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

FORM 10-K

(MARK ONE)

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

FOR THE FISCAL YEAR ENDED DECEMBER 31, 1996

OR

[_] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934 (NO FEE REQUIRED)

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 (ADDRESS OF PRINCIPAL EXECUTIVE OFFICES)	40202 (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, $.16 2/3 par value	New York Stock Exchange

SECURITIES REGISTERED PURSUANT TO SECTION 12(G) OF THE ACT:

NONE

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. [X]

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

The aggregate market value of voting stock held by non-affiliates of the Registrant as of February 28, 1997, was $2,978,429,730 calculated using the average price on such date of $19.5625. The number of shares outstanding of the Registrant's Common Stock as of February 28, 1997, was 162,716,329.

DOCUMENTS INCORPORATED BY REFERENCE

Part II and portions of Part IV incorporate herein by reference the Registrant's 1996 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 8, 1997.

The Exhibit Index begins on page 15.

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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, including the effects of either federal or state health care reform or other legislation, renewal of the Company's Medicare risk contracts with the federal government, the renewal of the Company's CHAMPUS contract with the federal government, and the effects of other general business conditions, including but not limited to, government regulation, competition, premium rate changes, retrospective premium adjustments relating to federal government contracts, medical cost trends, changes in Commercial and Medicare risk membership, capital requirements, 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.

Since 1983, the Company has offered managed health care products that integrate medical management with the delivery of health care services through a network of providers. This network of providers may share financial risk or have incentives to deliver quality medical services in a cost-effective manner. These products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracting providers. HMOs and PPOs control health care costs by various means, including pre-admission approval for hospital inpatient services and pre-authorization of outpatient surgical procedures. The Company also offers various specialty and administrative service products including dental, group life, workers' compensation, and pharmacy benefit management services.

The Company's HMO and PPO products are marketed primarily to employer and other groups ("Commercial") as well as Medicare and Medicaid-eligible individuals. The Company's Commercial products are licensed in 47 states and the District of Columbia. At December 31, 1996, the Company had a total of 2,814,800 fully insured Commercial customers, with an average group size of 24 members. The products marketed to Medicare-eligible individuals are either HMO products ("Medicare risk") or indemnity insurance policies that supplement Medicare benefits ("Medicare supplement"). The Medicare risk product provides managed care services that include all Medicare benefits and, in certain circumstances, additional managed care services. At December 31, 1996, the Company had 364,500 Medicare risk members and 97,700 Medicare supplement members. The Company also offers administrative services ("ASO") to employers who self-insure their employee health benefits. At December 31, 1996, the Company provided claims processing, utilization review and other administrative services to 471,000 ASO members.

On October 11, 1995, the Company acquired EMPHESYS Financial Group, Inc. ("EMPHESYS") for a total purchase price of approximately $650 million. The

purchase was funded through available cash of $400 million and bank borrowings of $250 million. EMPHESYS was a leading provider of a broad range of PPO and specialty products to small businesses. The medical loss and administrative cost ratios relating to the EMPHESYS business tend to be different from Humana's because of variances in the nature of each entity's products, customer base and the manner in which products and services are distributed to customers, as more fully described in Management's Discussion and Analysis of Financial Condition and Results of Operations contained in the Company's 1996 Annual Report to Stockholders.

On July 1, 1996, the Company began providing managed health care services to approximately 1.1 million eligible beneficiaries under a potential five-year contract (a one-year contract renewable annually at the government's option for up to four additional years) with the United States Department of Defense under the

Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"). Under the CHAMPUS contract, the Company provides managed care services to the beneficiaries of active military personnel and retired military personnel and their beneficiaries located in the southeastern United States. The Company has subcontracted with third parties to provide certain administration and specialty services under the contract. Three health benefit options are available to CHAMPUS beneficiaries. In addition to a traditional indemnity option, participants may enroll in an HMO-like point-of-service plan or take advantage of reduced copayments by using a network of preferred providers.

On January 31, 1997, the Company completed the sale of its Washington, D.C., health plan to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. On January 16, 1997, the Company signed a definitive agreement to sell its Alabama operations to PrimeHealth of Alabama, Inc. The Alabama sale excludes the Company's small group business and the Company's Alabama CHAMPUS operations. These transactions will not have a material impact on the Company's financial position, results of operations, or cash flows.

COMMERCIAL PRODUCTS

HMOs

An HMO provides prepaid health care services to its members through primary care and specialty physicians employed by the HMO at facilities owned by the HMO, and/or through a network of independent primary care and 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 other health care providers must be approved by the primary care physician, the HMO product is the most restrictive form of managed care.

At December 31, 1996, the Company owned and operated 18 HMOs, which contracted with approximately 37,700 physicians (including approximately 9,100 primary care physicians) and approximately 600 hospitals. In addition, the Company had approximately 2,800 contracts with other providers to provide services to HMO members. The Company also employed approximately 500 physicians in its staff model HMOs at December 31, 1996.

An HMO member, typically through the member's employer, pays a monthly fee which generally covers, with minimal copayments, health care services received from or approved by the member's primary care physician. For the year ended December 31, 1996, Commercial HMO premium revenues totaled approximately $1.8 billion or 27 percent of the Company's total premium revenues. Approximately $248 million of the Company's Commercial premium revenues for the year ended December 31, 1996, were derived from contracts with the United States Office of Personnel Management ("OPM"), under which the Company provides health care benefits to approximately 165,000 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. The Company's Washington, D.C., health plan, which was sold effective January 31, 1997, included approximately 45,000 OPM members at December 31, 1996, and premium revenues from these OPM contracts totaled approximately $71 million for the year ended December 31, 1996.

PPOs

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.

At December 31, 1996, approximately 37,800 physicians and approximately 630 hospitals contracted directly with the Company to provide services to PPO members. The Company also had approximately 3,200 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 21 leased provider networks throughout the country which provided services to approximately 75 percent of EMPHESYS' PPO membership.

For the year ended December 31, 1996, Commercial PPO premium revenues totaled approximately $2.3 billion or 34 percent of the Company's total premium revenues. During 1996, Commercial PPO premiums increased approximately $1.4 billion, primarily as a result of the acquisition of EMPHESYS in the fourth quarter of 1995.

Over the previous four years, changes in the Company's Commercial premium rates have ranged between an approximate 7 percent increase for the year ended December 31, 1993, to a 0.6 percent decrease for the year ended December 31, 1996. The Company expects that 1997 Commercial premium rates will increase approximately 2 to 3 percent from 1996 levels.

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.

Certain managed care companies which operate HMOs contract with the federal government's Health Care Financing Administration ("HCFA") to provide medical benefits to Medicare-eligible individuals residing in the geographic areas in which their HMOs operate in exchange for a fixed monthly payment per member from HCFA. Individuals who elect to participate in these Medicare risk 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. The enrollee pays the HMO a premium only in cases where the HMO provides additional benefits and where competitive market conditions permit.

Medicare Risk

A Medicare risk 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 upon 30 days' notice. The fixed monthly payment is determined and adjusted annually by HCFA, and takes into account, among other things, the cost of providing medical care in the geographic area where the member resides.

The Company markets a variety of Medicare risk HMO products. All of these products provide an enrolled individual with all of the benefits covered by the Medicare program but relieve the enrolled individual of the obligation to pay deductibles and coinsurance that would otherwise apply. Some of these products also provide additional benefits not covered by Medicare, such as vision and dental care services and prescription drugs.

Where competitive conditions permit, the Company charges a premium to members (in addition to the payment from HCFA) for some of its Medicare risk products. At December 31, 1996, approximately 42,000 members in 12 markets were paying premiums which totaled approximately $24 million for the year ended December 31, 1996.

As of January 1, 1997, the Company provides Medicare risk services under 10 contracts with HCFA ("HCFA Contracts") in 16 markets. During 1996, the Company received approval from HCFA to sell its Medicare risk product in Dallas, Texas, Cincinnati, Ohio, and several additional counties contiguous to existing markets where it has already been approved. Management believes that additional growth opportunities exist because only approximately 10 percent of the country's Medicare-eligible beneficiaries are enrolled in managed care programs similar to those offered by the Company. The Company intends to pursue those opportunities in under-penetrated markets which meet the Company's long-term growth strategies.

At December 31, 1996, HCFA Contracts covered approximately 364,500 Medicare risk members for which the Company received premium revenues of approximately $1.9 billion or 29 percent of the Company's total premium revenues for the year ended December 31, 1996. At December 31, 1996, one such HCFA Contract covered approximately 227,500 members in Florida and accounted for premium revenues of approximately $1.3 billion, which represented 67 percent of the Company's HCFA premium revenues or 19 percent of the Company's total premium revenues for the year ended December 31, 1996. HCFA Contracts are renewed for a one-year term each December 31 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 revenues, profitability, and business prospects of the Company.

