:_____
Title:_____

By:_____
Name:_____
Title:_____

BANCA MONTE DEI PASCHI DI SIENA, SPA

By:_____
Name:_____
Title:_____

By:_____
Name:_____
Title:_____

BANK HAPOALIM B.M.

By:_____
Name:_____
Title:_____

BANK ONE, KENTUCKY, NA

By:_____
Name:_____
Title:_____

BANK OF LOUISVILLE AND TRUST COMPANY

By:_____
Name:_____
Title:_____

BARNETT BANK, N.A.

By:_____
Name:_____
Title:_____

CITIBANK, N.A.

By:_____
Name:_____
Title:_____

FIRST UNION NATIONAL BANK

By:_____
Name:_____
Title:_____

FIFTH THIRD BANK OF KENTUCKY

By:_____
Name:_____
Title:_____

FIRST AMERICAN NATIONAL BANK

By:_____
Name:_____
Title:_____

FIRSTAR BANK, N.A. (formerly known as FIRSTAR BANK MILWAUKEE, N.A.)

By:_____
Name:_____
Title:_____

FIRSTAR BANK, N.A. (as successor by merger to STAR N.A.)

By:_____
Name:_____
Title:_____

KEYBANK NATIONAL ASSOCIATION

By:_____
Name:_____
Title:_____

MORGAN GUARANTY TRUST COMPANY OF NEW YORK

By:_____
Name:_____
Title:_____

NATIONAL CITY BANK OF KENTUCKY

By:_____
Name:_____
Title:_____

PARIBAS

By:_____
Name:_____
Title:_____

By:_____
Name:_____
Title:_____

PNC BANK, KENTUCKY, INC.

By:_____
Name:_____
Title:_____

STAR BANK, N.A.

By:_____
Name:_____
Title:_____

SUNTRUST BANK, NASHVILLE, N.A.

By:_____
Name:_____
Title:_____

THE BANK OF NEW YORK

By:_____
Name:_____
Title:_____

THE BANK OF NOVA SCOTIA

By:_____
Name:_____
Title:_____

BANK ONE, NA (formerly known as THE FIRST NATIONAL BANK OF CHICAGO)

By:_____
Name:_____
Title:_____

THE BANK OF TOKYO-MITSUBISHI, LTD., CHICAGO BRANCH

By:_____
Name:_____
Title:_____

THE SUMITOMO BANK, LIMITED

By:_____
Name:_____
Title:_____

THE SANWA BANK, LIMITED

By:_____
Name:_____
Title:_____

THE NORTHERN TRUST COMPANY

By:_____
Name:_____
Title:_____

WACHOVIA BANK, N.A.

By:_____
Name:_____
Title:_____

WELLS FARGO BANK, N.A.

By:_____
Name:_____
Title:_____

By:_____
Name:_____
Title:_____

EXHIBIT 12

HUMANA INC.
RATIO OF EARNINGS TO FIXED CHARGES
For the Years Ended December 31, 1999, 1998 and 1997
(Unaudited)

(Dollars in millions)

	1999	1998	1997
Earnings:			
(Loss) income before income taxes	$(404)	$ 203	$ 270
Fixed charges	53	61	30
Total (loss) earnings	$(351)	$ 264	$ 300
Fixed charges:			
Interest charged to expense	$ 33	$ 47	$ 20
One-third of rent expense (a)	20	14	10
Total fixed charges	$ 53	$ 61	$ 30
Ratio of earnings to fixed charges	(b)	4.3(c)	10.0

(a) For the purpose of determining earnings in the calculation of the ratio of earnings to fixed charges, earnings have been increased by the provision for income taxes and fixed charges. Fixed charges consist of interest expense on borrowings and one-third (the proportion deemed representative of the interest portion) of rent expense.

(b) Earnings (loss) for the year ended December 31, 1999 were not adequate to cover fixed charges. Exclusive of $585 million expense primarily related to goodwill write-down, losses on non-core asset sales, professional liability reserve strengthening, premium deficiency and medical reserve strengthening, the ratio of earnings to fixed charges would have been 4.4 for the year ended December 31, 1999.

(c) Exclusive of $132 million expense primarily related to the costs of certain market exits and product discontinuances, asset write-offs, premium deficiency and a one-time non-officer employee incentive, the ratio of earnings to fixed charges would have been 6.5 for the year ended December 31, 1998.

FINANCIAL SECTION

SELECTED FINANCIAL DATA

(Dollars in millions, except per share results) ***For the years ended December 31,***	***1999 (a)***	***1998 (b)***	***1997 (c)***	***1996 (d)***	***1995 (c)***
SUMMARY OF OPERATIONS					
Premiums	$ 9,959	$ 9,597	$ 7,880	$ 6,677	$ 4,605
Interest and other income	154	184	156	111	97
Total revenues	10,113	9,781	8,036	6,788	4,702
(Loss) income before income taxes	(404)	203	270	18	288
Net (loss) income	(382)	129	173	12	190
(Loss) earnings per common share	(2.28)	0.77	1.06	0.07	1.17
(Loss) earnings per common share — assuming dilution	(2.28)	0.77	1.05	0.07	1.16
Net cash provided by operations	217	55	279	341	150
FINANCIAL POSITION					
Cash and investments	$ 2,738	$ 2,812	$ 2,798	$ 1,880	$ 1,696
Total assets	4,900	5,496	5,600	3,306	3,056
Medical and other expenses payable	1,756	1,908	2,075	1,099	866
Debt and other long-term obligations	830	977	1,057	361	399
Stockholders’equity	1,268	1,688	1,501	1,292	1,287
OPERATING DATA					
Medical expense ratio	85.7%	83.8%	82.8%	84.3%	81.7%
Administrative expense ratio	15.0%	15.2%	15.5%	15.5%	13.9%
Medical membership by segment:					
Health Plan:					
Large group commercial	1,420,500	1,559,700	1,661,900	1,435,000	1,502,500
Medicare HMO	488,500	502,000	480,800	364,500	310,400
Medicaid and other	661,100	700,400	704,000	152,900	164,000
TRICARE	1,058,000	1,085,700	1,112,200	1,103,000	
Administrative services	648,000	646,200	651,200	471,000	495,100
Total Health Plan	4,276,100	4,494,000	4,610,100	3,526,400	2,472,000
Small Group:					

Small group commercial	1,663,100	1,701,800	1,596,700	1,324,600	1,332,400
Total medical membership	5,939,200	6,195,800	6,206,800	4,851,000	3,804,400
Specialty membership:					
Dental	1,628,200	1,375,500	936,400	844,800	797,000
Other	1,333,100	1,257,800	1,504,200	1,039,400	1,063,000
Total specialty membership	2,961,300	2,633,300	2,440,600	1,884,200	1,860,000

(a) Includes expenses of $585 million pretax ($499 million after tax, or $2.97 per diluted share) primarily related to goodwill write-down, losses on non-core asset sales, professional liability reserve strengthening, premium deficiency and medical reserve strengthening.

(b) Includes expenses of $132 million pretax ($84 million after tax, or $0.50 per diluted share) primarily related to the costs of certain market exits and product discontinuances, asset write-offs, premium deficiency and a one-time non-officer employee incentive.

(c) Includes the operations of Health Direct, Inc., Physician Corporation of America, ChoiceCare Corporation and EMPHESYS Financial Group, Inc. since their dates of acquisition, February 28, 1997, September 8, 1997, October 17, 1997 and October 11, 1995, respectively.

(d) Includes expenses of $215 million pretax ($140 million after tax, or $0.85 per diluted share) primarily related to the closing of the Washington, D.C. and certain other markets, severance and facility costs for workforce reductions, product discontinuance costs, premium deficiency, litigation and other costs.

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

The consolidated financial statements of Humana Inc. (the "Company" or "Humana") in this Annual Report present the Company's financial position, results of operations and cash flows, and should be read in conjunction with the following discussion and analysis. This discussion and analysis contains both historical and forward-looking information. The forward-looking statements may be significantly impacted by risks and uncertainties, and are made pursuant to the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. There can be no assurance that anticipated future results will be achieved because actual results may differ materially from those projected in the forward-looking statements. Readers are cautioned that a number of factors, which are described herein and in the Company's Annual Report on Form 10-K for the year ended December 31, 1999, could adversely affect the Company's ability to obtain these results. These include the effects of either federal or state health care reform or other legislation, including the Patients' Bill of Rights, any expanded right to sue managed care companies and alleged class action litigation directed against the managed care industry, changes in the Medicare reimbursement system, the ability of health care providers (including physician practice management companies) to comply with current contract terms, renewal of the Company's Medicare contracts with the federal government, renewal of the Company's contract with the federal government to administer the TRICARE program and renewal of the Company's Medicaid contracts with various state governments and the Health Insurance Administration in Puerto Rico. Such factors also include the effects of other general business conditions, including but not limited to, the success of the Company's improvement initiatives including its electronic business strategies, premium rate and yield changes, retrospective premium adjustments relating to federal government contracts, changes in commercial and Medicare HMO membership, medical and pharmacy cost trends, compliance with debt covenants, changes in the Company's debt rating and its ability to borrow under its commercial paper program, operating subsidiary capital requirements, competition, general economic conditions and the retention of key employees. In addition, past financial performance is not necessarily a reliable indicator of future performance and investors should not use historical performance to anticipate results or future period trends.

INTRODUCTION

Humana is one of the nation's largest publicly traded health services companies that facilitates the delivery of health care services through networks of providers to its approximately 5.9 million medical members. The Company's products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracted providers. HMOs and PPOs control health care costs by various means, including pre- admission approval for hospital inpatient services, pre-authorization of outpatient surgical procedures, and risk-sharing arrangements with providers. These providers may share medical cost risk or have other incentives to deliver quality medical services in a cost-effective manner. The Company also offers various specialty products to employers, including dental, group life and workers' compensation and administrative services ("ASO") to those who self-insure their employee health plans. The Company has entered into a definitive agreement to sell its workers' compensation business. In total, the Company's products are licensed in 49 states, the District of Columbia and Puerto Rico, with approximately 20 percent of its membership in the state of Florida.

During 1999, the Company realigned its organization to achieve greater accountability in its lines of business. As a result of this realignment, the Company organized into two business units: the Health Plan segment and the Small Group segment. The Health Plan segment includes the Company's large group commercial (100 employees and over), Medicare, Medicaid, ASO, workers' compensation and military or TRICARE business. The small group segment includes small group commercial (under 100 employees) and specialty benefit lines, including dental, life and short-term disability. Results of each segment are measured based upon results of operations before income taxes. The Company allocates administrative expenses, interest income and interest expense, but no assets, to the segments. Members served by the two segments generally utilize the same medical provider networks, enabling the Company to obtain more favorable contract terms with providers. As a result, the profitability of each segment is somewhat interdependent. In addition, premium revenue pricing to large group commercial employers has historically been more competitive than that to small group commercial employers, resulting in less favorable underwriting margins for the large group commercial line of business. Costs to distribute and administer products to small group commercial employers are higher compared to large group commercial employers resulting in small group's higher administrative expense ratio.

ACQUISITIONS AND DISPOSITIONS

Between December 30, 1999 and February 4, 2000, the Company entered into definitive agreements to sell its workers' compensation, Medicare supplement and North Florida Medicaid businesses for proceeds of approximately $115 million. The Company recorded a $118 million loss in 1999 related to these sale transactions.

On January 31, 2000, the Company acquired the Memorial Sisters of Charity Health Network ("MSCHN"), a Houston based health plan for approximately $50 million in cash.

On June 1, 1999, the Company reached an agreement with FPA Medical Management, Inc. ("FPA"), FPA's lenders and a federal bankruptcy court under which the Company acquired the operations of 50 medical centers from FPA for approximately $14 million in cash. The Company has subsequently reached agreements with 14 provider groups to assume operating responsibility for 38 of the 50 acquired FPA medical centers under long-term provider agreements with the Company.

On October 17, 1997, the Company acquired ChoiceCare Corporation ("ChoiceCare") for approximately $250 million in cash. The purchase was funded with borrowings under the Company's commercial paper program. ChoiceCare provided health services products to members in the Greater Cincinnati, Ohio, area.

On September 8, 1997, the Company acquired Physician Corporation of America ("PCA") for total consideration of $411 million in cash, consisting primarily of $7 per share for PCA's outstanding common stock and the assumption of $121 million in debt. The purchase was funded with borrowings under the Company's commercial paper program. PCA provided comprehensive health services through its HMOs in Florida, Texas and Puerto Rico. In addition, PCA provided workers' compensation third-party administrative management services. Prior to November 1996, PCA also was a direct writer of workers' compensation insurance in Florida. Long-term medical and other expenses payable in the accompanying Consolidated Balance Sheets includes the long-term portion of workers' compensation liabilities related to this business.

On February 28, 1997, the Company acquired Health Direct, Inc. ("Health Direct") from Advocate Health Care for approximately $23 million in cash.

The above acquisitions were accounted for under the purchase method of accounting. In connection with these acquisitions, the Company allocated the acquisition costs to net tangible and identifiable intangible assets based upon their fair values. Identifiable intangible assets, which are included in other long-term assets in the accompanying Consolidated Balance Sheets, primarily relate to subscriber and provider contracts. Any remaining value not assigned to net tangible or identifiable intangible assets was then allocated to cost in excess of net assets acquired, or goodwill. Goodwill and identifiable intangible assets acquired, recorded in connection with the acquisitions, was $17 million and $754 million in 1999 and 1997, respectively. Subscriber and provider contracts are amortized over their estimated useful lives (seven to 14 years), while goodwill has been amortized over periods from six to 40 years.

At December 31, 1999, goodwill and identifiable intangible assets represent 67% of total stockholders' equity. In accordance with the Company's policy, the carrying values of all long-lived assets including goodwill and identifiable intangible assets are periodically reviewed by management for impairment whenever adverse events or changes in circumstances occur. In addition, management periodically reviews the reasonableness of the estimated useful life assigned to goodwill and identifiable intangible assets. Impairment losses and/or changes in the estimated useful life related to these assets could have a material adverse impact on the Company's financial position and results of operations.