The Company's 1997 average rate of statutory increase under the HCFA Contracts is approximately 6 percent. However, the Company's expected 1997 HCFA Contract premium rate increase differs from the 6 percent statutory increase as a result of a 1996 change in the geographic mix of the Company's members. The Company expects its 1997 HCFA Contract premium rate increase will be approximately 4 to 5 percent. Over the last five years, annual increases have ranged from as low as 3 percent in January 1994 to as high as 12 percent in January 1993, with an average of approximately 7 percent, including the January 1997 increase.

Current legislative proposals are being considered which include modification of future reimbursement rates under the Medicare program and which encourage the use of managed health care for Medicare beneficiaries. 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 loss of these HCFA Contracts or significant changes in the Medicare risk 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 revenues, profitability, and business prospects of the Company.

Medicare Supplement

The Company's Medicare supplement product is an insurance policy which pays for hospital deductibles, copayments and coinsurance for which an individual enrolled in the traditional Medicare program is responsible.

Under the terms of existing Medicare supplement policies, the Company may

not reduce or cancel the benefits contracted for by policyholders. These policies are renewable annually by the insured at the Company's prevailing rates, which may increase subject to approval by appropriate state insurance regulators.

At December 31, 1996, the Company provided Medicare supplement benefits to approximately 97,700 members. For the year ended December 31, 1996, Medicare supplement premium revenues totaled approximately $93 million or 1 percent of the Company's total premium revenues.

MEDICAID PRODUCT

Medicaid is a federal program that is state-operated to provide 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 risk product discussed previously. In both instances, the Company receives a fixed monthly payment from a government agency for which it is required to provide managed health care services to enrolled members. For the year ended December 31, 1996, premium revenues from the Company's Medicaid products totaled approximately $71 million or 1 percent of the Company's total premium revenues. At December 31, 1996, the Company had approximately 55,200 Medicaid members in three markets. Due to the increased emphasis on state health care reform, more states are utilizing a managed care product in their Medicaid programs.

CHAMPUS

In 1993, the Company established Humana Military Healthcare Services, Inc., (a wholly owned subsidiary of the Company), to bid on contracts to provide managed care services to the beneficiaries of active military personnel and retired military personnel and their beneficiaries. In November 1995, the United States Department of Defense awarded the Company its first CHAMPUS 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 providing managed health care services to these approximate 1.1 million eligible beneficiaries under a potential five-year contract (a one year contract renewable annually at the government's option for up to four additional years.). The Company has subcontracted with third parties to provide certain administration and specialty services under the contract. Three health benefit options are available to CHAMPUS beneficiaries. In addition to a traditional indemnity option, participants may enroll in an HMO-like point-of-service plan or take advantage of reduced copayments by using a network of preferred providers. CHAMPUS premium revenues for the period July 1 through December 31, 1996, were approximately $351 million or 5 percent of the Company's total premium revenues for the year ended December 31, 1996.

The Company will actively seek opportunities to provide managed care services to beneficiaries of federal and state programs, including other CHAMPUS contracts.

OTHER RELATED PRODUCTS

The Company also offers various specialty and administrative service products including dental, group life, workers' compensation and pharmacy benefit management services. Specialty product membership at December 31, 1996, totaled approximately 1.9 million members, including approximately 517,000 members for which the Company provides only administrative services. Specialty administrative membership includes dental, workers' compensation, flexible benefit and purchasing pool administration services. The Company also operates a prescription drug management service which administers drug benefit

programs for various HMOs and PPOs, including those of the Company. Premiums and other income related to these specialty and administrative service products totaled approximately $208 million for the year ended December 31, 1996.

PROVIDER ARRANGEMENTS

The Company's HMOs contract with individual or groups of primary care physicians, generally for an actuarially determined, fixed, per-member-per-month fee called 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 other health care providers for the provision of all covered managed health care services to HMO members. This includes services provided by specialty physicians and other providers. The capitation payment does not vary with the nature or extent of services provided 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 employs approximately 500 physicians in markets where it operates staff model HMOs. 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 Company remains financially responsible for the provision of or payment for covered medical services if primary care or specialty physicians fail to perform their obligations under the contract.

The focal point for cost control in the Company's HMOs is generally the primary care physician, whether employed or under contract, who provides services and controls utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. 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, 1996, approximately 42 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 with physician-hospital organizations ("PHOs") and independent practice associations ("IPAs") pursuant to which the PHO or IPA is responsible for providing all covered managed health care services to its members.

During 1996, the Company began 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, end stage renal disease, diabetes and breast cancer screening. As in the case of bonus arrangements, payments generally are based on performance relative to certain budgeted targets.

QUALITY ASSESSMENT AND CUSTOMER SERVICE

Access to high quality health care services is an important element of the Company's business. All of the Company's contracts require that the provider

participate in the Company's quality assurance program. Physician participation in the Company's HMOs and PPOs is conditioned upon the physician meeting the Company's requirements concerning the physician's professional qualifications. When considering whether to contract with a physician, the Company performs rigorous on-going credentialing verifications and peer review that meet both regulatory and accrediting agency standards.

The Company has a program in place to monitor important aspects of HMO plan-wide service and quality indicators with oversight by a senior management committee. Such indicators as credentialing, quality concerns, customer service, disenrollment, and satisfaction are measured against standards. Another measure of quality is the reporting of Health Plan Employer Data Information Sets ("HEDIS"), which the Company has been reporting since June 1994. HEDIS is useful to purchasers of managed health care services to measure individual health plan quality and service. Each HMO has in place a peer review procedure which is implemented by a quality management committee ("QMC"). This committee is headed by the HMO's medical director and is composed of physicians and physician group representatives. The QMC performs initial evaluation of applicants for credentialing and reviews all providers on a periodic basis to monitor the appropriateness of members' care.

During 1996, the Company implemented several new programs intended to ensure that members receive high quality treatment in a cost-effective manner, improve members' health, and increase member satisfaction. Disease management programs are being implemented in various markets to address the specific needs of members with high risk or chronic diseases. These programs are designed to improve outcomes through close follow-up monitoring and data collection and to prevent costly medical episodes, including unnecessary hospital stays. The Company has also implemented a Demand Management program which provides members telephone access to registered nurses 24 hours a day, seven days a week. As of December 31, 1996, this service was available to approximately 600,000 fully insured members in nine markets and is expected to be available to all of the Company's remaining members by December 31, 1997.

HEALTH MAINTENANCE ORGANIZATION ACCREDITATION

With the increasing significance of managed care in the health care industry, several independent organizations have been formed for the purpose of responding to external demands for accountability over the managed care industry. The organizations utilized by the Company are the National Committee for Quality Assurance ("NCQA") and the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). NCQA performs site reviews of standards established for quality assurance, credentialing, utilization management, medical records, preventive services, and member rights and responsibilities. JCAHO reviews rights, responsibilities and ethics, continuum of care, education and communication, leadership, management of information and human resources, and network performance. Both organizations evaluate the mechanisms the organization has established to ensure continuous quality improvement.

In the states of Kansas and Florida, accreditation or external review by an accrediting agency is mandatory and generally required for licensure. As of December 31, 1996, nine of Humana's HMO markets achieved various levels of accreditation. Humana Medical Plan, Inc. in its South Florida, Orlando, Tampa, and Daytona markets, Humana Health Plan, Inc. in its Chicago market, and Humana Health Plan of Texas, Inc. in its San Antonio market (which includes Houston and Dallas), all received full accreditation status from NCQA. Humana Medical Plan, Inc. in its Fort Walton market received three year accreditation status from JCAHO. Humana Medical Plan, Inc. in its Jacksonville market and Humana Kansas City, Inc. each received one year accreditation from NCQA. The Company is currently developing plans for achieving accreditation for the remainder of its HMO plans, beginning with the review of the Cincinnati, Ohio market in February 1997. The Company is also developing a plan for accreditation of its Milwaukee, Wisconsin HMO plan which was previously denied accreditation (prior to purchase in December 1994). The Company has submitted an application to NCQA requesting a survey of the Milwaukee plan in May 1999. Management believes the Milwaukee denial has not had a material impact on the Company's financial position, results of operations, or cash flows.

MANAGEMENT INFORMATION SYSTEMS

The Company's managed care health plans use centralized, integrated information systems developed and/or customized specifically to meet the

Company's needs and to allow for aggregation of data and comparison across markets. These information systems support marketing, sales, underwriting, contract administration, billing, financial, and other administrative functions as well as customer service, appointment scheduling, authorization and referral management, concurrent review, physician capitation and claims administration, provider management, quality management, and utilization review.

Key to the Company's information systems are operational reports, used by market office and corporate personnel for such items as physician profiling, utilization review, quality assessment, member satisfaction measurement, and employer reporting. Clinical software is used as well to assess appropriateness of medical care provided to the Company's members. The Company's information systems are continually upgraded to support new products in an integrated manner as well as to take advantage of the latest advances in technology.

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 provide cost-effective quality care consistent with the needs and expectations of the employees or members.

The Company uses various methods to market its Commercial and Medicare products, including television, radio, telemarketing and mailings. At December 31, 1996, the Company used approximately 34,000 independently licensed brokers and agents and approximately 300 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, 1996, the Company used approximately 1,400 independently licensed brokers and approximately 600 employed sales representatives, who are each paid a salary and/or per member commission, to market the Company's Medicaid and Medicare products. The Company also used approximately 400 telemarketing representatives who assisted in the marketing of Medicaid and Medicare products by making appointments for broker/sales representatives with prospective members.

The following table lists the Company's medical membership at December 31, 1996, by state and product:

MEDICAL MEMBERSHIP
(IN THOUSANDS)

	COMMERCIAL		MEDICARE		MEDICARE			PERCENT OF
	PPO	HMO(1)	RISK	CHAMPUS	SUPPLEMENT	ASO	TOTAL	TOTAL
Florida	185.4	329.4	227.5	416.0	9.1	6.0	1,173.4	24.2%
Illinois	176.6	292.0	45.8	--	--	56.3	570.7	11.8%
Wisconsin	101.5	121.5	--	--	--	204.7	427.7	8.8%
Kentucky	145.5	108.4	8.1	--	34.5	81.8	378.3	7.8%
Georgia	85.8	--	--	261.9	5.2	1.0	353.9	7.3%
Texas	200.7	90.4	32.5	--	11.0	5.9	340.5	7.0%
Missouri/Kansas	63.1	124.2	16.7	--	7.6	40.6	252.2	5.2%
Alabama	4.8	16.7	--	108.7	16.7	7.0	153.9	3.2%
South Carolina	6.2	--	--	141.2	--	1.3	148.7	3.1%
Indiana	91.7	25.8	--	--	1.9	21.2	140.6	2.9%
Tennessee	58.0	--	--	71.7	1.3	1.5	132.5	2.7%
Other	467.6	119.5	33.9	103.5	10.4	43.7	778.6	16.0%
Total	1,586.9	1,227.9	364.5	1,103.0	97.7	471.0	4,851.0	100.0%

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(1) Includes 55,200 Medicaid members located in Illinois, Wisconsin and Missouri/Kansas.

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 risk 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 CHAMPUS 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 Blue Cross/Blue Shield (including HMOs and PPOs owned by Blue Cross/Blue Shield plans), national insurance companies and other HMOs and PPOs. Many of the Company's competitors have larger membership in local markets or greater financial resources. 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

Of the Company's 18 licensed HMO subsidiaries, nine are qualified under the Federal Health Maintenance Organization Act of 1973, as amended. Six of these federally qualified subsidiaries are parties to HCFA Contracts to provide Medicare risk HMO products in 12 states and the District of Columbia.

To obtain federal qualification, an HMO must meet certain requirements, including conformance with financial criteria, a standard method of rate setting, a comprehensive benefit package, and prohibition of medical underwriting of individuals. 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.

HCFA conducts audits of Medicare risk HMOs 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 HMO's administration and management (including management information and data collection systems), fiscal stability, utilization management and 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 and restrict the number of Medicare risk and Medicaid members to no more than the HMO's Commercial membership in a specified service area. HCFA regulations also require independent review of medical records and quality of care, review and approval by HCFA of all advertising, marketing and communication materials, and independent review of all denied claims and service complaints which are not resolved in favor of a member.

In addition, HCFA has finalized rules that require certain disclosures to HCFA and to Medicare beneficiaries concerning the financial arrangements which managed care organizations have with physicians with whom they contract. 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 Company's Medicaid product is regulated by the applicable state agency in the state which the Company sells its Medicaid product, in conformance with federal approval of the state plan, and is subject to periodic reviews by these agencies. The reviews are similar in nature to those performed by HCFA.

Laws in each of the states in which the Company operates its HMOs and PPOs regulate the Company's operations, including the scope of benefits, rate formulas, delivery systems, utilization review procedures, quality assurance, enrollment requirements, claim payments, marketing, and advertising. The HMO and PPO products offered by the Company are sold under licenses issued by the applicable state insurance regulators. The Company's HMOs and PPOs 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 PPOs 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 regulations. These regulations require, among other things, prior approval and/or notice of certain material transactions, dividend payments, and the filing of various financial and operational reports.

Management believes that the Company is in substantial compliance with all governmental laws and regulations affecting the Company's business.

HEALTH CARE REFORM

There continues 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 1996, Congress passed the Health Insurance Portability and Accountability Act ("HIPAA") which established portability, pre-existing conditions, nondiscrimination and guaranteed renewal rules for both the small and large group markets, including self-funded groups. HIPAA also extended guarantee issue rules for the small group market, defined as 2 to 50 employees.

Current legislative proposals are being considered which include modification of future reimbursement rates under the Medicare program and which encourage the use of managed health care for Medicare beneficiaries. Further, Congress is evaluating proposals to subsidize health insurance premiums for certain uninsured groups, including children and the unemployed. Congress is also likely to consider various managed care proposals to require all plans to meet minimum quality standards and service delivery requirements. Management believes that continuing concerns over health care accessability and the cost of the Medicare and Medicaid programs in their current form will result in continued legislative efforts to reform health care.

State

Legislation enacted in the states has included, among other things, small group market reforms, subscriber access standards for network health plans, and purchasing pools. Issues related to subscriber access and the delivery of care including any willing provider, mandatory length of stay, direct access and utilization review (as well as civil liability arising from these decisions) are being discussed. In addition, states will be addressing insurance market reform issues such as portability, pre-existing condition exclusions, medical savings accounts, and rating restrictions as they come into compliance with recently enacted federal legislation (such as HIPAA).

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 the revenues, profitability, and business prospects of the Company.

OTHER BUSINESSES

Hospital

The Company owns a 170-bed hospital in Lexington, Kentucky, which provides services primarily to members of the Company's managed care plans in Lexington. The Company contracted with an independent hospital management company (the "Management Company") whereby effective March 1, 1995, all operational functions of the hospital have been managed by the Management Company. The Company has terminated this contract with the Management Company effective February 21, 1998.

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. 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, 1996, the Company had approximately 18,300 employees, including approximately 1,200 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.

The Company provides medical services in owned or leased 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, 1996:

	MEDICAL CENTERS		ADMINISTRATIVE OFFICES		
	OWNED	LEASED	OWNED	LEASED	TOTAL
Florida	6	89	--	40	135
Illinois	8	18	--	9	35
Missouri/Kansas	3	10	--	6	19
Texas	5	4	1	9	19
Kentucky	8	3	1	3	15
California	--	--	--	10	10
Wisconsin	--	--	--	9	9
Other	4	11	1	55	71
Total	34	135	3	141	313

In addition, the Company owns buildings in Louisville, Kentucky, San Antonio,

Texas, and Green Bay, Wisconsin, and leases facilities in Jacksonville, Florida, and 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 a hospital and medical office building in Lexington, Kentucky.

ITEM 3. LEGAL PROCEEDINGS

1. A class action law suit styled Mary Forsyth, et al v. Humana Inc., et al, Case #CV-5-89-249-PMP (L.R.L.), (now restyled Marietta Cade, et al v. Humana Health Insurance of Nevada, Inc., et al) was filed on March 29, 1989, in the United States District Court for the District of Nevada (the "Forsyth" case). On November 19, 1996, the Company filed a Petition for Reconsideration on Rehearing En Banc in the Ninth Circuit Court of Appeals in the Forsyth case. The Court of Appeals, on November 5, 1996, had reinstated certain claims that had been dismissed by the U.S. District Court in Nevada in the case involving claims arising out of the method of calculation of coinsurance for Nevada insureds prior to 1988. The Petition requested the Court of Appeals to reconsider its ruling reinstating an antitrust claim and also to clarify the portion of its ruling reinstating a claim under the Racketeer Influenced and Corrupt Organizations Act.

2. On April 22, 1993, an alleged stockholder of the Company filed a purported shareholder derivative action in the Court of Chancery of the State of Delaware, County of New Castle, styled Lewis v. Austen, et al, Civil Action No. 12937. The action was purportedly brought on behalf of the Company and Galen Health Care, Inc. ("Galen") against all of the directors of both companies at the time Galen was spun off from the Company alleging, among other things, that the defendants had improperly amended the Company's existing stock option plans to bifurcate their existing options to allow employees of each company to receive options in the stock of the other company. The challenged amendment to the plan was approved by the Company's stockholders at the 1993 Annual Meeting of Stockholders. There has been little activity in this case. The defendants filed a motion to dismiss the case in October 1995. That motion is still pending. The Company believes that the complaint is without merit.

Damages for claims for personal injuries and medical benefit denials are usual in the Company's business. Personal injury claims are covered by insurance from the Subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance if awarded. Punitive damages generally are not paid where claims are settled and generally are awarded only where a court determines there has been a willful act or omission to act.