During 1999, the Company recorded an impairment loss and, effective January 1, 2000, adopted a 20 year amortization period from the date of acquisition for goodwill previously amortized over 40 years as discussed in the following section.

ASSET WRITE-DOWNS AND OPERATIONAL EXPENSES

The following table presents the components of the asset write-downs and operational expenses and their respective classifications in the 1999 and 1998 Consolidated Statements of Operations:

(In millions)	*Medical*	*Selling, General and Administrative*	*Asset Write-Downs and Other*	*Total*
1999:				
FIRST QUARTER 1999:				
Premium deficiency	$ 50			$ 50
Reserve strengthening	35			35
Provider costs	5			5
Total first quarter 1999	90			90
FOURTH QUARTER 1999:				
Long-lived asset impairment			$ 342	342
Losses on non-core asset sales			118	118
Professional liability reserve strengthening and other costs		$ 35		35
Total fourth quarter 1999		35	460	495
Total 1999	$ 90	$ 35	$ 460	$585

(In millions)	*Medical*	*Selling, General and Administrative*	*Asset Write-Downs and Other*	*Total*
1998:				
THIRD QUARTER 1998:				
Premium deficiency	$ 46			$ 46
Provider costs	27			27
Market exit costs			$ 15	15
Losses on non-core asset sales			12	12
Merger dissolution costs			7	7
Non-officer employee incentive and other costs		$ 25		25
Total third quarter 1998	$ 73	$ 25	$ 34	$ 132

1999 EXPENSES

Premium Deficiency, Reserve Strengthening and Provider Costs

As a result of management's assessment of the profitability of its contracts for providing health care services to its members in certain markets, the Company recorded a provision for probable future losses (premium deficiency) of $50 million during the first quarter of 1999. Ineffective provider risk-sharing contracts and the impact of the March 31, 1999 Columbia/HCA Healthcare Corporation ("Columbia/HCA") hospital agreement in Florida on current and projected future medical costs contributed to the premium deficiency. The beneficial effect from losses charged to the premium deficiency liability throughout 1999 was $50 million. Because the majority of the Company's customers' contracts renew annually, the Company does not anticipate the need for a premium deficiency in 2000, absent unanticipated adverse events or changes in circumstances.

Prior period adverse claims development primarily in the Company's PPO and Medicare products initially identified during an analysis of February and March 1999 medical claims resulted in the $35 million reserve strengthening. The Company releases or strengthens medical claims reserves when favorable or adverse development in prior periods exceed actuarial margins existing in the reserves. In addition, the Company paid Columbia/HCA $5 million to settle certain contractual issues associated with the March 31, 1999 hospital agreement in Florida.

Long-Lived Asset Impairment

Historical and current period operating losses in certain of the Company's markets prompted a review during the fourth quarter of 1999 for the possible impairment of long-lived assets. This review indicated that estimated future undiscounted cash flows were insufficient to recover the carrying value of long-lived assets, primarily goodwill, associated with the Company's Austin, Dallas and Milwaukee markets. Accordingly, the Company adjusted the carrying value of these long-lived assets to their estimated fair value resulting in a non-cash impairment charge of $342 million. Estimated fair value was based on discounted cash flows.

The long-lived assets associated with the Austin and Dallas markets primarily result from the Company's 1997 acquisition of PCA. Operating losses in Austin and Dallas were related to the deterioration of risk-sharing arrangements with providers and the failure to effectively convert the PCA operating model and computer platform to Humana's. The long-lived assets associated with the Milwaukee market primarily result from the Company's 1994 acquisition of CareNetwork, Inc. Operating losses in Milwaukee were the result of competitor pricing strategies resulting in lower premium levels to large employer groups as well as market dynamics dominated by limited provider groups causing higher than expected medical costs.

The Company also re-evaluated the amortization period of its goodwill and as a result, effective January 1, 2000, adopted a 20 year amortization period from the date of acquisition for goodwill previously amortized over 40 years.

The $342 million long-lived asset impairment will decrease depreciation and amortization expense $13 million annually ($13 million after tax, or $0.08 per diluted share), while the change in the amortization period of goodwill will increase amortization expense $25 million annually ($24 million after tax, or $0.15 per diluted share).

Losses on Non-Core Asset Sales

The Company has entered into definitive agreements for the disposition of its workers' compensation, Medicare supplement and North Florida Medicaid businesses, which are considered non-core. As a result of the carrying value of the net assets of these businesses exceeding the estimated sale proceeds, the Company has recorded a loss of $118 million. Estimated fair value was established based upon definitive sale agreements, net of expected transaction costs. These transactions are expected to be completed in the first and second quarters of 2000. Total assets of $725 million, primarily consisting of marketable securities and reinsurance recoverables and total liabilities of $490 million, primarily consisting of worker's compensation reserves related to these businesses are included in the accompanying Consolidated Balance Sheets. The accompanying Consolidated Statements of Operations include 1999 revenues of $214 million and pretax operating income of $38 million from these businesses. Included in 1999 and 1998 pretax operating (loss) income is $36 million and $5 million of workers' compensation reserve releases resulting from favorable claim liability development.

Professional Liability Reserve Strengthening and Other Costs

The Company insures substantially all professional liability risks through a wholly owned captive insurance subsidiary (the "Subsidiary"). The Subsidiary recorded an additional $25 million expense during the fourth quarter of 1999 primarily related to expected claim and legal costs to be incurred by the Company.

In addition, other expenses of $10 million were recorded during the fourth quarter related to a claim payment dispute with a contracted provider and government audits.

Activity related to the 1999 expenses follows:

(In millions)	1999 Expenses	1999 Activity		Balance at December 31, 1999
		Cash	Non-Cash	
Premium deficiency	$ 50	$ (50)		—
Reserve strengthening	35	(35)		—
Provider costs	5	(5)		—
Long-lived asset impairment	342		$ (342)	—
Losses on non-core asset sales	118		(28)	$ 90
Professional liability reserve strengthening and other costs	35			35
	$ 585	$ (90)	$ (370)	$ 125

1998 EXPENSES

Market Exits, Non-Core Asset Sales and Merger Dissolution Costs
On August 10, 1998, the Company and UnitedHealth Group Company ("United") announced their mutual agreement to terminate the previously announced Agreement and Plan of Merger, dated May 27, 1998. The planned merger, among other things, was expected to improve the operating results of the Company's products and markets due to overlapping markets with United. Following the merger's termination, the Company conducted a strategic evaluation, which included assessing the Company's competitive market positions and profit potential. As a result, the Company recognized expenses of $34 million during the third quarter of 1998. The expenses included costs associated with exiting five markets ($15 million), losses on disposals of non-core assets ($12 million) and merger dissolution costs ($7 million).

The costs associated with the market exits of $15 million included severance, lease termination costs as well as write-offs of equipment and uncollectible provider receivables. The planned market exits were Sarasota and Treasure Coast, Florida, Springfield and Jefferson City, Missouri and Puerto Rico. Severance costs were estimated based upon the provisions of the Company's employee benefit plans. The plan to exit these markets was expected to reduce the Company's market office workforce, primarily in Puerto Rico, by approximately 470 employees. In 1999, the Company reversed $2 million of the severance and lease discontinuance liabilities after the Company contractually agreed with the Health Insurance Administration in Puerto Rico to extend the Company's Medicaid contract, with more favorable terms. The Company estimated annual pretax savings of approximately $40 million, after all market exits were completed by June 30, 1999, primarily from a reduction in underwriting losses. Approximately 100 employees were ultimately terminated resulting in insignificant severance payments.

In accordance with the Company's policy on impairment of long-lived assets, equipment of $5 million in the exited markets was written down to its fair value after an evaluation of undiscounted cash flow in each of the markets. The fair value of equipment was based upon discounted cash flows for the same markets. Following the write-down, the equipment was fully depreciated.

Premium Deficiency and Provider Costs
As a result of management's assessment of the profitability of its contracts for providing health care services to its members in certain markets, the Company recorded a provision for probable future losses (premium deficiency) of $46 million during the third quarter of 1998. The premium deficiency resulted from events prompted by the terminated merger with United wherein the Company had expected to realize improved operating results in those markets that overlapped with United, including more favorable risk-sharing arrangements. The beneficial effect from losses charged to the premium deficiency liability in 1999 and 1998 was $23 million and $17 million, respectively. In 1999, the Company reversed $6 million of premium deficiency liabilities after the Company contractually agreed with the Health Insurance Administration in Puerto Rico to extend the Company's Medicaid contract, with more favorable terms.

The Company also recorded $27 million of expense related to receivables written-off from financially troubled physician groups, including certain bankrupt providers.

Non-Officer Employee Incentive and Other Costs
During the third quarter of 1998, the Company recorded a one-time incentive of $16 million paid to non-officer employees and a $9 million settlement related to a third party pharmacy processing contract.

Activity related to the 1998 expenses follows:

(In millions)	*1998 Expenses*	*1998 Activity*		*Balance at December 31, 1998*	*1999 Activity*		*Balance at December 31, 1999*
		Cash	*Non-cash*		*Cash*	*Adjustment*	
Premium deficiency	$ 46	$ (17)		$ 29	$ (23)	$ (6)	$ —
Provider costs	27		$ (27)				
Market exit costs	15		(10)	5	(2)	(2)	1
Losses from non-core asset sales	12	(5)	(7)				
Merger dissolution costs	7	(5)		2	(2)		—
Non-officer employee incentive and other costs	25	(25)					—
	$ 132	$ (52)	$ (44)	$ 36	$ (27)	$ (8)	$ 1

COMPARISON OF RESULTS OF OPERATIONS

In order to enhance comparability as well as to provide a baseline against which historical and prospective periods can be measured, the following discussion comparing results for the years ended December 31, 1999, 1998 and 1997, excludes the previously described expenses, but does include the beneficial effect related to premium deficiency on operating results for the periods shown. There were no adjustments to results for 1997. The following table reconciles the results reported in the Consolidated Statements of Operations ("Reported Results") to the results contained in the following discussion ("Adjusted Results") for 1999 and 1998:

	Reported Results		Excluded Expenses		Adjusted Results	
(In millions, except per share results)	*1999*	*1998*	*1999 (a)*	*1998 (b)*	*1999*	*1998*
Consolidated Statements of Operations caption items that are adjusted:						
Operating expenses:						
Medical	$ 8,532	$ 8,041	$ (90)	$ (73)	$8,442	$7,968
Selling, general and administrative	1,368	1,328	(35)	(25)	1,333	1,303
Depreciation and amortization	124	128			124	128
Asset write-downs and other expenses	460	34	(460)	(34)	—	—
Total operating expenses	10,484	9,531	(585)	(132)	9,899	9,399
(Loss) income from operations	(371)	250	585	132	214	382
(Loss) income before income taxes	(404)	203	585	132	181	335
Net (loss) income	$ (382)	$ 129	$ 499	$ 84	$ 117	$ 213
(Loss) earnings per common share	$ (2.28)	$ 0.77	$ 2.97	$ 0.50	$ 0.69	$ 1.28
Diluted (loss) earnings per common share	$ (2.28)	$ 0.77	$ 2.97	$ 0.50	$ 0.69	$ 1.27

	Reported Ratios		Ratio Effect of Excluded Expenses		Adjusted Ratios	
	1999	*1998*	*1999 (a)*	*1998 (b)*	*1999*	*1998*
Medical expense ratios:						
Health Plan	87.4%	85.3%	(1.0)%	(0.9)%	86.4%	84.4%
Small Group	81.9%	80.2%	(0.7)%	(0.5)%	81.2%	79.7%
Total	85.7%	83.8%	(0.9)%	(0.8)%	84.8%	83.0%
Administrative expense ratios:						
Health Plan	12.5%	12.8%	(0.4)%	(0.2)%	12.1%	12.6%
Small Group	20.4%	20.7%	(0.3)%	(0.4)%	20.1%	20.3%
Total	15.0%	15.2%	(0.4)%	(0.3)%	14.6%	14.9%

(a) Reflects the previously discussed medical, administrative, asset write-downs and other expenses of $90 million, $35 million and $460 million, respectively.

(b) Reflects the previously discussed medical, administrative, asset write-downs and other expenses of $73 million, $25 million and $34 million, respectively.

YEARS ENDED DECEMBER 31, 1999 AND 1998

Adjusted income before income taxes totaled $181 million for the year ended December 31, 1999, compared to $335 million for the year ended December 31, 1998. Adjusted net income was $117 million or $0.69 per diluted share in 1999, compared to $213 million or $1.27 per diluted share in 1998. The earnings decline was attributable to higher medical cost trends which were not adequately anticipated by the Company when it established premium rates for 1999. These higher medical cost trends primarily resulted from the introduction and rapid growth of an open access product, ineffective risk-sharing arrangements, significant increases in pharmacy costs and the unfavorable negotiations of the Florida Columbia/HCA provider contract. During 1999, the Company implemented initiatives to mitigate the effect of these issues. The initiatives include pricing products commensurate with the higher medical costs, rationalizing markets and products, rehabilitating the large group commercial business, re-contracting with providers and cost management improvements focused mainly on medical and claims cost management disciplines. These initiatives began to improve operating results in the second half of 1999 but in large part will be realized in January 2000 when the majority of the Company's large group commercial customers renew and when the Company's Medicare product offerings were adjusted.

The Company's premium revenues increased 3.8 percent to a record $10.0 billion for 1999, compared to $9.6 billion for 1998. Higher premium revenues resulted from increased premium yields of 7.4 percent and 3.4 percent for the Company's commercial and Medicare HMO products, respectively. This increase was partially offset by a decline in commercial membership of 177,900, due to selling the Florida individual business line and the result of substantial premium increases delivered to large group and small group commercial customers. Membership levels are expected to decline in 2000 due to the sale of certain non-core businesses and substantial premium rate increases. The Company expects commercial and Medicare HMO premium yields to approximate 10 to 12 percent and 6 to 7 percent, respectively, in 2000, the result of commercial premium rate increases and newly introduced Medicare member premiums.