Management does not believe that any pending legal actions will have a material adverse effect on the Company's financial position, result 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 February 28, 1997, their positions, date of election to such position and the date first elected an officer of the Company:

NAME	AGE	POSITION	SERVD IN SUCH CAPACITY SINCE	FIRST ELECTED OFFICER
David A. Jones.....	65	Chairman of the Board and Chief Executive Officer	08/69	09/64(1)
Gregory H. Wolf.....	40	President and Chief Operating Officer	09/96	10/95(2)

David R. Astar.....	44	Vice President--Customer Service and Quality	12/96	09/96(3)
Karen A. Coughlin.....	49	Division II--President	07/96	09/88
Kenneth J. Fasola.....	37	Vice President and National Sales Manager	12/96	05/96(4)
Arthur P. Hipwell.....	48	Senior Vice President and General Counsel	06/94	08/90(5)
Gail H. Knopf.....	50	Vice President--Information Systems	12/96	08/85
Michael B. McCallister..	44	Division I--President	07/96	09/89
James E. Murray.....	43	Chief Financial Officer	01/97	08/90
David R. Nelson.....	42	Vice President--Risk Management and Chief Actuary	12/96	09/96(6)
Bruce D. Perkins.....	42	Senior Vice President--Provider Affairs and Reengineering	07/96	09/94

NAME	AGE	POSITION	SERVD IN SUCH CAPACITY SINCE	FIRST ELECTED OFFICER
Jerry D. Reeves, M.D....	52	Senior Vice President and Chief Medical Officer	01/97	01/97(7)
Gregory K. Rotherham....	40	Vice President--Marketing	12/96	09/96(8)
Kirk E. Rothrock.....	38	Vice President--Specialty Products and Business Development	12/96	05/96(9)
George W. Vieth, Jr.....	41	Vice President--Development and Planning	12/96	12/95(10)
Tod J. Zacharias.....	35	Vice President--Employers Health Insurance Company	12/96	05/94(11)

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(1) Elected an officer of a predecessor corporation in 1961.

(2) Mr. Wolf was initially elected an officer of the Company at the time of the acquisition of EMPHESYS in 1995. Mr. Wolf had been President and Chief Operating Officer of EMPHESYS (now a wholly owned subsidiary of the Company) since November 1994. Mr. Wolf was named Executive Vice President for Employers Health Insurance Company ("EHIC") (a wholly owned subsidiary of EMPHESYS) in 1993 and was named Senior Vice President for EHIC in 1990 for Marketing, Sales and Business Development.

(3) Mr. Astar was elected to the above position in September 1996. Prior to his appointment, Mr. Astar was Vice President of Customer Service of EHIC since 1990.

(4) Mr. Fasola was initially elected as Vice President Commercial Sales of the Company in May 1996. Prior to his appointment, Mr. Fasola was Vice President and National Sales Manager of EHIC since 1989.

(5) Mr. Hipwell was initially elected an officer of the Company in 1990 and previously served in his current capacity since July 1992. Effective with the spinoff of Galen Health Care Inc. ("Galen"), 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.

(6) Mr. Nelson was elected to the above position in September 1996. Prior to his appointment, Mr. Nelson was Vice President and Chief Actuary of EHIC since 1992.

(7) Dr. Reeves, a pediatric oncologist, joined the Company in January 1997 in the above position. Prior to his appointment, Dr. Reeves was Senior Vice President--Health Care Operations and Chief Medical Officer at Sierra Health Services, Inc. in Las Vegas, Nevada. Dr. Reeves was employed by Sierra for eight years.

(8) Mr. Rotherham was elected to the above position in September 1996. Prior to his appointment, Mr. Rotherham served in a similar capacity as Vice President for EHIC since 1994 and for Schneider National, Inc. in Green Bay, Wisconsin since 1985.

(9) Mr. Rothrock was elected to the above position in May 1996. Prior to his appointment, Mr. Rothrock served in a similar capacity as Vice President for EHIC since 1993 and as an Assistant Vice President since 1991.

(10) Mr. Vieth was elected to the above position in December 1995, having joined the Company in November 1992 as Director of Development and Planning. Before joining the Company, Mr. Vieth was Vice President and

General Counsel of Glenmore Distilleries in Louisville, Kentucky since 1989.

(11) Mr. Zacharias was elected to the above position with EHIC in May 1994. He joined EHIC in 1989 as Controller.

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 directors or executive officers of the Company, except that Mr. Jones is the father of David A. Jones, Jr., the Vice Chairman of the Board of Directors. Unless otherwise noted, all of the above-named executive officers have been employees of the Company for more than five consecutive years.

PART II

Information for Items 5 through 8 of this report, which appears in the 1996 Annual Report to Stockholders as indicated on the following table, is incorporated by reference herein in this report and filed as an exhibit hereto:

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 8, 1997, appearing under the caption "ELECTION OF DIRECTORS OF THE COMPANY FOR 1997" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

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 8, 1997, 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 8, 1997, 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 8, 1997, 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) Financial Statement Schedules--All 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(a) to the Company's Current Report on Form 8-K (File No. 1-5975) filed March 5, 1993, is incorporated by reference herein.
4(a)	Restated Certificate of Incorporation as amended and corrected and By-laws as amended. (See 3(a) and 3(b) above.)
(b)	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.
(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 1996 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)*	1981 Non-Qualified Stock Option Plan, as amended. Exhibit 10(c) to the Company's Form SE filed on November 25, 1987, is incorporated by reference herein.
(b)*	Amendment No. 2 to the 1981 Non-Qualified Stock Option Plan, as amended. Annex A to the Company's Proxy Statement covering the Annual Meeting of Stockholders held on February 18, 1993, is incorporated by reference herein.

(c)* 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.

(d)* 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.

(e)* 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.

(f)* 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.

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

10(g)* 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.

(h)* 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.

(i)* 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.

(j)* Executive Management Incentive Compensation Plan--Group I, Corporate. Exhibit 10(j) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1993, is incorporated by reference herein.

(k)* Regional Incentive Compensation Plan--Group I, Regional Senior Vice President. Exhibit 10(k) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1993, is incorporated by reference herein.

(l)* Senior Management Incentive Compensation Plan--Group II, Corporate. Exhibit 10(l) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1993, is incorporated by reference herein.

(m)* 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, 1994, is incorporated by reference herein.

(n)* Employment Agreement--David A. Jones, as amended. Exhibit 10(m) to the Company's Annual Report on Form 10-K for the fiscal year ended August 31, 1991, is incorporated by reference herein.

(o)* Directors' Retirement Policy as amended. Exhibit 10(p) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1995, is incorporated by reference herein.

(p)* Humana Officers' Target Retirement Plan as amended. Exhibit 10(q) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1994, is incorporated by reference herein.

(q)* Form Letter Agreement concerning Humana Officers' Target Retirement Plan dated June 18, 1992, for David A. Jones. Exhibit 10(s) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1993, is incorporated by reference herein.

(r)* 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.

(s)* 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.

(t)* 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(u)* Retention Bonus Agreement between Gregory H. Wolf and the Company. Exhibit 10(w) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1995, is incorporated by reference herein.

(v)* Executive Change in Control Severance Policy for EMPHESYS Financial Group, Inc. and Employers Health Insurance Company, filed herewith.

(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) Humana Inc. Agreement and Amended Credit Agreement dated August 1, 1995, and an Amendment and Restatement dated as of September 26, 1995. Exhibit (b)(2) to Amendment No. 4 of the Company's Schedule 14D-1 and 13D is incorporated by reference herein.

(z) 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.

(aa) Loss Portfolio Reinsurance Agreement between Health Care Indemnity, Inc. and Managed Care Indemnity, Inc. Exhibit 10(j) to the Company's Current Report on Form 8-K filed on March 5, 1993, is incorporated by reference herein.

(bb) Alternative Dispute Resolution Agreement between the Company and Galen dated March 8, 1993. Exhibit 10(qq) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 1993, is incorporated by reference herein.

(cc) 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 1996 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 Coopers & Lybrand L.L.P., filed herewith.

27 Financial Data Schedule, filed herewith.

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

(b) Reports on Form 8-K:

No reports on Form 8-K were filed by the Company during the last quarter of the period covered by this report.

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.

/s/ James E. Murray
By_____
James E. Murray
Chief Financial Officer
Date: March 28, 1997

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 Financial Officer (Principal Accounting Officer)	March 28, 1997
/s/ David A. Jones David A. Jones	Chairman of the Board and Chief Executive Officer	March 28, 1997
/s/ David A. Jones, Jr. David A. Jones, Jr.	Vice Chairman of the Board	March 28, 1997
/s/ K. Frank Austen, M.D. K. Frank Austen, M.D.	Director	March 28, 1997
/s/ Michael E. Gellert Michael E. Gellert	Director	March 28, 1997
/s/ John R. Hall John R. Hall	Director	March 28, 1997
/s/ Irwin Lerner Irwin Lerner	Director	March 28, 1997
/s/ W. Ann Reynolds, Ph.D. W. Ann Reynolds, Ph.D.	Director	March 28, 1997

Exhibit 10(v)

EXECUTIVE CHANGE IN CONTROL SEVERANCE POLICY

CHANGE IN CONTROL SEVERANCE POLICY

PARTICIPANT:

SCOPE: This policy applies to Designated Officers of EMPHESYS Financial Group, Inc. and Employers Health Insurance.

PURPOSE: To provide a uniform policy that will insure the retention of Key Individuals during a possible transitionary phase to any new form of ownership and to provide a uniform policy for the administration of severance benefits for designated individuals in the event of a "Change in control" as defined in this policy.

ELIGIBILITY: Termination of employment after a "Change in Control". In the event that an employee covered under the scope of this policy is terminated by the company while this policy is in effect within eighteen months following a Change in Control (as defined in this policy) with or without good cause; or if employee terminates their own employment within 6 months after a 25% or more reduction in base annual salary following a Change of Control, the company shall (1) pay to Employee an amount equal to their current annual base salary accrued through the date the termination becomes effective, (2) pay to employee an amount equal to their Management Incentive Bonus accrued through the date the termination becomes effective (3) pay to the employee an amount equal to the benefits shown in the benefits section of this policy. The payment of this severance shall be made in the form of a salary continuance for the period specified in the schedule and will also provide for the continuance of current medical insurance and life insurance for the same period of time. The severance paid under this plan will be paid in lieu of any severance benefits provided under any other company provided severance plans.

BENEFITS: Employees covered under the scope of this policy shall be eligible for continuation of Base Salary and Benefits for Six/Nine Months from the date of termination.

DEFINITION: For the purposes of this policy, "Change in Control" shall be deemed to have occurred if, during, of following the consummation of, a stock purchase plan, tender offer, exchange offer, merger, consolidation, sale of assets, contested election or any combination of the foregoing transactions, any person, entity, or group of persons acting in concert, directly or indirectly, (i) acquires ownership of the power to vote 40% of the voting securities of EFG and one or more of its representatives are elected to the Board, (ii) acquires ownership of the power to vote in excess of 50% of the voting powers of EFG, or (iii) otherwise acquires effective control of the business and affairs of EFG; provided however, that acquisition of shares pursuant to the initial public offering of EFG shall not be used to compute the percentage ownership for purposes of defining Change of Control.

REQUIREMENTS: In order to receive the benefits under this policy, the covered employee must agree in writing to the Settlement Agreement and General Release that will be provided in advance of the receiving of any benefits. Such employee will not receive any of the described benefits or any other severance benefits in the absence of executing and agreeing to the Letter and Agreement.

MISCELLANEOUS: This policy statement is intended as an overview of the benefits provided. In the case of any discrepancies, the actual language of the Settlement Agreement and General Release shall be the binding language. This policy will be administered by the Chief Executive Officer and the Vice President and Human Resources.

Exhibit 12

HUMANA INC.
RATIO OF EARNINGS TO FIXED CHARGES
For the Years Ended December 31, 1996, 1995 and 1994
(Unaudited)

	Years Ended December 31,		
	1996	1995	1994
Earnings:			
Income before income taxes	$ 18	$288	$257
Fixed charges	19	17	9
	$ 37	$305	$266
Fixed charges:			
Interest charged to expense	$ 11	$ 11	$ 4(c)
One-third of rent expense (a)	8	6	5
	$ 19	$ 17	$ 9
Ratio of earnings to fixed charges	2.0(b)	17.9	28.9

(a) One-third of rent expense is considered representative of the underlying interest.

(b) Excluding special charges of $215 million before income taxes, the ratio of earnings to fixed charges for the year ended December 31, 1996, would have been 13.3.

(c) Interest expense for the year ended December 31, 1994, excludes nonrecurring income related to the favorable settlement of income tax disputes with the Internal Revenue Service.

EXHIBIT 13

FINANCIAL SECTION

Humana Inc.

SELECTED FINANCIAL DATA

Humana Inc.

Dollars in millions, except per share results

For the years ended December 31,	1996 (A)	1995(b)	1994 (c)	1993	1992 (d)
SUMMARY OF OPERATIONS					
Revenues:					
Premiums:					
Commercial	$ 4,326	$ 2,934	$ 2,056	$ 1,709	$ 1,642
Medicare risk	1,907	1,569	1,406	1,296	1,112
CHAMPUS	351				
Medicare supplement	93	102	114	132	127
Total premiums	6,677	4,605	3,576	3,137	2,881
Interest	101	87	62	48	36
Other income	10	10	16	10	4
Total revenues	6,788	4,702	3,654	3,195	2,921
Income (loss) before income taxes	18	288	257	143	(154)
Net income (loss)	12	190	176	89	(107)
Earnings (loss) per common share	.07	1.17	1.10	.56	(.68)
Net cash provided by operations	341	150	298	185	124
FINANCIAL POSITION					

Cash and investments	$ 1,727	$ 1,518	$ 1,203	$ 1,134	$ 614
Total assets	3,153	2,878	1,957	1,731	1,189
Medical costs payable	1,099	866	527	448	400
Debt and other long-term obligations	361	399	83	71	80
Stockholders' equity	1,292	1,287	1,058	889	376
OPERATING DATA					
Medical loss ratio	84.3%	81.7%	81.6%	83.8%	86.3%
Administrative cost ratio	15.5%	13.9%	13.6%	13.2%	14.1%
Medical membership:					
Commercial	2,814,800	2,883,900	1,528,300	1,214,000	1,219,800
Medicare risk	364,500	310,400	287,400	270,800	266,300
CHAMPUS	1,103,000				
Medicare supplement	97,700	115,000	131,700	153,600	198,900
	4,380,000	3,309,300	1,947,400	1,638,400	1,685,000
Administrative services	471,000	495,100	93,500	63,700	30,600
Total	4,851,000	3,804,400	2,040,900	1,702,100	1,715,600
Specialty membership:					
Dental	844,800	797,000			
Group life	642,700	576,300			
Workers' compensation	132,700	234,200			
Other	264,000	252,500			
Total	1,884,200	1,860,000			

(a) Includes special charges of $215 million pretax ($140 million after tax or $.86 per share) related to the restructuring of the Washington, D.C., health plan, provision for expected future losses on insurance contracts, closing 13 service areas, discontinuing unprofitable products in three markets, a litigation settlement, and planned workforce reductions.
(b) Includes the operations of EMPHESYS Financial Group, Inc. since October 11, 1995, the date of acquisition.
(c) Includes nonrecurring income of $11 million pretax ($17 million after tax or $.10 per share) related to the favorable settlement of income tax disputes with the Internal Revenue Service partially offset by the write-down of a nonoperational asset.
(d) Includes $171 million pretax ($118 million after tax or $.75 per share) of restructuring and unusual charges.

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

Humana Inc.

The consolidated financial statements of Humana Inc. ("Humana" or the "Company") 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. Readers are cautioned that a number of factors, which are described herein and defined below, could adversely affect the Company's ability to obtain these results, including the effects of either federal or state health care reform, renewal of the Company's Medicare risk contracts with the federal government, the renewal of the Company's CHAMPUS contract with the federal government, and the effects of other general business conditions, including but

not limited to, government regulation, competition, premium rate changes, medical cost trends, changes in Commercial and Medicare risk membership, capital requirements, general economic conditions and the retention of key employees. Readers are also directed to the Company's Annual Report on Form 10-K for the year ended December 31, 1996, for additional discussion of risk factors.

INTRODUCTION

The Company offers managed health care products that integrate medical management with the delivery of health care services through a network of providers. This network of providers may share financial risk or have incentives to deliver quality medical services in a cost-effective manner. These products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracting providers. HMOs and PPOs control health care costs by various means, including pre-admission approval for hospital inpatient services and pre-authorization of outpatient surgical procedures. The Company also offers various specialty and administrative service products including dental, group life, workers' compensation, and pharmacy benefit management services.

The Company's HMO and PPO products are marketed primarily to employer and other groups ("Commercial") as well as Medicare and Medicaid-eligible individuals. The products marketed to Medicare-eligible individuals are either HMO products ("Medicare risk") or indemnity insurance policies that supplement Medicare benefits ("Medicare supplement"). The Medicare risk product provides managed care services that include all Medicare benefits and, in certain circumstances, additional managed care services.

On October 11, 1995, the Company acquired EMPHESYS Financial Group, Inc. ("EMPHESYS") for a total purchase price of approximately $650 million. The purchase was funded through available cash of $400 million and bank borrowings of $250 million. EMPHESYS is a leading provider of a broad range of managed care products to small businesses. EMPHESYS' medical loss and administrative cost ratios tend to be different from Humana's because of variances in the nature of each entity's products, customer base and the manner in which products and services are distributed to customers.