The Company's adjusted medical expense ratio for 1999 was 84.8 percent, compared to 83.0 percent for 1998. The increase was the result of medical cost increases in the Company's commercial products exceeding premium rate increases. Offsetting the impact of the increasing commercial medical costs was the continued favorable claim liability development in the Company's run-off workers' compensation business acquired in connection with its acquisition of PCA. After evaluating the workers' compensation claim liabilities against claim payments and file closings, the Company reduced these liabilities by $36 million ($23 million after tax, or $0.14 per diluted share) and $5 million ($3 million after tax, or $0.02 per diluted share) in 1999 and 1998, respectively.

The adjusted administrative expense ratio improved during 1999 to 14.6 percent from 14.9 percent in 1998. The year-over-year improvement in the administrative expense ratio reflects continued rationalization of staffing levels commensurate with membership levels. The administrative expense ratio is expected to increase slightly in 2000 from increased spending on information technology.

Interest income totaled $132 million for 1999 and $150 million for 1998. This decrease resulted from a decrease in realized investment gains, lower average invested balances and lower investment yields. The tax equivalent yield on invested assets approximated 7.1 percent for 1999 and 7.7 percent for 1998. Tax equivalent yield is the rate earned on invested assets, excluding unrealized gains and losses, adjusted for the benefit of nontaxable investment income. The weighted average investment life was 2.7 years at both December 31, 1999 and 1998. Other income declined $12 million during 1999, due to the reduction of income from ancillary businesses the Company sold in 1998 and a lower contribution from the Company's ASO business, partially offset by a $12 million gain from the sale of a tangible asset in 1999. Interest expense declined $14 million during 1999 as a result of lower average outstanding borrowings.

BUSINESS SEGMENT INFORMATION FOR THE YEARS ENDED DECEMBER 31, 1999 AND 1998

The following table presents segment medical membership and activity for 1999 and 1998:

	1999			1998		
(In thousands)	***Health Plan***	***Small Group***	***Total***	***Health Plan***	***Small Group***	***Total***
Beginning medical membership	4,494	1,702	6,196	4,610	1,597	6,207
Sales	588	436	1,024	610	571	1,181
Cancellations	(778)	(475)	(1,253)	(700)	(466)	(1,166)
TRICARE change	(28)		(28)	(26)		(26)
Ending medical membership	4,276	1,663	5,939	4,494	1,702	6,196
Ending specialty membership	477	2,484	2,961	444	2,189	2,633

The following table presents certain financial data for the Company's two segments for the years ended December 31, 1999 and 1998:

(In millions)	***1999 (a)***	***1998 (b)***
Premium revenues:		
Health Plan	$ 6,827	$ 6,734
Small Group	3,132	2,863
	$ 9,959	$ 9,597
Adjusted income (loss) before income taxes:		
Health Plan	$ 184	$ 304
Small Group	(3)	31
	$ 181	$ 335
Adjusted medical expense ratios:		
Health Plan	86.4%	84.4%
Small Group	81.2%	79.7%
	84.8%	83.0%
Adjusted administrative expense ratios:		
Health Plan	12.1%	12.6%

Small Group	20.1%	20.3%
	14.6%	14.9%

(a) Excludes the previously discussed medical expenses of $90 million ($66 million Health Plan and $24 million Small Group), administrative expenses of $35 million ($27 million Health Plan and $8 million Small Group) and asset write-downs and other expenses of $460 million ($460 million Health Plan).

(b) Excludes the previously discussed medical expenses of $73 million ($60 million Health Plan and $13 million Small Group), administrative expenses of $25 million ($13 million Health Plan and $12 million Small Group) and asset write-downs and other expenses of $34 million ($23 million Health Plan and $11 million Small Group).

Health Plan
Adjusted income before income taxes totaled $184 million for 1999 compared to $304 million for 1998. The earnings decline was attributable to higher medical cost trends which were not adequately anticipated by the Company when it established premium rates for 1999. These higher medical cost trends primarily resulted from ineffective risk-sharing arrangements, pharmacy cost increases and the result of unfavorable negotiations of the Florida Columbia/HCA provider contract. Initiatives to mitigate the effect of these issues include significant large group commercial rate increases, re-contracting with, or eliminating certain risk-sharing providers, implementing three-tier pharmacy benefit designs, instituting Medicare HMO member premium and benefit changes and exiting various Medicare markets. These initiatives began to improve operating results in the second half of 1999 but in large part will be realized in January 2000 when the majority of the Company's large group commercial customers renew and when the Company's Medicare product offerings were adjusted.

The Health Plan segment's premium revenues increased 1.4 percent to $6.8 billion for 1999. Large group commercial and Medicare HMO premiums remained unchanged at $2.3 billion and $2.9 billion, respectively. Higher premium yields of 5.5 percent and 3.4 percent for the large group commercial and Medicare HMO lines, respectively, were offset by membership reductions. Large group commercial membership decreased 139,200 from 1998 reflecting the effects of the Company's commercial premium pricing actions intended to maintain profitability. Medicare HMO membership decreased 13,500 members from the exit of the Treasure Coast and Sarasota, Florida markets. The Medicare HMO membership reduction from market exits was somewhat mitigated by increased membership achieved through the redirecting of sales and marketing efforts focused on key Medicare markets like Chicago, Tampa and South Florida. The Company's Medicaid premiums increased 8.8 percent to $603 million for 1999 compared to $554 million in 1998. This increase resulted from the more favorable rates obtained from the renewal of the Company's contract with the Health Insurance Administration in Puerto Rico in the second quarter of 1999. TRICARE premium revenues increased 8.3 percent to $866 million in 1999, from $800 million in 1998, resulting from an annual contract rate increase and additional premiums recorded related to TRICARE's risk-sharing arrangement with the government.

The Health Plan segment's adjusted medical expense ratio for 1999 was 86.4 percent, increasing from 84.4 percent in 1998. The increase was the result of large group commercial and Medicare HMO medical costs exceeding premium increases. These higher medical cost trends were attributable to the inability of certain risk-sharing providers to effectively manage medical costs within their contractual arrangements, higher pharmacy utilization and generally higher medical cost trends across the industry. The Company expects to realize improvements in its medical cost trends in 2000 resulting from implementation of the three-tier pharmacy benefit designs, improvements in risk-sharing arrangements, the exit of unprofitable Medicare HMO counties and the sale of its Medicare supplement and North Florida Medicaid businesses.

The adjusted administrative expense ratio improved 50 basis points from 1998 to 12.1 percent, the result of the continued rationalization of staffing levels commensurate with membership levels.

Small Group
The Small Group segment's adjusted loss before income taxes was $3 million for 1999 compared to adjusted income before income taxes of $31 million for 1998. The decline in profitability is attributable to higher medical costs which were not adequately anticipated by the Company when it established premium rates for 1999. To mitigate the effect of higher medical costs, the Small Group segment's improvement initiatives include significant premium rate increases, improving claim payment processes, provider re-contracting, rationalizing markets and products and implementing three-tier pharmacy benefit designs.

The Small Group segment's premium revenues increased 9.4 percent for 1999 to $3.1 billion from $2.9 billion for 1998. This premium increase was the result of increased premium yields, offset by a reduction of 38,700 members from the sale of the individual line of business in Florida.

The Small Group segment's adjusted medical expense ratio for 1999 was 81.2 percent, increasing from 79.7 percent for 1998. The medical expense ratio increase was the result of medical costs exceeding premium yields. These higher medical cost trends were the result of the rapid growth of the Company's more costly open access products, higher pharmacy utilization and the greater than expected impact of the Health Insurance Portability and Accountability Act or HIPAA and its guarantee issue requirements.

The adjusted administrative expense ratio improved during 1999 to 20.1 percent from 20.3 percent for 1998.

YEARS ENDED DECEMBER 31, 1998 AND 1997

Adjusted income before income taxes totaled $335 million for the year ended December 31, 1998, compared to $270 million for the year ended December 31, 1997. Adjusted net income was $213 million or $1.27 per diluted share in 1998, compared to $173 million or $1.05 per diluted share in 1997. The earnings increase was a result of the full year contribution from the 1997 PCA and ChoiceCare acquisitions, higher commercial premium yields, provider risk-sharing initiatives, improved claims payment accuracy across various product lines, and increased interest and other income. These favorable items were partially offset by higher interest expense and increased pharmacy costs.

The Company's 1998 premium revenues increased 21.8 percent to $9.6 billion, from $7.9 billion for the year ended December 31, 1997. This increase was attributable to the current year effect of 1997 acquisitions, commercial and Medicare HMO same-plan membership growth and increased premium rates for the Company's commercial products. PCA and ChoiceCare premium revenues contributed approximately $1.6 billion, a $1.1 billion increase over 1997. Same-plan membership growth contributed $120 million and commercial premium rate increases added approximately $186 million, as same-plan commercial premium yields increased 4.8 percent. Changes in Medicare HMO premium yield had little effect on premium revenues as same-plan yields declined 0.4 percent in 1998. The Medicare 2 percent statutory rate increase for 1998 was offset by membership growth in geographic areas with lower reimbursement rates.

During 1998, the Company's adjusted medical expense ratio increased to 83.0 percent from 82.8 percent for the year ended December 31, 1997. The year to year increase was the result of the higher medical expense ratio of acquired plans being included for a full year during 1998. The same-plan medical expense ratio improved 20 basis points to 82.2 percent from 82.4 percent in 1997, the result of the aforementioned premium rate increases, provider risk-sharing initiatives and improved claim payment accuracy. These improvements were partially offset by increased year-over-year pharmacy costs of 16 percent and 9 percent for the Company's commercial and Medicare HMO products, respectively.

The Company's adjusted administrative expense ratio was 14.9 percent and 15.5 percent for the years ended December 31, 1998 and 1997, respectively. This improvement was the result of efforts to streamline the organization, as well as realized cost savings from the Company's 1997 acquisitions.

Interest income totaled $150 million for the year ended December 31, 1998, compared to $131 million for the year ended December 31, 1997. The increase was attributable to the full year impact of including PCA's and ChoiceCare's investment portfolios, as well as increased realized investment gains. The tax equivalent yield on invested assets approximated 7.7 percent and 7.5 percent for the years ended December 31, 1998 and 1997, respectively. Tax equivalent yield is the rate earned on invested assets, excluding unrealized gains and losses, adjusted for the benefit of nontaxable investment income. The weighted average investment life increased to 2.7 years at December 31, 1998, from 2.6 years at December 31, 1997. Interest expense increased $27 million during 1998 from funding the PCA and ChoiceCare acquisitions with additional borrowings.

BUSINESS SEGMENT INFORMATION FOR THE YEARS ENDED DECEMBER 31, 1998 AND 1997

The following table presents segment medical membership and activity for 1998 and 1997:

	1998			*1997*		
(In thousands)	***Health Plan***	***Small Group***	***Total***	***Health Plan***	***Small Group***	***Total***
Beginning medical membership	4,610	1,597	6,207	3,526	1,325	4,851
Sales	610	571	1,181	499	458	957
Cancellations	(700)	(466)	(1,166)	(465)	(392)	(857)
Acquisitions				1,188	206	1,394
Dispositions				(147)		(147)
TRICARE change	(26)		(26)	9		9
Ending medical membership	4,494	1,702	6,196	4,610	1,597	6,207
Ending specialty membership	444	2,189	2,633	507	1,934	2,441

The following table presents certain financial data for the Company's two segments for the years ended December 31, 1998 and 1997:

(In millions)	***1998 (a)***	***1997***
Premium revenues:		
Health Plan	$ 6,734	$ 5,487
Small Group	2,863	2,393
	$ 9,597	$ 7,880
Adjusted income before income taxes:		
Health Plan	$ 304	$ 244
Small Group	31	26
	$ 335	$ 270
Adjusted medical expense ratios:		
Health Plan	84.4%	84.3%
Small Group	79.7%	79.4%
	83.0%	82.8%
Adjusted administrative expense ratios:		
Health Plan	12.6%	13.1%
Small Group	20.3%	21.0%
	14.9%	15.5%

(a) Excludes the previously discussed medical expenses of $73 million ($60 million Health Plan and $13 million Small Group), administrative expenses of $25 million ($13 million Health Plan and $12 million Small Group) and asset write-downs and other expenses of $34 million ($23 million Health Plan and $11 million Small Group).

Health Plan
Adjusted income before income taxes totaled $304 million in 1998 compared to $244 million in 1997. The earnings increase is attributable to the full year contribution from 1997 acquisitions of PCA and ChoiceCare, improved claim payment accuracy and administrative expense reductions.

The Health Plan segment's premium revenues increased 22.7 percent to $6.7 billion in 1998. This increase was attributable to the current year effect of the 1997 acquisitions, large group commercial and Medicare HMO same-plan membership growth and higher large group commercial premium yields.

The Health Plan segment's adjusted medical expense ratio increased 10 basis points to 84.4 percent. The increase was the result of the higher medical expense ratio of acquired plans being included for a full year during 1998 and higher pharmacy costs.

The adjusted administrative expense ratio improved during 1998 to 12.6 percent from 13.1 percent in 1997 in the Health Plan segment. This improvement reflects realized cost savings from integrating the PCA and ChoiceCare acquisitions into Humana's operating model.

Small Group
Adjusted income before income taxes was $31 million in 1998 compared to $26 million in 1997. The earnings increase is primarily attributable to improved claims payment accuracy, increased interest and other income and administrative expense reductions. These favorable items were partially offset by higher interest expense and increased pharmacy costs.

The Small Group segment's premium revenues increased 19.6 percent to $2.9 billion in 1998. This increase was primarily attributable to the current year effect of the 1997 acquisitions and small group commercial and specialty same-plan membership growth.

The Small Group segment's adjusted medical expense ratio increased 30 basis points to 79.7 percent. The year to year increase was the result of the higher medical expense ratio of acquired plans being included for a full year during 1998 and higher pharmacy costs.

The adjusted administrative expense ratio improved during 1998 to 20.3 percent from 21.0 percent in 1997 in the Small Group segment. This improvement reflects the continued rationalization of staffing levels commensurate with membership levels.

LIQUIDITY

Operating cash flows improved to $217 million in 1999 from $55 million in 1998, due to increased premium receipts and reduced payments for accrued expenses, taxes, severance and professional liabilities. Partially offsetting these improvements were higher claim payments related to the Company's run-off workers' compensation business.

Cash provided by investing activities was $18 million in 1999, compared to $28 million in 1998. These amounts reflect the net effect of investment and capital expenditure transactions.

Cash used in financing activities totaled $170 million in 1999 compared to cash provided by financing activities of $51 million in 1998. This decrease primarily resulted from 1999 debt repayments and changes in book overdrafts.

The Company's subsidiaries operate in states that require minimum levels of equity and regulate the payment of dividends to the parent company. As a result, the Company's ability to use operating subsidiaries' cash flows is restricted to the extent of the subsidiaries' ability to obtain regulatory approval to pay dividends.

The National Association of Insurance Commissioners has recommended that states adopt a risk-based capital ("RBC") formula for companies established as HMO entities, similar to the current requirement for insurance companies. The RBC provisions may require new minimum capital and surplus levels for some of the Company's HMO subsidiaries. Many states have not yet determined when they will adopt the RBC formula or if they will allow a phase-in to the required levels of capital and surplus.

The Company currently maintains approximately $768 million of capital and surplus in its health insurance and HMO entities, compared to the minimum statutory required capital and surplus levels of approximately $569 million. If the states in which the Company conducts business adopt the proposed RBC formula, without a phase-in provision, the Company estimates it would be required to fund additional capital into its various subsidiaries of approximately $45 million. After this capital infusion, the Company would have $138 million of capital and surplus above the required RBC level.

The Company maintains a revolving credit agreement ("Credit Agreement") which provides a line of credit of up to $1.0 billion and expires in August 2002. Principal amounts outstanding under the Credit Agreement bear interest at either a fixed rate or a floating rate, ranging from LIBOR plus 35 basis points to LIBOR plus 80 basis points, depending on the Company's credit ratings. The Credit Agreement, which was amended in 1999 to reduce the line of credit by $500 million from $1.5 billion and modify certain covenants, contains customary covenants and events of default including, but not limited to, financial tests for interest coverage and leverage. The Company is in compliance with all covenants. The Company also maintains and issues short-term debt securities under a commercial paper program.

Management believes that funds from planned divestitures, future operating cash flows and funds available under the existing Credit Agreement and commercial paper program are sufficient to meet future liquidity needs. Management also believes the aforementioned sources of funds are adequate to allow the Company to pursue selected acquisition and expansion opportunities, as well as to fund capital requirements.

RISK-SENSITIVE FINANCIAL INSTRUMENTS AND POSITIONS

The Company's risk of fluctuation in earnings due to changes in interest income from its fixed income portfolio is partially mitigated by the Company's debt position, as well as the short duration of the fixed income portfolio.

The Company has evaluated the interest income and debt expense impact resulting from a hypothetical change in interest rates of 100, 200 and 300 basis points over the next twelve-month period, as reflected in the following table. In the past ten years, annual changes in commercial paper rates have never exceeded 300 basis points, changed between 200 and 300 basis points twice and changed between 100 and 200 basis points once. The modeling technique used to calculate the pro forma net change considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes

during a prospective twelve-month period.

(In millions)	Increase (decrease) in earnings given an interest rate decrease of X basis points			Increase (decrease) in earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
1999						
Fixed income portfolio	$ (10.1)	$ (6.7)	$ (3.4)	$ 3.4	$ 6.8	$ 10.2
Debt	9.1	6.1	3.0	(3.0)	(6.1)	(9.1)
Total	$ (1.0)	$ (0.6)	$ (0.4)	$ 0.4	$ 0.7	$ 1.1
1998						
Fixed income portfolio	$ (11.9)	$ (7.9)	$ (4.0)	$ 4.0	$ 8.0	$ 12.0
Debt	5.7	3.8	1.9	(1.9)	(3.8)	(5.7)
Total	$ (6.2)	$ (4.1)	$ (2.1)	$ 2.1	$ 4.2	$ 6.3

The following table presents the hypothetical change in fair market values of common equity securities held by the Company at December 31, 1999 and 1998, which are sensitive to changes in stock market values. These common equity securities are held for purposes other than trading.

(In millions)	*Decrease in valuation of securities given an X% decrease in each equity security's value*			*Fair Value at December 31,*	*Increase in valuation of securities given an X% increase in each equity security's value*		
	(30%)	(20%)	(10%)		10%	20%	30%
1999							
Common equity securities	$ (5.6)	$ (3.7)	$ (1.9)	$ 18.6	$ 1.9	$ 3.7	$ 5.6
1998							
Common equity securities	$ (18.6)	$ (12.4)	$ (6.2)	$ 62.1	$ 6.2	$ 12.4	$ 18.6

Changes in equity valuations (based upon the Standard & Poor's 500 stock index) over the past ten years which were in excess of 30 percent occurred four times, between 20 percent and 30 percent occurred three times and between 10 percent and 20 percent also occurred three times.

CAPITAL RESOURCES

The Company's ongoing capital expenditures relate primarily to information systems and administrative facilities necessary for activities such as claims processing, billing and collections, medical utilization review and customer service. Total capital expenditures, excluding acquisitions, were $89 million, $104 million and $73 million for the years ended December 31, 1999, 1998 and 1997, respectively. Capital expenditures during 1998 included the $32 million purchase and renovation of a regional customer service center in Jacksonville, Florida.

Excluding acquisitions, planned capital spending in 2000 will approximate $130 million to $140 million for the funding of the Company's technology initiatives and expansion and improvement of its administrative facilities.

EFFECTS OF INFLATION AND CHANGING PRICES

The Company's operations are regulated by various state and federal government agencies. Actuarially determined premium rate increases for commercial products are generally approved by the respective state insurance commissioners, while increases in premiums for Medicaid and Medicare HMO products are established by various state governments and the Health Care Financing Administration. Premium rates under the TRICARE contract with the United States Department of Defense may be adjusted on a year by year basis to reflect inflation, changes in the workload volumes of military medical facilities and contract modifications.

The Company's 2000 average rate of statutory increase under the Medicare HMO contracts is approximately two percent. Over the last five years, annual increases have ranged from as low as the January 1999 increase of two percent to as high as nine percent in January 1996, with an average of approximately five percent. The Company's Medicare HMO contracts with the federal government are renewed for a one-year term each December 31 unless terminated 90 days prior thereto.

Legislative proposals are being considered which may revise the Medicare program's current support of the use of managed health care for Medicare beneficiaries and the future reimbursement rates thereunder. Management is unable to predict the outcome of these proposals or the impact they may have on the Company's financial position, results of operations or cash flows. The Company's Medicaid contracts are generally annual contracts with various states except for the two-year contract with the Health Insurance Administration in Puerto Rico. Additionally, the Company's TRICARE contract is a one-year contract renewable on July 1, 2000, for one additional year. The loss of these contracts or significant changes in these programs as a result of legislative action, including reductions in payments or increases in benefits without corresponding increases in payments, would have a material adverse effect on the revenues, profitability and business prospects of the Company.

In addition, the Company continually contracts and seeks to renew contracts with providers at rates designed to ensure adequate profitability. To the extent the Company is unable to obtain such rates, its financial position, results of operations and cash flows could be adversely impacted.

THE COMPANY'S YEAR 2000 DISCLOSURE STATEMENT

The Company commenced its assessment of Year 2000 exposures in early 1996. In December 1998, the Company was 100 percent complete with the remediation of its core business systems and by December 1999 had remediated 100 percent of its business application systems. As of December 31, 1999, the Company had completed all Year 2000 initiatives.

To date, the Company has experienced no outages or problems related to the Year 2000 date rollover. All business systems are functioning normally and the Company has not experienced any disruptions in service with third party organizations with which it interacts related to the century change.

The Company's application systems are largely developed and maintained in-house by a staff of 400 application programmers who are versed in the utilization of state-of-the-art technology. All application systems are fully integrated and automatically pass data through various system processes. The Company's primary data center and the majority of its programming and support staff are located at the Company's corporate offices in Louisville, Kentucky. In order to create the necessary internal focus surrounding the Year 2000 issue, the Company established a centralized Year 2000 Program Management Office ("PMO") which is charged with overall coordination of enterprise wide Year 2000 initiatives and regular progress reporting to the Company's senior management.

The Year 2000 project is currently estimated to have a minimum total cost of approximately $30 million of which approximately $10 million was spent during 1999. Year 2000 expenses represented less than ten percent of the Information Systems budget during 1999. Year 2000 costs are expensed as incurred and funded with cash flows from operations. The Company does not expect to incur significant Year 2000 project costs in the year 2000.

The extent and magnitude of the Year 2000 project, as it will affect the Company for some period after January 1, 2000, is difficult to predict or quantify. In order to mitigate these risks, the Company developed business continuity and contingency plans which were finalized in the second quarter of 1999. These plans would be enacted if Year 2000 problems were to occur within the Company, or if third party constituents have failures due to the millennium change. Contingency plans were developed for six major functional areas encompassing 22 operational subdivisions that require contingency plan development. The six major functional areas are: providers, service centers, suppliers and vendors, customers and brokers, banking and finance and legal services.

While the Company presently believes that the timely completion of its Year 2000 project limited the exposure, so that the Year 2000 issue has not posed material operational problems, the Company recognizes that it does not control third party constituents. If these third party organizations have failures related to the Year 2000 century change and/or fail to properly implement appropriate contingency plans, Year 2000 failures may result. These failures could potentially have a material adverse impact on the Company's financial position, results of operations and cash flows.

LEGAL PROCEEDINGS

During 1999, six purported class action complaints have been filed against the Company and certain of its current and former directors and officers claiming that the Company and the individual defendants knowingly or recklessly made false or misleading statements in press releases and public filings concerning the Company's financial condition. All seek money damages of unspecified amounts.

Since October 1999, the Company has received purported class action complaints alleging, among other things, that Humana intentionally concealed from its members information concerning the various ways Humana decides what claims will be paid, what procedures will be deemed medically necessary, and what criteria and procedures are used to determine the extent and type of their coverage. The complaints also allege that Humana concealed from members the existence of direct financial incentives to treating physicians and other health care providers to deny coverage. The complaints, generally, do not allege that any member was denied coverage for services that should have been covered but, instead, claim that Humana provided health insurance benefits of lesser value than promised. All seek money damages of unspecified amounts. The Company has requested to consolidate these complaints to a single court.

The Company believes the allegations in all of the above complaints are without merit and intends to pursue the defense of the actions vigorously.

On January 4, 2000, a jury in Palm Beach County, Florida, issued a verdict against Humana Health Insurance Company of Florida, Inc., awarding $79 million to Mark Chipps, an insured who had sued individually and on behalf of his minor daughter. The claim arose from the removal of the child from a case management program which had provided her with benefits in excess of those available under her policy. The award included $78 million for punitive damages, $1 million for emotional distress and $28,000 for contractual benefits. The Company is in the process of appealing the verdict.

During 1999, the Company reached an agreement in principle with the United States Department of Justice and the Department of Health and Human Services on a $15 million settlement relating to Medicare premium overpayments. The settlement is expected to be paid sometime during 2000. The Company had previously established adequate liabilities for the resolution of these issues and, therefore, the settlement did not have a material impact on the Company's financial position or results of operations.

Damages for claims for personal injuries and medical benefit denials are usual in the Company's business. Personal injury and medical benefit denial claims are covered by insurance from the Company's wholly owned captive insurance Subsidiary and excess carriers, except to the extent that claimants seek punitive damages, in states which prohibit insurable coverage for punitive damages. In connection with the Chipps case, the excess carriers have preliminarily indicated that they believe no coverage may be available for a punitive damages award.

During the ordinary course of its business, the Company is or may become subject to pending or threatened litigation or other legal actions. Management does not believe that any pending and threatened legal actions against the Company or audits by agencies will have a material adverse effect on the Company's financial position or results of operations.

RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS

In June 1998, the Financial Accounting Standards Board issued Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"). In general, SFAS No. 133 requires that all derivatives be recognized as either assets or liabilities in the balance sheet at their fair value, and sets forth the manner in which gains or losses thereon are to be recorded. The treatment of such gains or losses is dependent upon the type of exposure, if any, for which the derivative is designated as a hedge. This standard is effective for the Company's financial statements beginning January 1, 2001, with early adoption permitted. Management of the Company anticipates that the adoption of SFAS No. 133 on January 1, 2001 will not have a material impact on the Company's financial position, results of operations or cash flows.

CONSOLIDATED BALANCE SHEETS

(In millions, except share amounts) ***December 31,***	***1999***	***1998***
ASSETS		
Current assets:		
Cash and cash equivalents	$ 978	$ 913
Marketable securities	1,507	1,594
Premiums receivable, less allowance for doubtful accounts of $61 in 1999 and $62 in 1998	225	276
Deferred income taxes	161	129
Other	193	207
Total current assets	3,064	3,119
Property and equipment, net	418	433
Other assets:		
Long-term marketable securities	253	305
Cost in excess of net assets acquired	806	1,188
Deferred income taxes	54	64
Other	305	387
Total other assets	1,418	1,944
Total assets	$ 4,900	$ 5,496
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical and other expenses payable	$ 1,432	$ 1,470
Trade accounts payable and accrued expenses	392	395
Book overdraft	215	234
Unearned premium revenues	349	294
Accrued losses on asset sales	90	
Commercial paper	686	730
Total current liabilities	3,164	3,123
Long-term medical and other expenses payable	324	438
Professional liability and other obligations	144	154
Debt		93
Total liabilities	3,632	3,808
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; authorized 10,000,000 shares; none issued		
Common stock, $0.16 2/3 par; authorized 300,000,000 shares; issued and outstanding 167,514,710 shares — 1999 and 167,515,362 shares — 1998	28	28
Capital in excess of par value	899	903
Deferred compensation — restricted stock	(2)	(9)
Retained earnings	371	753
Accumulated other comprehensive (loss) income	(28)	13
Total stockholders' equity	1,268	1,688
Total liabilities and stockholders' equity	$ 4,900	$ 5,496

The accompanying notes are an integral part of the consolidated financial statements.