On July 1, 1996, the Company began providing managed health care services to approximately 1.1 million eligible beneficiaries under a potential five-year contract (a one-year contract renewable annually for up to four additional years) with the United States Department of Defense under the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"). Under the CHAMPUS contract, the Company provides managed care services to the beneficiaries of active military personnel and retired military personnel and their beneficiaries located in the southeastern United States. The Company has subcontracted with third parties to provide certain administration and specialty services under the contract. Three health benefit options are available to CHAMPUS beneficiaries. In addition to a traditional indemnity option, participants may enroll in an HMO point-of-service plan or take advantage of reduced co-payments by using a network of preferred providers.

On January 31, 1997, the Company completed the sale of its Washington, D.C., health plan to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. On January 16, 1997, the Company signed a definitive agreement to sell its Alabama operations to PrimeHealth of Alabama, Inc. The sale excludes the Company's small group business and the Company's Alabama CHAMPUS operations. These transactions will not have a material impact on the Company's financial position, results of operations, or cash flows.

SPECIAL CHARGES

During the second quarter of 1996, the Company recognized special charges of $200 million pretax ($130 million after tax or $.80 per share). The second

quarter special charges included provisions for expected future losses on insurance contracts ($105 million) as well as an estimate of the costs to be incurred in restructuring the Washington, D.C., health plan and closing markets or discontinuing product lines in 16 service areas. The special charges also included the write-off of miscellaneous assets, a litigation settlement, and other costs. During 1996, the beneficial effect of the second quarter charges approximated $30 million pretax ($20 million after tax or $.12 per share). The beneficial effect consisted primarily of charges against liabilities for expected future losses on insurance contracts.

The second quarter special charges are presented in the accompanying consolidated statement of income for the year ended December 31, 1996, as follows: the provision for expected future losses on insurance contracts ($105 million) has been included in medical costs; asset write-downs, restructuring costs, market closing and product discontinuance costs have been included in asset write-downs and other special charges ($81 million); and litigation and certain other costs have been included in selling, general and administrative expenses ($14 million).

During the fourth quarter of 1996, the Company recognized an additional special charge of $15 million pretax ($10 million after tax or $.06 per share). This charge included severance and facility costs related to planned workforce reductions, scheduled to be completed in 1997. The fourth quarter special charge has been included in the accompanying consolidated statement of income in asset write-downs and other special charges.

For additional information, see Note 3 of Notes to Consolidated Financial Statements.

COMPARISON OF RESULTS OF OPERATIONS
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Years Ended December 31, 1996 and 1995

In order to enhance comparability, the following discussion comparing the year ended December 31, 1996, to the year ended December 31, 1995, excludes the impact of the $215 million pretax ($140 million after tax or $.86 per share) asset write-downs and other special charges recorded in 1996 related to provisions for expected future losses on insurance contracts, the restructuring of the Washington, D.C., health plan, closing 13 service areas, discontinuing unprofitable products in three markets, a litigation settlement, and planned workforce reductions.

The Company's premium revenues increased 46 percent to $6.7 billion for the year ended December 31, 1996, from $4.6 billion for the year ended December 31, 1995. The premium revenue increase is primarily attributable to the acquisition of EMPHESYS in the fourth quarter of 1995 and the commencing of health care services under the CHAMPUS contract during the third quarter of 1996. EMPHESYS premium revenues totaled approximately $1.7 billion for the year ended December 31, 1996, compared to approximately $370 million for the period October 11 through December 31, 1995. CHAMPUS premium revenues were approximately $351 million for the period July 1 through December 31, 1996. During 1996, Commercial premium rates declined 0.6 percent and the Medicare risk premium rates increased 7.8 percent. The effect of premium rate changes increased 1996 premium revenues by approximately $127 million. For 1997, Commercial premium rates are expected to increase approximately 2 to 3 percent, while Medicare risk premium rates are expected to increase approximately 4 to 5 percent. The Company's expected 1997 Medicare risk premium rate increase differs from an approximate 6 percent statutory increase as a result of a 1996 change in the geographic mix of the Company's members.

Membership in the Company's fully insured Commercial products declined 69,100 or 2 percent during the year ended December 31, 1996, due to the closing or sale of certain markets and the pricing of products at rates which are intended to maintain adequate profitability. This decline compares to an increase (excluding the EMPHESYS acquisition) of 276,900 or 19 percent for the year ended December 31, 1995. Medicare risk membership increased 54,100 or 17 percent for the year

ended December 31, 1996, compared to an increase of 23,000 or 8 percent in 1995. Medicare supplement membership declined 17,300 during 1996, compared to a decline of 16,700 in 1995, while administrative services only ("ASO") membership declined 24,100 during 1996, compared to an increase (excluding the EMPHESYS acquisition) of 184,700 during 1995. Membership changes increased 1996 premium revenues by approximately $260 million. The membership changes which increased premium revenues included the Medicare risk membership growth described above and the beneficial effect on 1996 premium revenues of 1995 Commercial membership growth partially offset by the 1996 Commercial membership declines described above.

January 1997 fully insured Commercial membership declined 87,500 compared to a decline of 25,000 in January 1996. The January 1997 membership decline is the result of the Company's new pricing discipline as well as the closing or sale of certain markets. Management expects Commercial membership to be flat to slightly down for 1997 while Medicare risk membership is expected to increase approximately 20 percent.

Medical membership data at December 31, 1996 and 1995, follows:

In thousands	1996	1995
Beginning medical membership	3,804.4	2,040.9
Same-store sales	783.3	739.0
Acquisitions		1,344.3
Same-store cancellations	(839.7)	(319.8)
CHAMPUS	1,103.0	
Ending medical membership	4,851.0	3,804.4

The Company's medical loss ratio increased to 82.7 percent (excluding special charges) for the year ended December 31, 1996, from 81.7 percent for the year ended December 31, 1995. The increase in the medical loss ratio was due to increased medical costs during a Commercial pricing environment which saw premium rates decline 0.6 percent. Medical cost increases were most notable in hospital outpatient, physician, and pharmacy services in both the Commercial and Medicare risk products. Partially offsetting these cost increases was improvement in hospital inpatient utilization in both products. With the benefit of new pricing disciplines and medical management initiatives currently underway, modest improvement in the medical loss ratio is anticipated during 1997.

The Company's administrative cost ratio was 15.3 percent (excluding special charges) and 13.9 percent for the years ended December 31, 1996 and 1995, respectively. The increase in the administrative cost ratio was the result of higher administrative costs associated with both the EMPHESYS small-group and CHAMPUS businesses. Excluding the effect of the EMPHESYS acquisition and the addition of the CHAMPUS business, the Company's administrative cost ratio was 13.2 percent and 13.3 percent for the years ended December 31, 1996 and 1995, respectively. As a result of investment spending in such areas as customer service, information systems and Medicare risk product growth initiatives, the administrative cost ratio may increase modestly during 1997, most notably during the first half of the year.

Interest income totaled $101 million for the year ended December 31, 1996, compared to $87 million for the year ended December 31, 1995. The increase is primarily attributable to higher levels of cash, cash equivalents and marketable securities resulting from the addition of EMPHESYS. The tax equivalent yield on invested assets approximated 8 percent for the years ended December 31, 1996 and 1995. 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 decreased to 3.1 years at December 31, 1996, from 4.0 years at December 31, 1995.

Income before income taxes, excluding the $215 million special charges previously discussed, totaled $234 million for the year ended December 31, 1996, compared to $288 million for the year ended December 31, 1995. Net income, also excluding the special charges, was $152 million or $.93 per share for the year ended December 31, 1996, compared to $190 million or $1.17 per share for the year ended December 31, 1995.

Years Ended December 31, 1995 and 1994

In order to enhance comparability, the following discussion comparing the year ended December 31, 1995, to the year ended December 31, 1994, excludes the impact of the $11 million pretax ($17 million after tax or $.10 per share) nonrecurring income recorded in 1994 related to the favorable settlement of income tax disputes with the Internal Revenue Service (the "IRS") partially offset by the write-down of a nonoperational asset.

The Company's premium revenues increased 29 percent to $4.6 billion for the year ended December 31, 1995, from $3.6 billion for the year ended December 31, 1994. The increase in premium revenues was attributable to the acquisition of EMPHESYS, same-store membership gains, and the 1994 acquisitions of CareNetwork, Inc. and Group Health Association. The Company's 5 percent increase in Medicare risk premium rates was generally offset by a 2 percent reduction in Commercial premium rates.

Membership in the Company's Commercial products increased 1,355,600 or 89 percent during the year ended December 31, 1995, which included 1.1 million fully-insured members resulting from the acquisition of EMPHESYS. On a same-store basis, Commercial membership for the year ended December 31, 1995, increased 276,900 or 19 percent compared to 113,200 or 9 percent in 1994. Medicare risk membership increased 23,000 or 8 percent for the year ended December 31, 1995, compared to an increase of 16,600 or 6 percent in 1994. Medicare supplement membership declined 16,700 members during the year ended December 31, 1995. ASO membership at December 31, 1995, increased to 495,100 members, including 216,900 members of EMPHESYS, from 93,500 members at December 31, 1994.