CONSOLIDATED STATEMENTS OF OPERATIONS

(In millions, except per share results) *For the years ended December 31,*	*1999*	*1998*	*1997*
Revenues:			
Premiums	$ 9,959	$ 9,597	$ 7,880
Interest and other income	154	184	156
Total revenues	10,113	9,781	8,036
Operating expenses:			
Medical	8,532	8,041	6,522
Selling, general and administrative	1,368	1,328	1,116
Depreciation and amortization	124	128	108
Asset write-downs and other expenses	460	34	
Total operating expenses	10,484	9,531	7,746
(Loss) income from operations	(371)	250	290
Interest expense	33	47	20
(Loss) income before income taxes	(404)	203	270
(Benefit) provision for income taxes	(22)	74	97
Net (loss) income	$ (382)	$ 129	$ 173
(Loss) earnings per common share	$ (2.28)	$ 0.77	$ 1.06
(Loss) earnings per common share – assuming dilution	$ (2.28)	$ 0.77	$ 1.05

The accompanying notes are an integral part of the consolidated financial statements.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		*Capital In Excess of Par Value*	*Deferred Compensation — Restricted Stock*	*Retained Earnings*	*Accumulated Other Comprehensive (Loss) Income*	*Total Stockholders' Equity*
(In millions)	*Shares*	*Amount*					
Balances, January 1, 1997	163	$ 27	$ 824	$ (2)	$ 451	$ (8)	$ 1,292
Comprehensive income:							
Net income					173		173
Other comprehensive income:							
Net unrealized investment gains, net of $10 tax						17	17
Comprehensive income							190
Change in deferred compensation			2	(2)			—
Restricted stock amortization				1			1
Stock option exercises	1		11				11
Stock option tax benefit			7				7
Balances, December 31, 1997	164	27	844	(3)	624	9	1,501
Comprehensive income:							
Net income					129		129

Other comprehensive income:							
Net unrealized investment gains, net of $2 tax						4	4
Comprehensive income							133
Change in deferred compensation			8	(8)			—
Restricted stock amortization				2			2
Stock option exercises	4	1	35				36
Stock option tax benefit			16				16
Balances, December 31, 1998	168	28	903	(9)	753	13	1,688
Comprehensive loss:							
Net loss					(382)		(382)
Other comprehensive loss:							
Net unrealized investment losses, net of $27 tax						(41)	(41)
Comprehensive loss							(423)
Change in deferred compensation			(5)	5			—
Restricted stock amortization				2			2
Stock option exercises			1				1
Balances, December 31, 1999	168	$ 28	$ 899	$ (2)	$ 371	$ (28)	$ 1,268

The accompanying notes are an integral part of the consolidated financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(In millions) ***For the years ended December 31,***	***1999***	***1998***	***1997***
CASH FLOWS FROM OPERATING ACTIVITIES			
Net (loss) income	$(382)	$ 129	$ 173
Adjustments to reconcile net (loss) income to net cash provided by operating activities:			
Asset write-downs and other expenses	460	17	
Depreciation and amortization	124	128	108
Gain on sale of property and equipment	(12)		
Gain on sale of marketable securities	(11)	(21)	(10)
Deferred income taxes	5	26	40
Provision for doubtful accounts	12	11	10
Changes in operating assets and liabilities:			
Premiums receivable	39	34	(112)
Other assets	54	32	(47)
Medical and other expenses payable	(23)	(22)	(118)
Workers' compensation liabilities	(150)	(134)	(31)
Other liabilities	45	(135)	57
Unearned premium revenues	56	(10)	203
Other			6
Net cash provided by operating activities	217	55	279
CASH FLOWS FROM INVESTING ACTIVITIES			
Acquisitions of health plan assets, net of cash acquired	(14)		(669)
Purchases of property and equipment	(89)	(104)	(73)

Dispositions of property and equipment	54	12	15
Purchases of marketable securities	(781)	(1,037)	(608)
Maturities of marketable securities	391	380	341
Proceeds from sales of marketable securities	472	815	317
Other	(15)	(38)	23
Net cash provided by (used in) investing activities	18	28	(654)
CASH FLOWS FROM FINANCING ACTIVITIES			
Issuance of long-term debt		123	300
Repayment of long-term debt	(93)	(330)	
Net commercial paper (repayments) borrowings	(44)	141	367
Change in book overdraft	(19)	82	(1)
Other	(14)	35	13
Net cash (used in) provided by financing activities	(170)	51	679
Increase in cash and cash equivalents	65	134	304
Cash and cash equivalents at beginning of period	913	779	475
Cash and cash equivalents at end of period	$ 978	$ 913	$ 779
Supplemental cash flow disclosures:			
Interest payments	$ 33	$ 49	$ 15
Income tax (refunds) payments, net	(58)	69	8
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired	$ 20		$ 1,973
Less: liabilities assumed	(6)		(1,304)
Cash paid for acquired businesses, net of cash acquired	$ 14		$ 669

The accompanying notes are an integral part of the consolidated financial statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc. (the "Company" or "Humana") is one of the nation's largest publicly traded health services companies that facilitates the delivery of health care services through networks of providers to its approximately 5.9 million medical members. The Company's products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracted providers. HMOs and PPOs control health care costs by various means, including pre-admission approval for hospital inpatient services, pre-authorization of outpatient surgical procedures, and risk-sharing arrangements with providers. These providers may share medical cost risk or have other incentives to deliver quality medical services in a cost-effective manner. The Company also offers various specialty products to employers, including dental, group life and workers' compensation and administrative services ("ASO") to those who self-insure their employee health plans. The Company has entered into a definitive agreement to sell its workers' compensation business. In total, the Company's products are licensed in 49 states, the District of Columbia and Puerto Rico, with approximately 20 percent of its membership in the state of Florida.

During 1999, the Company realigned its organization to achieve greater accountability in its lines of business. As a result of this realignment, the Company organized into two business units: the Health Plan segment and the Small Group segment. The Health Plan segment includes the Company's large group commercial (100 employees and over), Medicare, Medicaid, ASO, workers' compensation and military or TRICARE business. The small group segment includes small group commercial (under 100 employees) and specialty benefit lines, including dental, life and short-term disability. Results of each segment are measured based upon results of operations before income taxes. The Company allocates administrative expenses, interest income and interest expense, but no assets, to the segments. Members served by the two segments generally utilize the same medical provider networks, enabling the Company to obtain more favorable contract terms with providers. As a result, the profitability of each segment is somewhat interdependent. In addition, premium revenue pricing to large group commercial employers has historically been more competitive than that to small group commercial employers, resulting in less favorable underwriting margins for the large group commercial line of business. Costs to distribute and administer products to small group commercial employers are higher compared to large group commercial employers resulting in small group's higher administrative expense ratio.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Consolidation

The consolidated financial statements include all subsidiaries of the Company. All significant intercompany accounts and transactions have been eliminated.

Use of Estimates in Preparation of Financial Statements
The preparation of financial statements in accordance with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Although these estimates are based on knowledge of current events and anticipated future events, actual results may ultimately differ from those estimates.

Cash and Cash Equivalents
Cash and cash equivalents include cash, time deposits, money market funds, commercial paper and certain U.S. Government securities with an original maturity of three months or less. Carrying value approximates fair value due to the short-term maturity of the investments.

Marketable Securities
Marketable debt and equity securities have been categorized as available for sale and, as a result, are stated at fair value based generally on quoted market prices. Marketable debt and equity securities available for current operations are classified as current assets. Marketable securities available for the Company's capital spending, professional liability, long-term insurance product requirements and payment of long-term workers' compensation claims are classified as long-term assets. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity until realized.

For the purpose of determining gross realized gains and losses, the cost of securities sold is based upon specific identification.

Long-Lived Assets
Property and equipment is carried at cost, and is comprised of the following at December 31, 1999 and 1998:

(In millions)	*1999*	*1998*
Land	$ 32	$ 33
Buildings	364	355
Equipment and computer software	432	400
	828	788
Accumulated depreciation	(410)	(355)
	$ 418	$ 433

Depreciation is computed using the straight-line method over estimated useful lives ranging from three to ten years for equipment, three to five years for computer software and twenty years for buildings. Depreciation expense was $79 million, $75 million and $66 million for the years ended December 31, 1999, 1998 and 1997, respectively.

Cost in excess of net assets acquired, or goodwill, represents the unamortized excess of cost over the fair value of net tangible and identifiable intangible assets acquired. Identifiable intangible assets, which are included in other long-term assets in the accompanying Consolidated Balance Sheets, primarily relate to subscriber and provider contracts. Goodwill and identifiable intangible assets are amortized on a straight-line method over their estimated useful lives. Goodwill has been amortized over periods ranging from six to 40 years and identifiable intangible assets are being amortized over periods ranging from seven to 14 years. After a re-evaluation, effective January 1, 2000, the Company adopted a 20 year amortization period from the date of acquisition for goodwill previously amortized over 40 years. Amortization expense was $45 million, $53 million and $42 million for the years ended December 31, 1999, 1998 and 1997, respectively.

The carrying values of all long-lived assets are periodically reviewed by management for impairment, based upon undiscounted market level cash flows, whenever adverse events or changes in circumstances occur. Losses are recognized when the carrying value of a long-lived asset may not be recoverable. See Note 3 for a discussion related to the Company's impairment review.

Revenue and Medical Cost Recognition
Premium revenues are recognized as income in the period members are entitled to receive services. Premiums received prior to such period are recorded as unearned premium revenues.

Medical costs include claim payments, capitation payments, physician salaries, allocations of certain centralized expenses and various other costs incurred to provide medical care to members, as well as estimates of future payments to hospitals and others for medical care provided prior to the balance sheet date. Capitation payments represent monthly prepaid fees disbursed to participating primary care physicians and other providers who are responsible for providing medical care to members. The estimates of future medical claim and other expense payments are developed using actuarial methods and assumptions based upon payment patterns, medical inflation, historical development and other relevant factors. Estimates of future payments relating to services incurred in the current and prior periods are continually reviewed by management and adjusted as necessary.

The Company assesses the profitability of its contracts for providing health care services to its members when current market operating results or forecasts indicate probable future losses. The Company records a premium deficiency in current operations to the extent that the sum of expected health care costs, claim adjustment expenses and maintenance costs exceeds related future premiums. Anticipated investment income is not considered for purposes of computing the premium deficiency. Because the majority of the Company's member contracts renew annually, the Company does not anticipate premium deficiencies, except when unanticipated adverse events or changes in circumstances indicate otherwise. See Note 3 for a discussion related to premium deficiencies.

Management believes the Company's medical and other expenses payable are adequate to cover future claims payments required, however, such estimates are based on knowledge of current events and anticipated future events, and, therefore, the actual liability could differ from amounts provided.

Book Overdraft
Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes and are classified as a current liability in the Consolidated Balance Sheets.

Stock Options

The Company has adopted the disclosure-only provisions of Statement of Financial Accounting Standards No. 123, "Accounting for Stock-Based Compensation" ("SFAS 123 ") and uses Accounting Principles Board Opinion No. 25 and related interpretations in the accounting for its stock option plans. No compensation expense has been recognized in connection with the granting of stock options. See Note 8 for discussion of stock options and the disclosures required by SFAS 123.

(Loss) Earnings Per Common Share
Detail supporting the computation of (loss) earnings per common share and (loss) earnings per common share-assuming dilution follows:

(Dollars in millions, except per share results)	*Net (Loss) Income*	*Shares*	*Per Share Results*
YEAR ENDED DECEMBER 31, 1999			
Loss per common share	$ (382)	167,555,917	$ (2.28)
Effect of dilutive stock options			
Loss per common share — assuming dilution	$ (382)	167,555,917	$ (2.28)
YEAR ENDED DECEMBER 31, 1998			
Earnings per common share	$ 129	166,471,824	$ 0.77
Effect of dilutive stock options		1,792,756	
Earnings per common share — assuming dilution	$ 129	168,264,580	$ 0.77
YEAR ENDED DECEMBER 31, 1997			
Earnings per common share	$ 173	163,406,460	$ 1.06
Effect of dilutive stock options		2,436,019	(0.01)
Earnings per common share — assuming dilution	$ 173	165,842,479	$ 1.05

Options to purchase 9,427,060, 1,562,949 and 2,414,148 shares for the years ended December 31, 1999, 1998 and 1997, respectively, were not included in the computation of (loss) earnings per common share-assuming dilution due to the Company's loss in 1999 and because the options' exercise prices were greater than the average market price of the Company's common stock in 1998 and 1997.

Reclassifications
Certain reclassifications have been made to the prior years' consolidated financial statements to conform with the current year presentation.

Recently Issued Accounting Pronouncements
In June 1998, the Financial Accounting Standards Board issued Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"). In general, SFAS No. 133 requires that all derivatives be recognized as either assets or liabilities in the balance sheet at their fair value, and sets forth the manner in which gains or losses thereon are to be recorded. The treatment of such gains or losses is dependent upon the type of exposure, if any, for which the derivative is designated as a hedge. This standard is effective for the Company's financial statements beginning January 1, 2001, with early adoption permitted. Management of the Company anticipates that the adoption of SFAS No. 133 on January 1, 2001 will not have a material impact on the Company's financial position, results of operations or cash flows.

3. ASSET WRITE-DOWNS AND OPERATIONAL EXPENSES

The following table presents the components of the asset write-downs and operational expenses and their respective classifications in the 1999 and 1998 Consolidated Statements of Operations:

(In millions)	*Medical*	*Selling, General and Administrative*	*Asset Write-Downs and Other*	*Total*
1999:				
FIRST QUARTER 1999:				
Premium deficiency	$ 50			$ 50
Reserve strengthening	35			35
Provider costs	5			5

Total first quarter 1999	90			90
FOURTH QUARTER 1999:				
Long-lived asset impairment			$ 342	342
Losses on non-core asset sales			118	118
Professional liability reserve strengthening and other costs		$ 35		35
Total fourth quarter 1999		35	460	495
Total 1999	$ 90	$ 35	$ 460	$ 585
1998:				
THIRD QUARTER 1998:				
Premium deficiency	$ 46			$ 46
Provider costs	27			27
Market exit costs			$ 15	15
Losses on non-core asset sales			12	12
Merger dissolution costs			7	7
Non-officer employee incentive and other costs		$ 25		25
Total third quarter 1998	$ 73	$ 25	$ 34	$ 132

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1999 EXPENSES

Premium Deficiency, Reserve Strengthening and Provider Costs
As a result of management's assessment of the profitability of its contracts for providing health care services to its members in certain markets, the Company recorded a provision for probable future losses (premium deficiency) of $50 million during the first quarter of 1999. Ineffective provider risk-sharing contracts and the impact of the March 31, 1999 Columbia/HCA Healthcare Corporation ("Columbia/HCA") hospital agreement in Florida on current and projected future medical costs contributed to the premium deficiency. The beneficial effect from losses charged to the premium deficiency liability throughout 1999 was $50 million. Because the majority of the Company's customers' contracts renew annually, the Company does not anticipate the need for a premium deficiency in 2000, absent unanticipated adverse events or changes in circumstances.