Medical membership data at December 31, 1995 and 1994, follows:

In thousands	1995	1994
Beginning medical membership	2,040.9	1,702.1
Same-store sales	739.0	396.6
Acquisitions	1,344.3	224.1
Same-store cancellations	(319.8)	(281.9)
Ending medical membership	3,804.4	2,040.9

Excluding EMPHESYS, the Company's medical loss ratio increased to 82.0 percent for the year ended December 31, 1995, from 81.6 percent for the year ended December 31, 1994. The increase in the medical loss ratio was related primarily to an increase in hospital outpatient, physician, and pharmacy services in the Commercial product. In addition, the Company experienced greater than expected medical costs for membership in areas contiguous to existing markets, which was where a significant amount of 1995 membership growth occurred. Including EMPHESYS, the Company's 1995 medical loss ratio was 81.7 percent.

The Company's administrative cost ratio was 13.9 percent and 13.6 percent for

the years ended December 31, 1995 and 1994, respectively. The increase in the administrative cost ratio was the result of higher administrative costs associated with EMPHESYS' small-group business. Excluding the effect of the EMPHESYS acquisition, the Company's administrative cost ratio was 13.3 percent for the year ended December 31, 1995. The reduction from 1994 was the result of increased premium revenues benefitting the fixed portion of administrative costs.

Interest income totaled $87 million for the year ended December 31, 1995, compared to $62 million for the year ended December 31, 1994. The increase was primarily attributable to increased yields and higher levels of cash, cash equivalents and marketable securities resulting from the addition of EMPHESYS. The tax equivalent yield on invested assets approximated 8 percent and 6 percent for the years ended December 31, 1995 and 1994, respectively. The weighted average investment life increased to 4.0 years at December 31, 1995, from 2.3 years at December 31, 1994, primarily related to the addition of EMPHESYS' portfolio.

Income before income taxes, excluding the $11 million nonrecurring income previously discussed, totaled $288 million for the year ended December 31, 1995, compared to $246 million for the year ended December 31, 1994. Net income, also excluding the nonrecurring income, increased to $190 million or $1.17 per share from $159 million or $1.00 per share for the years ended December 31, 1995 and 1994, respectively.

LIQUIDITY
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Cash provided by the Company's operations totaled $341 million and $150 million for the years ended December 31, 1996 and 1995, respectively. The increase in operating cash flows was primarily attributable to the timing of payments for medical costs and other liabilities, due in large part to the commencing of operations under the CHAMPUS contract. Also impacting operating cash flows was a decrease in net income.

Cash provided by the Company's operations totaled $150 million and $298 million for the years ended December 31, 1995 and 1994, respectively. Operating cash flows for 1995 were below those of 1994 primarily as a result of a $71 million favorable settlement of tax disputes with the IRS received in 1994. The timing of cash receipts and disbursements related to premiums receivable, medical costs and other liabilities further reduced 1995 operating cash flows.

The Company maintains a revolving credit agreement (the "Credit Agreement") which provides a revolving line of credit of up to $600 million. Principal amounts outstanding under the Credit Agreement bear interest depending on the ratio of debt to debt plus net worth at rates ranging from LIBOR plus 16 basis points to LIBOR plus 40 basis points. The Credit Agreement, under which there were no outstanding borrowings at December 31, 1996, contains customary covenants and events of default and expires in September 2000.

On April 16, 1996, the Company implemented a commercial paper program and began issuing debt securities thereunder. At December 31, 1996, borrowings under the commercial paper program totaled approximately $222 million. The average interest rate for 1996 borrowings was 5.6 percent. Borrowings under the commercial paper program have been classified as long-term debt based on management's ability and intent to refinance borrowings on a long-term basis. The commercial paper program is backed by the Credit Agreement.

The Company's subsidiaries operate in states which 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.

Management believes that existing working capital, future operating cash flows, and funds available under the 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 strategic acquisition and expansion opportunities, as well as fund capital requirements.

CAPITAL RESOURCES

The Company's ongoing capital expenditures relate primarily to medical care facilities used by either employed or affiliated physicians, as well as administrative facilities and related information systems necessary for activities such as claims processing, billing and collections, medical utilization review, and customer service. Total capital expenditures, excluding acquisitions, were $72 million, $54 million, and $39 million for the years ended December 31, 1996, 1995 and 1994, respectively.

Excluding acquisitions, planned capital spending in 1997 will approximate $80 to $90 million for the expansion and improvement of medical care facilities, administrative facilities and related information systems.

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 and Medicare supplement products are generally approved by the respective state insurance commissioners, while increases in premiums for Medicare risk products are established and implemented by the Health Care Financing Administration. Medicare risk premiums approximated 29 percent, 34 percent and 39 percent of the Company's premium revenues for the years ended December 31, 1996, 1995 and 1994, respectively. The Company's 1997 average rate of statutory increase under the Medicare risk contracts is approximately 6 percent. However, the Company's expected 1997 Medicare risk premium rate increase differs from the 6 percent statutory increase as a result of a change in the geographic mix of the Company's members. Over the last five years, annual increases have ranged from as low as 3 percent in January 1994 to as high as 12 percent in January 1993, with an average of approximately 7 percent, including the January 1997 increase. The Company's Medicare risk contracts with the federal government are renewed for a one-year term each December 31 unless terminated 90 days prior thereto. Current legislative proposals are being considered which include modification of future reimbursement rates under the Medicare program and which encourage the use of managed health care for Medicare beneficiaries. 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. Additionally, the Company's CHAMPUS contract is a one year contract renewable annually for up to four additional years. 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.

OTHER INFORMATION

Resolution of various loss contingencies, including litigation pending against the Company in the ordinary course of business, is not expected to have a material adverse effect on the Company's financial position, results of operations, or cash flows.

CONSOLIDATED BALANCE SHEET

Humana Inc.

Dollars in millions, except per share amounts

December 31,	1996	1995
ASSETS		
Current assets:		
Cash and cash equivalents	$ 322	$ 182
Marketable securities	1,262	1,156
Premiums receivable, less allowance for doubtful accounts of $38 in 1996 and $36 in 1995	211	131
Deferred income taxes	94	52
Other	113	72
Total current assets	2,002	1,593
Property and equipment, net	371	382
Other assets:		
Long-term marketable securities	143	180
Cost in excess of net assets acquired	488	536
Deferred income taxes	17	25
Other	132	162
Total other assets	780	903
Total Assets	$3,153	$2,878
LIABILITIES AND COMMON STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical costs payable	$1,099	$ 866
Trade accounts payable and accrued expenses	369	291
Income taxes payable	32	35
Total current liabilities	1,500	1,192
Long-term debt	225	250
Professional liability and other obligations	136	149
Total liabilities	1,861	1,591
Contingencies		
Common stockholders' equity:		
Common stock, $.16 2/3 par; authorized 300,000,000 shares; issued and outstanding 162,681,123 shares - 1996 and 162,099,403 shares - 1995	27	27
Capital in excess of par value	822	815
Retained earnings	451	439
Net unrealized investment gains (losses)	(8)	6
Total common stockholders' equity	1,292	1,287
Total Liabilities and Common Stockholders' Equity	$3,153	$2,878

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

CONSOLIDATED STATEMENT OF INCOME

Humana Inc.

Dollars in millions, except per share results

Years Ended December 31,	1996	1995	1994
Revenues:			
Premiums	$6,677	$4,605	$3,576
Interest	101	87	62
Other income	10	10	16
Total revenues	6,788	4,702	3,654
Operating expenses:			
Medical costs	5,625	3,762	2,918
Selling, general and administrative	940	571	436
Depreciation and amortization	98	70	50
Asset write-downs and other special charges	96		18
Total operating expenses	6,759	4,403	3,422
Income from operations	29	299	232
Interest expense (recovery)	11	11	(25)
Income before income taxes	18	288	257
Provision for income taxes	6	98	81
Net income	$ 12	$ 190	$ 176
Earnings per common share	$.07	$ 1.17	$ 1.10

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

CONSOLIDATED STATEMENT OF COMMON STOCKHOLDERS' EQUITY

Humana Inc.

In millions

	Common Stock		Capital In Excess of	Retained	Net Unrealized Investment	Total Common Stockholders'
	Shares	Amount	Par Value	Earnings	Gains (Losses)	Equity
Balance, January 1, 1994	160	$27	$785	$ 73	$ 4	$ 889
Net income				176		176
Other	1		18		(25)	(7)
Balance, December 31, 1994	161	27	803	249	(21)	1,058
Net income				190		190
Other	1		12		27	39

Balance, December 31, 1995	162	27	815	439	6	1,287
Net income				12		12
Other	1		7		(14)	(7)
BALANCE, DECEMBER 31, 1996	163	$27	$822	$451	$ (8)	$1,292

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

CONSOLIDATED STATEMENT OF CASH FLOWS

Humana Inc.