Prior period adverse claims development primarily in the Company's PPO and Medicare products initially identified during an analysis of February and March 1999 medical claims resulted in the $35 million reserve strengthening. The Company releases or strengthens medical claims reserves when favorable or adverse development in prior periods exceed actuarial margins existing in the reserves. In addition, the Company paid Columbia/HCA $5 million to settle certain contractual issues associated with the March 31, 1999 hospital agreement in Florida.

Long-Lived Asset Impairment
Historical and current period operating losses in certain of the Company's markets prompted a review during the fourth quarter of 1999 for the possible impairment of long-lived assets. This review indicated that estimated future undiscounted cash flows were insufficient to recover the carrying value of long-lived assets, primarily goodwill, associated with the Company's Austin, Dallas and Milwaukee markets. Accordingly, the Company adjusted the carrying value of these long-lived assets to their estimated fair value resulting in a non-cash impairment charge of $342 million. Estimated fair value was based on discounted cash flows.

The long-lived assets associated with the Austin and Dallas markets primarily result from the Company's 1997 acquisition of Physician Corporation of America ("PCA"). Operating losses in Austin and Dallas were related to the deterioration of risk-sharing arrangements with providers and the failure to effectively convert the PCA operating model and computer platform to Humana's. The long-lived assets associated with the Milwaukee market primarily result from the Company's 1994 acquisition of CareNetwork, Inc. Operating losses in Milwaukee were the result of competitor pricing strategies resulting in lower premium levels to large employer groups as well as market dynamics dominated by limited provider groups causing higher than expected medical costs.

The Company also re-evaluated the amortization period of its goodwill and as a result, effective January 1, 2000, adopted a 20 year amortization period from the date of acquisition for goodwill previously amortized over 40 years.

The $342 million long-lived asset impairment will decrease depreciation and amortization expense $13 million annually ($13 million after tax, or $0.08 per diluted share), while the change in the amortization period of goodwill will increase amortization expense $25 million annually ($24 million after tax, or $0.15 per diluted share).

Losses on Non-Core Asset Sales
The Company has entered into definitive agreements for the disposition of its workers' compensation, Medicare supplement and North Florida Medicaid businesses, which are considered non-core. As a result of the carrying value of the net assets of these businesses exceeding the estimated sale proceeds, the Company has recorded a loss of $118 million. Estimated fair value was established based upon definitive sale agreements, net of expected transaction costs. These transactions are expected to be completed in the first and second quarters of 2000. Total assets of $725 million, primarily consisting of marketable securities and reinsurance recoverables, and total liabilities of $490 million, primarily consisting of workers' compensation reserves related to these businesses are included in the accompanying Consolidated Balance Sheets. The accompanying Consolidated Statements of Operations include 1999 revenues of $214 million and pretax operating income of $38 million from these businesses. Included in 1999 and 1998 pretax operating (loss) income is $36

million and $5 million of workers' compensation reserve releases resulting from favorable claim liability development.

Professional Liability Reserve Strengthening and Other Costs
The Company insures substantially all professional liability risks through a wholly owned captive insurance subsidiary (the "Subsidiary"). The Subsidiary recorded an additional $25 million expense during the fourth quarter of 1999 primarily related to expected claim and legal costs to be incurred by the Company.

In addition, other expenses of $10 million were recorded during the fourth quarter related to a claim payment dispute with a contracted provider and government audits.

Activity related to the 1999 expenses follows:

		1999 Activity		
(In millions)	*1999 Expenses*	*Cash*	*Non-Cash*	*Balance at December 31, 1999*
Premium deficiency	$ 50	$ (50)		—
Reserve strengthening	35	(35)		—
Provider costs	5	(5)		—
Long-lived asset impairment	342		$ (342)	—
Losses on non-core asset sales	118		(28)	$ 90
Professional liability reserve strengthening and other costs	35			35
	$ 585	$ (90)	$ (370)	$ 125

1998 EXPENSES

Market Exits, Non-Core Asset Sales and Merger Dissolution Costs
On August 10, 1998, the Company and UnitedHealth Group Company ("United") announced their mutual agreement to terminate the previously announced Agreement and Plan of Merger, dated May 27, 1998. The planned merger, among other things, was expected to improve the operating results of the Company's products and markets due to overlapping markets with United. Following the merger's termination, the Company conducted a strategic evaluation, which included assessing the Company's competitive market positions and profit potential. As a result, the Company recognized expenses of $34 million during the third quarter of 1998. The expenses included costs associated with exiting five markets ($15 million), losses on disposals of non-core assets ($12 million) and merger dissolution costs ($7 million).

The costs associated with the market exits of $15 million included severance, lease termination costs as well as write-offs of equipment and uncollectible provider receivables. The planned market exits were Sarasota and Treasure Coast, Florida, Springfield and Jefferson City, Missouri and Puerto Rico. Severance costs were estimated based upon the provisions of the Company's employee benefit plans. The plan to exit these markets was expected to reduce the Company's market office workforce, primarily in Puerto Rico, by approximately 470 employees. In 1999, the Company reversed $2 million of the severance and lease discontinuance liabilities after the Company contractually agreed with the Health Insurance Administration in Puerto Rico to extend the Company's Medicaid contract, with more favorable terms. The Company estimated annual pretax savings of approximately $40 million, after all market exits were completed by June 30, 1999, primarily from a reduction in underwriting losses. Approximately 100 employees were ultimately terminated resulting in insignificant severance payments.

In accordance with the Company's policy on impairment of long-lived assets, equipment of $5 million in the exited markets was written down to its fair value after an evaluation of undiscounted cash flow in each of the markets. The fair value of equipment was based upon discounted cash flows for the same markets. Following the write-down, the equipment was fully depreciated.

Premium Deficiency and Provider Costs
As a result of management's assessment of the profitability of its contracts for providing health care services to its members in certain markets, the Company recorded a provision for probable future losses (premium deficiency) of $46 million during the third quarter of 1998. The premium deficiency resulted from events prompted by the terminated merger with United wherein the Company had expected to realize improved operating results in those markets that overlapped with United, including more favorable risk-sharing arrangements. The beneficial effect from losses charged to the premium deficiency liability in 1999 and 1998 was $23 million and $17 million, respectively. In 1999, the Company reversed $6 million of premium deficiency liabilities after the Company contractually agreed with the Health Insurance Administration in Puerto Rico to extend the Company's Medicaid contract, with more favorable terms.

The Company also recorded $27 million of expense related to receivables written-off from financially troubled physician groups, including certain bankrupt providers.

Non-Officer Employee Incentive and Other Costs
During the third quarter of 1998, the Company recorded a one-time incentive of $16 million paid to non-officer employees and a $9 million settlement related to a third party pharmacy processing contract.

Activity related to the 1998 expenses follows:

		1998 Activity		Balance at December 31,	1999 Activity		Balance at December 31,
(In millions)	*1998 Expenses*	*Cash*	*Non-cash*	*1998*	*Cash*	*Adjustment*	*1999*
Premium deficiency	$ 46	$ (17)		$ 29	$ (23)	$ (6)	$ —
Provider costs	27		$ (27)				—
Market exit costs	15		(10)	5	(2)	(2)	1
Losses from non-core asset sales	12	(5)	(7)				—
Merger dissolution costs	7	(5)		2	(2)		—
Non-officer employee incentive and other costs	25	(25)					—
	$ 132	$ (52)	$ (44)	$ 36	$ (27)	$ (8)	$ 1

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

4. MARKETABLE SECURITIES

Marketable securities classified as current assets at December 31, 1999 and 1998 included the following:

	1999				1998			
(In millions)	*Amortized Cost*	*Gross Unrealized Gains*	*Gross Unrealized Losses*	*Fair Value*	*Amortized Cost*	*Gross Unrealized Gains*	*Gross Unrealized Losses*	*Fair Value*
U.S. Government obligations	$ 178		(3)	$ 175	$ 165	$ 4		$ 169
Tax exempt municipal bonds	889		$ (24)	865	845	6		851
Corporate Bonds	234		(7)	227	250	8		258
Redeemable preferred stocks	67		(2)	65	124	1		125
Marketable equity securities	96	$ 9	(6)	99	129	2	$ (2)	129
Other	77		(1)	76	59	3		62
	$ 1,541	$ 9	$ (43)	$ 1,507	$ 1,572	$ 24	$ (2)	$ 1,594

Marketable securities classified as long-term assets at December 31, 1999 and 1998 included the following:

	1999				1998			
(In millions)	*Amortized Cost*	*Gross Unrealized Gains*	*Gross Unrealized Losses*	*Fair Value*	*Amortized Cost*	*Gross Unrealized Gains*	*Gross Unrealized Losses*	*Fair Value*
U.S. Government obligations	$ 16			$ 16	$ 5			$ 5
Tax exempt municipal bonds	180		$ (7)	173	234	$ 4	$ (1)	237
Redeemable preferred stocks	27		(1)	26	31			31
Marketable equity securities	10		(1)	9	2			2
Other	29			29	30			30
	$ 262		$ (9)	$ 253	$ 302	$ 4	$ (1)	$ 305

The contractual maturities of debt securities available for sale at December 31, 1999, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

(In millions)	Amortized Cost	Fair Value
Due within one year	$ 209	$ 207
Due after one year through five years	499	490
Due after five years through ten years	384	370
Due after ten years	210	204
Not due at a single maturity date	395	381
	$ 1,697	$ 1,652

Gross realized investment gains were $18 million, $30 million and $11 million and gross realized investment losses were $7 million, $9 million and $1 million in 1999, 1998 and 1997, respectively.

5. INCOME TAXES

The (benefit) provision for income taxes consisted of the following:

	Years Ended December 31,		
(In millions)	1999	1998	1997
Current (benefit) provision:			
Federal	$ (18)	$ 39	$ 51
State	(9)	9	6
	(27)	48	57
Deferred provision:			
Federal	4	24	36
State	1	2	4
	5	26	40
	$ (22)	$ 74	$ 97

The (benefit) provision for income taxes was different from the amount computed using the federal statutory rate due to the following:

	Years Ended December 31,		
(In millions)	1999	1998	1997
Income tax (benefit) provision at federal statutory rate	$ (142)	$ 71	$ 95
State income taxes, net of federal benefit	(16)	8	10
Tax exempt investment income	(19)	(18)	(13)
Amortization	11	17	10
Long-lived asset impairment	143		
Other	1	(4)	(5)
	$ (22)	$ 74	$ 97

Deferred income tax balances reflect the impact of temporary differences between the carrying amounts of assets and liabilities and their tax bases, and are stated at enacted tax rates expected to be in effect when taxes are actually paid or recovered. Principal components of the net deferred tax balances for the Company at December 31, 1999 and 1998 are as follows:

	Assets (Liabilities)	
(In millions)	1999	1998
Marketable securities	$ 18	$ (8)
Long-term assets	(55)	(46)
Medical and other expenses payable	95	95
Asset write-downs and operational expenses	36	16

Professional liability risks	9	7
Net operating loss carryforwards	58	58
Workers' compensation liabilities	25	40
Compensation and other accruals	29	31
	$ 215	$ 193

At December 31, 1999, the Company has available tax net operating loss carryforwards of approximately $150 million related to prior acquisitions. These loss carryforwards, if unused to offset future taxable income, will expire in 2000 through 2011.

Based on the Company's historical taxable income record and estimates of future profitability, management has concluded that operating income will more likely than not be sufficient to give rise to tax expense to recover all deferred tax assets.

6. DEBT

The Company maintains a revolving credit agreement ("Credit Agreement") which provides a line of credit of up to $1.0 billion and expires in August 2002. Principal amounts outstanding under the Credit Agreement bear interest at either a fixed rate or a floating rate, ranging from LIBOR plus 35 basis points to LIBOR plus 80 basis points, depending on the Company's credit ratings. The Credit Agreement, which was amended in 1999 to reduce the line of credit by $500 million from $1.5 billion and modify certain covenants, contains customary covenants and events of default including, but not limited to, financial tests for interest coverage and leverage. The Company is in compliance with all covenants. The Company also maintains and issues short-term debt securities under a commercial paper program. The carrying value of commercial paper approximates fair value due to its short-term maturity.

Borrowings and the weighted average interest rate on those borrowings at December 31, 1999 and 1998 are as follows:

	1999		***1998***	
(In millions)	***Amount***	***Weighted Average Interest Rate***	***Amount***	***Weighted Average Interest Rate***
Credit agreement		5.7%	$ 93	5.9%
Commercial paper program	$ 686	5.6%	730	5.9%
	$ 686		$ 823	

7. PROFESSIONAL LIABILITY AND OTHER OBLIGATIONS

The components of professional liability and other obligations at December 31, 1999 and 1998 are as follows:

(in millions)	***1999***	***1998***
Allowance for professional liabilities	$ 133	$ 123
Liabilities for disability and other long-term insurance products, the Company's retirement and benefit plans and other	44	53
Less: current portion of allowance for professional liabilities	(33)	(22)
	$ 144	$ 154

The Company insures substantially all professional liability risks through a wholly owned subsidiary (the "Subsidiary"). Provisions for such risks, including expenses incident to claim settlements, were $57 million, $27 million and $32 million for the years ended December 31, 1999, 1998 and 1997, respectively. The amount for 1999 includes $25 million of professional liability reserve strengthening discussed in Note 3. The Subsidiary reinsures levels of coverage for losses in excess of its retained limits with unrelated insurance carriers. Reinsurance recoverables were $29 million and $40 million at December 31, 1999 and 1998, respectively. The current portion of allowance for professional liabilities is included with trade accounts payable and accrued expenses in the Consolidated Balance Sheets.

In 1998, the Subsidiary entered into a loss portfolio transfer agreement with unrelated insurance carriers for approximately $39 million, providing for the transfer of all professional and workers' compensation liabilities on claims incurred prior to December 31, 1997 limited to individual and maximum claim retention levels.

8. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

The Company has defined contribution retirement and savings plans covering qualified employees. The Company's contribution to these plans are based on various percentages of compensation, and in some instances, are based upon the amount of the employees' contributions to the plans. The cost of these plans amounted to approximately $27 million, $40 million and $24 million in 1999, 1998 and 1997, respectively, the substantial portion of which was funded currently. The amount for 1998 includes the $16 million one-time incentive paid to non-officer employees discussed in Note 3.

Stock Based Compensation

The Company has plans under which restricted stock awards and options to purchase common stock have been granted to officers, directors and key

employees. In 1998, the Company awarded 400,000 shares of performance-based restricted stock to officers and key employees. The shares had the potential to vest in equal one-third installments beginning January 1, 2000, provided the Company met certain earnings goals. As the goal was not met for 1999, and the awards are cumulative, two-thirds has the potential to vest in 2000 and one-third in 2001. Unearned compensation under the restricted stock awards plan is amortized over the vesting period. Compensation expense recognized related to the restricted stock award plans was $2 million for each of the years ended December 31, 1999 and 1998 and $1 million for the year ended December 31, 1997.

Options are granted at the average market price on the date of grant. Exercise provisions vary, but most options vest in whole or in part one to five years after grant and expire ten years after grant. At December 31, 1999, there were 13,977,221 shares reserved for employee and director stock option plans. At December 31, 1999, there were 2,658,040 shares of common stock available for future grants.

On September 17, 1998, the Company repriced 5,503,491 of its stock options with original exercise prices ranging from $18.31 to $26.31 to the market price of the Company's common stock on that date of $15.59. Outstanding stock options with an exercise price in excess of $18.13 per share could be exchanged in return for a reduced number of options, with a deferred vesting date of one year after the exchange date. The repricing resulted in the cancellation of 5,503,491 options and the granting of 4,559,438 options.

The Company's option plan activity for the years ended December 31, 1999, 1998 and 1997 is summarized below:

	Shares Under Option	*Exercise Price Per Share*			*Weighted Average Exercise Price*
Balance, January 1, 1997	10,921,887	$ 4.32	to	$ 26.94	$ 13.71
Granted	2,819,000	18.31	to	23.69	19.79
Exercised	(1,247,793)	4.32	to	23.06	8.67
Canceled or lapsed	(270,830)	6.56	to	23.06	17.32
Balance, December 31, 1997	12,222,264	5.80	to	26.94	15.54
Granted	6,403,788	15.59	to	26.22	17.04
Exercised	(3,067,202)	5.80	to	26.31	11.72
Canceled or lapsed	(6,753,198)	6.56	to	26.31	20.03
Balance, December 31, 1998	8,805,652	6.56	to	26.94	14.52
Granted	3,966,750	6.88	to	19.25	14.16
Exercised	(105,232)	6.56	to	8.91	16.75
Canceled or lapsed	(1,347,989)	8.00	to	26.31	18.32
Balance, December 31, 1999	11,319,181	$ 6.56	to	$ 26.94	$ 14.00

A summary of stock options outstanding and exercisable at December 31, 1999 follows:

	Stock Options Outstanding			*Stock Options Exercisable*	
Range of Exercise Prices	*Shares*	*Weighted Average Remaining Contractual Life*	*Weighted Average Exercise Price*	*Shares*	*Weighted Average Exercise Price*
$ 6.56 to $ 9.64	3,820,428	6.5 years	$ 8.05	1,914,178	$ 6.95
10.54 to 13.31	225,200	6.2 years	11.89	89,700	10.86
14.44 to 17.94	4,530,671	6.3 years	15.69	3,268,920	15.73
18.72 to 21.94	2,518,082	7.1 years	19.32	811,761	19.41
22.44 to 26.94	224,800	5.3 years	23.48	202,267	23.53
$ 6.56 to $26.94	11,319,181	6.5 years	$ 14.00	6,286,826	$ 13.71

As of December 31, 1998 and 1997, there were 3,636,481 and 6,215,776 options exercisable, respectively. The weighted average exercise price of options exercisable during 1998 and 1997 was $12.32 and $13.32, respectively. If the Company had adopted the expense recognition provisions of SFAS 123 for purposes of determining compensation expense related to stock options granted during the years ended December 31, 1999, 1998 and 1997, net (loss) income and (loss) earnings per common share would have been changed to the pro forma amounts shown below:

		Years Ended December 31,		
(In millions, except per share results)		*1999*	*1998*	*1997*
Net (loss) income	As reported	$ (382)	$ 129	$ 173
	Pro forma	(402)	116	159
(Loss) earnings per common share	As reported	$ (2.28)	$ 0.77	$ 1.06

	Pro forma	(2.40)	0.69	0.97
(Loss) earnings per common share -	As reported	$ (2.28)	$ 0.77	$ 1.05
assuming dilution	Pro forma	(2.40)	0.69	0.96

The fair value of each option granted during 1999, 1998 and 1997 was estimated on the date of grant using the Black-Scholes pricing model with the following weighted average assumptions:

	1999	1998	1997
Dividend yield	None	None	None
Expected volatility	43.8%	40.9%	38.5%
Risk-free interest rate	5.6%	4.9%	6.1%
Expected option life (years)	8.3	6.8	5.4
Weighted average fair value at grant date	$ 8.10	$ 8.59	$ 8.88

The effects of applying SFAS 123 in the pro forma disclosures are not likely to be representative of the effects on pro forma net income for future years since variables such as option grants, exercises and stock price volatility included in the disclosures may not be indicative of future activity.

9. STOCKHOLDERS' EQUITY

The Company adopted a stockholders' rights plan designed to deter takeover initiatives not considered to be in the best interests of the Company's stockholders. The rights are redeemable by action of the Company's Board of Directors at a price of $0.01 per right at any time prior to their becoming exercisable. Pursuant to the plan, under certain conditions, each share of stock has a right to acquire 1/100th of a share of Series A Participating Preferred Stock at a price of $145 per share. The plan expires in 2006.

10. COMMITMENTS AND CONTINGENCIES

Leases
The Company leases facilities, computer hardware and other equipment under long-term operating leases that are noncancelable and expire on various dates through 2017. Rent expense and sublease income for all operating leases are as follows:

	Years Ended December 31,		
(In millions)	*1999*	*1998*	*1997*
Rent expense	$ 61	$ 42	$ 31
Sublease rental income	(25)	(9)	(3)
Net rent expense	$ 36	$ 33	$ 28

Future annual minimum payments under all noncancelable operating leases in excess of one year subsequent to December 31, 1999 are as follows:

(In millions)	
2000	$ 54
2001	46
2002	31
2003	26
2004	22
Thereafter	62
Total minimum lease payments	$ 241
Less: minimum sublease rental income	(112)
Net minimum lease payments	$ 129

Government and Other Contracts
The Company's Medicare HMO contracts with the federal government are renewed for a one-year term each December 31, unless terminated 90 days prior thereto. Legislative proposals are being considered which may revise the Medicare program's current support of the use of managed health care for Medicare beneficiaries and future reimbursement rates thereunder. Management is unable to predict the outcome of these proposals or the impact they may have on the Company's financial position, results of operations or cash flows. The Company's Medicaid contracts are generally annual contracts with various states except for the two-year contract with the Health Insurance Administration in Puerto Rico. Additionally, the Company's TRICARE contract is a one-year contract renewable on July 1, 2000, for one additional year. The loss of these contracts or significant changes in these programs as a result of legislative action, including reductions in payments or increases in benefits without corresponding increases in payments, would have a material adverse effect on the

revenues, profitability and business prospects of the Company. In addition, the Company continually contracts and seeks to renew contracts with providers at rates designed to ensure adequate profitability. To the extent the Company is unable to obtain such rates, its financial position, results of operations and cash flows could be adversely impacted.

Legal Proceedings
During 1999, six purported class action complaints have been filed against the Company and certain of its current and former directors and officers claiming that the Company and the individual defendants knowingly or recklessly made false or misleading statements in press releases and public filings concerning the Company's financial condition. All seek money damages of unspecified amounts.

Since October 1999, the Company has received purported class action complaints alleging, among other things, that Humana intentionally concealed from its members information concerning the various ways Humana decides what claims will be paid, what procedures will be deemed medically necessary, and what criteria and procedures are used to determine the extent and type of their coverage. The complaints also allege that Humana concealed from members the existence of direct financial incentives to treating physicians and other health care providers to deny coverage. The complaints, generally, do not allege that any member was denied coverage for services that should have been covered but, instead, claim that Humana provided health insurance benefits of lesser value than promised. All seek money damages of unspecified amounts. The Company has requested to consolidate these complaints to a single court.

The Company believes the allegations in all of the above complaints are without merit and intends to pursue the defense of the actions vigorously.

On January 4, 2000, a jury in Palm Beach County, Florida, issued a verdict against Humana Health Insurance Company of Florida, Inc., awarding $79 million to Mark Chipps, an insured who had sued individually and on behalf of his minor daughter. The claim arose from the removal of the child from a case management program which had provided her with benefits in excess of those available under her policy. The award included $78 million for punitive damages, $1 million for emotional distress and $28,000 for contractual benefits. The Company is in the process of appealing the verdict.

During 1999, the Company reached an agreement in principle with the United States Department of Justice and the Department of Health and Human Services on a $15 million settlement relating to Medicare premium overpayments. The settlement is expected to be paid sometime during 2000. The Company had previously established adequate liabilities for the resolution of these issues and, therefore, the settlement did not have a material impact on the Company's financial position or results of operations.

Damages for claims for personal injuries and medical benefit denials are usual in the Company's business. Personal injury and medical benefit denial claims are covered by insurance from the Company's wholly owned captive insurance Subsidiary and excess carriers, except to the extent that claimants seek punitive damages, in states which prohibit insurable coverage for punitive damages. In connection with the Chipps case, the excess carriers have preliminarily indicated that they believe no coverage may be available for a punitive damages award.

During the ordinary course of its business, the Company is or may become subject to pending or threatened litigation or other legal actions. Management does not believe that any pending and threatened legal actions against the Company or audits by agencies will have a material adverse effect on the Company's financial position or results of operations.

11. ACQUISITIONS AND DISPOSITIONS

Between December 30, 1999 and February 4, 2000, the Company entered into definitive agreements to sell its workers' compensation, Medicare supplement and North Florida Medicaid businesses for proceeds of approximately $115 million. The Company recorded a $118 million loss in 1999 related to these sale transactions.

On January 31, 2000, the Company acquired the Memorial Sisters of Charity Health Network ("MSCHN"), a Houston based health plan for approximately $50 million in cash.

On June 1, 1999, the Company reached an agreement with FPA Medical Management, Inc. ("FPA"), FPA's lenders and a federal bankruptcy court under which the Company acquired the operations of 50 medical centers from FPA for approximately $14 million in cash. The Company has subsequently reached agreements with 14 provider groups to assume operating responsibility for 38 of the 50 acquired FPA medical centers under long-term provider agreements with the Company.

On October 17, 1997, the Company acquired ChoiceCare Corporation ("ChoiceCare") for approximately $250 million in cash. The purchase was funded with borrowings under the Company's commercial paper program. ChoiceCare provided health services products to members in the Greater Cincinnati, Ohio, area.

On September 8, 1997, the Company acquired PCA for total consideration of $411 million in cash, consisting primarily of $7 per share for PCA's outstanding common stock and the assumption of $121 million in debt. The purchase was funded with borrowings under the Company's commercial paper program. PCA provided comprehensive health services through its HMOs in Florida, Texas and Puerto Rico. In addition, PCA provided workers' compensation third-party administrative management services. Prior to November 1996, PCA also was a direct writer of workers' compensation insurance in Florida. Long-term medical and other expenses payable in the accompanying Consolidated Balance Sheets includes the long-term portion of workers' compensation liabilities related to this business.

On February 28, 1997, the Company acquired Health Direct, Inc. ("Health Direct") from Advocate Health Care for approximately $23 million in cash.

The above acquisitions were accounted for under the purchase method of accounting. In connection with these acquisitions, the Company allocated the acquisition costs to net tangible and identifiable intangible assets based upon their fair values. Identifiable intangible assets, which are included in other long-term assets in the accompanying Consolidated Balance Sheets, primarily relate to subscriber and provider contracts. Any remaining value not assigned to net tangible or identifiable intangible assets was then allocated to cost in excess of net assets acquired, or goodwill. Goodwill and identifiable intangible assets acquired, recorded in connection with the acquisitions, was $17 million and $754 million in 1999 and 1997, respectively. Subscriber and provider contracts are amortized over their estimated useful lives (seven to 14 years), while goodwill has been amortized over periods from six to 40 years. After a re-evaluation, effective January 1, 2000, the Company adopted a 20 year amortization period from the date of acquisition for goodwill previously amortized over 40 years.

The results of operations for the previously mentioned acquisitions have been included in the accompanying Consolidated Statements of Operations since the date of acquisition. The following unaudited pro forma data summarize the consolidated results of operations for the year ended December 31, 1997 as if the 1997 acquisitions referred to above had been completed as of the beginning of 1997:

(In millions, except per share results)

Revenues	$ 9,272
Net income	64
Earnings per common share	$ 0.39
Earnings per common share — assuming dilution	0.39

The unaudited pro forma information above may not necessarily reflect future results of operations or what the results of operations would have been had the acquisitions actually been consummated at the beginning of 1997.

12. SEGMENT INFORMATION

During 1999, the Company realigned its organization to achieve greater accountability in its lines of business. As a result of this realignment, the Company organized into two business units: the Health Plan segment and the Small Group segment. The Health Plan segment includes the Company's large group commercial (100 employees and over), Medicare, Medicaid, ASO, workers' compensation and military or TRICARE business. The small group segment includes small group commercial (under 100 employees) and specialty benefit lines, including dental, life and short-term disability. Results of each segment are measured based upon results of operations before income taxes. The Company does not allocate assets to the segments, but allocates administrative expenses, interest income and interest expense to the segments. These allocations are based on systematic and rational methods which consider the nature of activities and volume of business associated with the segments' products. Members served by the two segments generally utilize the same medical provider networks, enabling the Company to obtain more favorable contract terms with providers. As a result, the profitability of each segment is somewhat interdependent. In addition, premium revenue pricing to large group commercial employers has historically been more competitive than that to small group commercial employers, resulting in less favorable underwriting margins for the large group commercial line of business. Costs to distribute and administer products to small group commercial employers are higher compared to large group commercial employers resulting in small group's higher administrative expense ratio. The accounting policies of each segment are similar and are described in Note 2.

The segment results for the years ended December 31, 1999, 1998 and 1997 are as follows:

(In millions)	***Health Plan***	***Small Group***	***Total***
1999			
Revenues:			
Premiums	$ 6,827	$ 3,132	$ 9,959
Interest and other income	106	48	154
Total revenues	6,933	3,180	10,113
Underwriting margin	861	566	1,427
Depreciation and amortization	70	54	124
Loss before income taxes	(369)	(35)	(404)

(In millions)	***Health Plan***	***Small Group***	***Total***
1998			
Revenues:			
Premiums	$ 6,734	$ 2,863	$ 9,597
Interest and other income	140	44	184
Total revenues	6,874	2,907	9,781
Underwriting margin	988	568	1,556
Depreciation and amortization	76	52	128
Income (loss) before income taxes	208	(5)	203

(In millions)	***Health Plan***	***Small Group***	***Total***
1997			
Revenues:			
Premiums	$ 5,487	$ 2,393	$ 7,880
Interest and other income	115	41	156
Total revenues	5,602	2,434	8,036
Underwriting margin	864	494	1,358

Depreciation and amortization	64	44	108
Income before income taxes	244	26	270

As previously discussed, during 1999 and 1998, the Company recorded pretax expenses of $585 million and $132 million, respectively. The following table details the reduction on operating results from these expenses for the Health Plan and Small Group segments for the years ended December 31, 1999 and 1998:

	1999			*1998*		
(In millions)	***Health Plan***	***Small Group***	***Total***	***Health Plan***	***Small Group***	***Total***
Underwriting margin	$ 66	$ 24	$ 90	$ 60	$ 13	$ 73
Income before income taxes	$ 553	$ 32	$ 585	$ 96	$ 36	$ 132

The Company's product offerings include managed health care products and specialty products. Managed health care product premiums were approximately $9.7 billion, $9.4 billion and $7.7 billion for the years ended December 31, 1999, 1998 and 1997, respectively. Specialty product premiums were approximately $277 million, $239 million, and $230 million for the years ended December 31, 1999, 1998 and 1997, respectively.

Premium revenues derived from contracts with the federal government in 1999, 1998 and 1997 represent approximately 40 percent, 41 percent and 43 percent, respectively, of total premium revenues.

REPORT OF INDEPENDENT ACCOUNTANTS

To the Board of Directors and Stockholders
Humana Inc.

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of operations, stockholders' equity and cash flows present fairly, in all material respects, the consolidated financial position of Humana Inc. and its subsidiaries at December 31, 1999 and 1998, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 1999, in conformity with accounting principles generally accepted in the United States. These financial statements are the responsibility of the Company's management; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for the opinion expressed above.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky
February 9, 2000

QUARTERLY FINANCIAL INFORMATION (UNAUDITED)

A summary of the Company's quarterly unaudited results of operations for the years ended December 31, 1999 and 1998 follows:

(In millions, except per share results)	*1999*			
	First (a)	***Second***	***Third***	***Fourth (b)***
Revenues	$ 2,477	$2,505	$ 2,557	$ 2,574
(Loss) income before income taxes	(25)	44	34	(457)
Net (loss) income	(16)	28	22	(416)
(Loss) earnings per common share	(0.10)	0.17	0.13	(2.48)
(Loss) earnings per common share — assuming dilution	(0.10)	0.17	0.13	(2.48)

(In millions, except per share results)	*1998*			
	First	***Second***	***Third (c)***	***Fourth***
Revenues	$ 2,402	$2,446	$ 2,464	$ 2,469
Income (loss) before income taxes	79	82	(47)	89

Net income (loss)	50	52	(30)	57
Earnings (loss) per common share	0.30	0.31	(0.18)	0.34
Earnings (loss) per common share — assuming dilution	0.30	0.31	(0.18)	0.34

(a) Includes expenses of $90 million pretax ($58 million after tax, or $0.34 per diluted share) primarily related to premium deficiency and medical reserve strengthening.
(b) Includes expenses of $495 million pretax ($441 after tax, or $2.63 per diluted share) primarily related to goodwill write-down, losses on non-core asset sales and professional liability reserve strengthening.
(c) Includes expenses of $132 million ($84 million after tax, or $0.50 per diluted share) primarily related to the costs of certain market exits and product discontinuances, asset write-downs, premium deficiency and a one-time non-officer employee incentive.

BOARD OF DIRECTORS

K. Frank Austen, M.D.

Theodore B. Bayles Professor of Medicine, Harvard Medical School and the Brigham and Women's Hospital

Michael E. Gellert

General Partner, Windcrest Partners, private investment partnership

John R. Hall

Retired Chairman of the Board and Chief Executive Officer, Ashland Inc.

David A. Jones

Chairman of the Board, Humana Inc.

David A. Jones, Jr.

Vice Chairman, Humana Inc.
Chairman and Managing Director, Chrysalis Ventures, L.L.C.
venture capital firm

Irwin Lerner

Retired Chairman of the Board and of the Executive Committee, Hoffmann-LaRoche Inc.

Michael B. McCallister

President and Chief Executive Officer, Humana Inc.

W. Ann Reynolds, Ph.D.

President, University of Alabama at Birmingham

BOARD COMMITTEES

Executive Committee

David A. Jones, *Chairman*
Michael E. Gellert
David A. Jones, Jr.
Michael B. McCallister

Audit Committee

Michael E. Gellert, *Chairman*
K. Frank Austen, M.D.
John R. Hall
Irwin Lerner

Investment Committee

W. Ann Reynolds, Ph.D., *Chairwoman*
K. Frank Austen, M.D.
Michael E. Gellert
David A. Jones, Jr.

Medical Affairs Committee

K. Frank Austen, M.D., *Chairman*
Irwin Lerner
W. Ann Reynolds, Ph.D.

Nominating and Corporate Governance Committee

John R. Hall, *Chairman*
David A. Jones, Jr.
W. Ann Reynolds, Ph.D.

Organization and Compensation Committee

Irwin Lerner, *Chairman*
K. Frank Austen, M.D.
Michael E. Gellert
John R. Hall

SENIOR OFFICERS

Michael B. McCallister
Kenneth J. Fasola
Heidi S. Margulis

President and Chief Executive Officer

Chief Operating Officer — Small Group Division

Senior Vice President — Government Affairs

James E. Murray
Chief Operating Officer — Health Plan Division and Chief Financial Officer

Sheri E. Mitchell
Senior Vice President and Chief Compliance Officer

Douglas R. Carlisle
Senior Vice President — Market Operations

Thomas T. Noland, Jr.
Senior Vice President — Corporate Communications

Bruce J. Goodman
Senior Vice President and Chief Information Officer

Bruce D. Perkins
Senior Vice President — National Networks

Bonita C. Hathcock
Senior Vice President — Human Resources

George W. Vieth, Jr.
Senior Vice President — Large Group Commercial

Arthur P. Hipwell
Senior Vice President and General Counsel

ADDITIONAL INFORMATION

TRANSFER AGENT

National City Bank
Stock Transfer Department
Post Office Box 92301
Cleveland, Ohio 44193-0900
(800) 622-6757

CORPORATE HEADQUARTERS

Humana Inc.
The Humana Building
500 West Main Street
Louisville, Kentucky 40202
(502) 580-1000

FORM 10-K

Copies of the Company's Form 10-K filed with the Securities and Exchange Commission may be obtained, without charge, by writing:

Investor Relations

Humana Inc.
Post Office Box 1438
Louisville, Kentucky 40201-1438

INDEPENDENT ACCOUNTANTS

PricewaterhouseCoopers LLP
Louisville, Kentucky

ANNUAL MEETING

The Company's Annual Meeting of Stockholders will be held on Thursday, May 18, 2000, at 10:00 a.m. EDT in the Auditorium on the 25th floor of the Humana Building.

Copies of the Company's Form 10-K and other Company information can also be obtained through the Internet at the following address:

http://www.humana.com

STOCK LISTING

The Company's common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Tape:

1999	*High*	*Low*

First Quarter	20-3/4	16-15/16
Second Quarter	16-7/16	11
Third Quarter	13-1/8	6-7/8
Fourth Quarter	8-1/4	5-7/8

1998	*High*	*Low*
First Quarter	26-3/8	19-1/2
Second Quarter	31-11/16	24-15/16
Third Quarter	31-7/8	12-7/8
Fourth Quarter	21-9/16	14-3/8

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ALABAMA
---
1. QuestCare, Inc.

DELAWARE
---
1. Advanced Care Partners, Inc.
2. EMPHESYS Financial Group, Inc.
3. Health Value Management, Inc. - Doing Business As:
   a. ChoiceCare Network
   b. Health Value Management Network (NH)
4. Humana HealthChicago, Inc
5. Humana Inc. - Doing Business As:
   a. H.A.C. Inc.
   b. Humana of Delaware, Inc.
6. Humana Military Healthcare Services, Inc. - Doing Business As:
   a. Humana Military Health Services, Inc. (IL)
7. Humana Workers' Compensation Services of Delaware, Inc.
8. Humrealty, Inc.
9. Medstep, Inc.
10. Physician Corporation of America

FLORIDA
---

1. Humana Health Insurance Company of Florida, Inc.
2. Humana Medical Plan, Inc. - Doing Business As:
   a. Coastal Pediatrics-Daytona
   b. Coastal Pediatrics-Port Orange
   c. Coastal Pediatric-Ormond
   d. Flagler Family Practice
   e. Florida Dermatology Center
   f. Humana Medical Plan-West Palm Beach
   g. Internal Medicine of Daytona
   h. Orange Park Family Health Care
   i. Suncoast Medical Associates
3. Humana Workers' Compensation Services, Inc. - Doing Business As:
   a. Humana Workers' Compensation Insurance Services (UT)
4. PCA Property & Casualty Insurance Co.

GEORGIA
---
1. Humana Employers Health Plan of Georgia, Inc. f/k/a Emphesys Healthcare of Georgia, Inc.

ILLINOIS
---
1. Humana Health Direct, Inc
2. Humana HealthChicago Insurance Company - Doing Business As:
   a. Goldcare 65
3. The Dental Concern, Ltd. - Doing Business As:
   a. TDC (MO)

KENTUCKY
---
1. Humana Health Plan, Inc. - Doing Business As:
   a. Humana Health Care Plans of Indiana (IN)
   b. Madison Family and Industrial Medicine (KY)
2. Humana Insurance Company of Kentucky
3. Humco, Inc.
4. Marketpoint Agency, Inc.
5. The Dental Concern, Inc. (f/k/a Randmark, Inc.) - Doing Business As:
   a. The Dental Concern/KY, Inc. (IN)
   b. The Dental Concern/KY, Inc. (MO)

LOUISIANA

---
1. Humana Workers' Compensation Services of Louisiana, Inc.

MISSOURI
---

1. Humana Insurance Company
2. Humana Kansas City, Inc. - Doing Business As:
   a. Humana Prime Health Plan

NEVADA
---
1. Humana Health Insurance of Nevada, Inc.
2. Humana Workers' Compensation Services of Nevada, Inc.

OHIO
---
1. Humana Health Plan of Ohio, Inc. f/k/a ChoiceCare Health Plans, Inc. - Doing Business As:
   a. ChoiceCare/Humana (IL, IN, KY, OH)

PUERTO RICO
---
1. Humana Health Plans of Puerto Rico, Inc.
2. Humana Insurance of Puerto Rico, Inc.

TEXAS
---
1. Humana Health Plan of Texas, Inc. - Doing Business As:
   a. Humana Health Plan of San Antonio
   b. Humana Regional Service Center
   c. Leon Valley Health Center
   d. Lincoln Heights Medical Center
   e. MedCentre Plaza Health Center
   f. Perrin Oaks Health Center
   g. Val Verde Health Center
   h. West Lakes Health Center
   i. Wurzbach Family Medical Center
2. Humana HMO Texas, Inc.
3. Humana Workers' Compensation Services of Texas, Inc. f/k/a Lomas General Insurance Services, Inc.
4. PCA Health Plans of Texas, Inc.
5. PCA Life Insurance Company of Texas, Inc.

VERMONT
---
1. Managed Care Indemnity, Inc. - Doing Business As:
   a. Witherspoon Parking Garage (KY)

VIRGINIA
---
1. Humana Group Health Plan, Inc.

WISCONSIN
---
1. CareNetwork, Inc. - Doing Business As:
   a. CARENETWORK
2. EMPHESYS Wisconsin Insurance Company
3. Employers Health Insurance Company
4. Humana Wisconsin Health Organization Insurance Corporation - Doing Business As:
   a. WHOIC
   b. WHO
5. Independent Care, Inc.
6. Network EPO, Inc.
7. Wisconsin Employers Group, Inc.

FOREIGN

BERMUDA
---
1. Hallmark RE Ltd.

EXHIBIT 23

CONSENT OF INDEPENDENT ACCOUNTANTS

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (No. 33-33072, No. 33-49305, No. 33-52593, No. 33-54455, No. 33-04435, No. 333-57095 and No. 333-86801) of Humana Inc. of our report dated February 9, 2000 relating to the financial statements, which appears in the Annual Report to Stockholders, which is incorporated in this Annual Report on Form 10-K. We also consent to the incorporation by reference of our report dated February 9, 2000 relating to the financial statement schedules, which appears in this Form 10-K.

PricewaterhouseCoopers LLP
Louisville, Kentucky
March 30, 2000

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