Dollars in millions

Years Ended December 31,	1996	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net income	$ 12	$ 190	$ 176
Adjustments to reconcile net income to net cash provided by operating activities:			
Asset write-downs	70		18
Depreciation and amortization	98	70	50
Deferred income taxes	(25)	13	58
Changes in operating assets and liabilities:			
Premiums receivable	(81)	(27)	(8)
Other assets	(31)	(4)	8
Medical costs payable	215	(9)	36
Other liabilities	81	(83)	67
Unearned premium revenues			(110)
Other	2		3
Net cash provided by operating activities	341	150	298
CASH FLOWS FROM INVESTING ACTIVITIES:			
Acquisitions of health plan assets	(6)	(697)	(162)
Purchases of property and equipment	(72)	(54)	(39)
Dispositions of property and equipment	5	5	13
Purchases of marketable securities	(440)	(402)	(523)
Maturities and sales of marketable securities	356	731	337
Other	(17)	(33)	(28)
Net cash used in investing activities	(174)	(450)	(402)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Issuance of long-term debt		250	
Repayment of long-term debt	(250)	(51)	
Net commercial paper borrowings	222		
Other	1	11	4
Net cash (used in) provided by financing activities	(27)	210	4
Increase (decrease) in cash and cash equivalents	140	(90)	(100)
Cash and cash equivalents at beginning of period	182	272	372
Cash and cash equivalents at end of period	$322	$182	$272
Interest payments (refunds), net	$ 11	$ 12	$(20)
Income tax payments, net	39	94	21

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

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Humana Inc.

1. REPORTING ENTITY

Nature of Operations

Humana Inc. ("Humana" or the "Company") offers managed health care products that integrate medical management with the delivery of health care services through a network of providers. This network of providers may share financial risk or have incentives to deliver quality medical services in a cost-effective manner. These products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracting providers. HMOs and PPOs control health care costs by various means, including pre-admission approval for hospital inpatient services and pre-authorization of outpatient surgical procedures. The Company also offers various specialty and administrative service products including dental, group life, workers' compensation, and pharmacy benefit management services.

The Company's HMO and PPO products are marketed primarily to employer and other groups ("Commercial") as well as Medicare and Medicaid-eligible individuals. The products marketed to Medicare-eligible individuals are either HMO products ("Medicare risk") or indemnity insurance policies that supplement Medicare benefits ("Medicare supplement"). The Medicare risk product provides managed care services that include all Medicare benefits and, in certain circumstances, additional managed care services.

On July 1, 1996, the Company began providing managed health care services to approximately 1.1 million eligible beneficiaries under a potential five-year contract (a one-year contract renewable annually for up to four additional years) with the United States Department of Defense under the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"). Under the CHAMPUS contract, the Company provides managed care services to the beneficiaries of active military personnel and retired military personnel and their beneficiaries located in the southeastern United States. The Company has subcontracted with third parties to provide certain administration and specialty services under the contract. Three health benefit options are available to CHAMPUS beneficiaries. In addition to a traditional indemnity option, participants may enroll in an HMO point-of-service plan or take advantage of reduced co-payments by using a network of preferred providers.

Basis of Presentation

The preparation of the Company's consolidated financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect (a) the reported amounts of assets and liabilities, (b) disclosure of contingent assets and liabilities at the date of the financial statements and (c) reported amounts of revenues and expenditures during the reporting period. Actual results could differ from those estimates.

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.

Cash and Cash Equivalents

Cash and cash equivalents include cash, 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 maturities of the investments.

Marketable Securities

At December 31, 1996 and 1995, 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. Commercial mortgage loans are carried at cost. Marketable debt and equity securities available for current operations are classified as current assets. Marketable securities available for the Company's future acquisition, capital spending, professional liability, and long-term insurance product requirements are classified as long-term assets. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of common stockholders' equity until realized.

Property and Equipment

Property and equipment is carried at cost and comprises the following at December 31, 1996 and 1995:

Dollars in millions	1996	1995
Land	$ 33	$ 34
Buildings	278	282
Equipment	370	333
	681	649
Accumulated depreciation	(310)	(267)
	$ 371	$ 382

Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 25 years. Depreciation expense was $59 million, $50 million, and $39 million for the years ended December 31, 1996, 1995 and 1994, respectively.

Cost in Excess of Net Assets Acquired

Cost in excess of net assets acquired represents the unamortized excess of cost over the fair value of tangible and identifiable intangible assets acquired and is being amortized on a straight-line basis over varying periods not exceeding 40 years. The carrying values of all intangible assets are periodically reviewed by management and impairments are recognized when the expected undiscounted future operating cash flows derived from operations associated with such intangible assets are less than their carrying value. Accumulated amortization totaled $18 million and $8 million at December 31, 1996 and 1995, respectively.

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 periods are recorded as unearned premium revenues.

Medical costs include claim payments, capitation payments, physician salaries, and various other costs incurred to provide medical care to members, and estimates of future payments to hospitals and others for medical care provided prior to the balance sheet date. Capitation payments represent monthly prepaid fees paid to participating primary care physicians and other providers, who are responsible for providing medical care to members. The estimates of future medical claim 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. Management believes the Company's medical costs payable are adequate to cover claims incurred; however, such estimates are subject to changes in assumption, and therefore, the actual liability could

differ from amounts provided.

Earnings per Common Share

Earnings per common share are based upon the weighted average number of common shares outstanding. Shares used in computing earnings per common share were 162,531,524, 162,268,815, and 160,910,641 for the years ended December 31, 1996, 1995 and 1994, respectively.

3. SPECIAL CHARGES

During the second quarter of 1996, the Company recognized special charges of $200 million pretax ($130 million after tax or $.80 per share). The second quarter special charges included provisions for expected future losses on insurance contracts ($105 million) as well as an estimate of the costs to be incurred in restructuring the Washington, D.C., health plan and closing markets or discontinuing product lines in 16 market areas. The special charges also included the write-off of miscellaneous assets, a litigation settlement, and other costs. During 1996, the beneficial effect of the second quarter charges approximated $30 million pretax ($20 million after tax or $.12 per share). The beneficial effect consisted primarily of charges against liabilities for expected future losses on insurance contracts.

The special charges included $70 million of asset write-downs, related to long-lived assets, primarily associated with the Company's Washington, D.C., health plan. In accordance with Statement of Financial Accounting Standards No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to Be Disposed Of, " the Company conducted a review of the carrying value of its Washington, D.C., health plan's long-lived assets. This review was initiated because the health plan was experiencing significant operating losses. A forecast of expected undiscounted future cash flows was prepared to determine whether an impairment existed and fair values were used to measure the amount of the impairment. As a result of the review, the Washington, D.C., health plan's long-lived assets were written down to their estimated fair value.

The second quarter special charges have been included in the accompanying consolidated statement of income for the year ended December 31, 1996, as follows: the provision for expected future losses on insurance contracts ($105 million) has been included in medical costs; asset write-downs, restructuring costs, market closing and product discontinuance costs have been included in asset write-downs and other special charges ($81 million); and litigation and certain other costs have been included in selling, general and administrative expenses ($14 million).

During the fourth quarter of 1996, the Company recognized an additional special charge of $15 million pretax ($10 million after taxes or $.06 per share). This charge included severance and facility costs related to planned workforce reductions, scheduled to be completed in 1997. The fourth quarter special charge has been included in the accompanying consolidated statement of income in asset write-downs and other special charges.

The components and usage of the 1996 special charges follows:

Dollars in millions	Liability For Expected Future Losses On Insurance Contracts	Asset Write-downs & Workforce Reductions	Other	Total
Provision for special charges	$105	$ 96	$ 14	$215
1996 usage (cash)	(30)	(11)	(10)	(51)
1996 usage (non-cash)		(70)		(70)

Balances at December 31, 1996	$ 75	$ 15	$ 4	$ 94

On January 31, 1997, the Company completed the sale of its Washington, D.C., health plan. On January 16, 1997, the Company signed a definitive agreement to sell its Alabama operations. These transactions will further reduce the liability for expected future losses on insurance contracts by approximately $30 to $35 million. As a result, these transactions will not have a material impact on the Company's financial position, results of operations, or cash flows.

At December 31, 1996, there were additional liabilities totaling approximately $50 million included in the accompanying consolidated balance sheet, primarily related to contract disputes. This liability was originally recognized in August 1992. Management regularly evaluates the continued reasonableness of this liability, as well as the 1996 special charges, and to the extent adjustments are necessary, current earnings are charged or credited.

In June 1994, the Company recorded an $18 million pretax charge ($11 million after tax or $.07 per share) to reduce the net book value of a nonoperational asset to its estimated fair value.

4. MARKETABLE SECURITIES

Marketable securities classified as current assets at December 31, 1996 and 1995, included the following:

	1996				1995			
Dollars 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 securities	$ 67		$ (1)	$ 66	$ 77	$ 1	$(1)	$ 77
Tax exempt municipal bonds	613	$ 3	(6)	610	560	6	(3)	563
Corporate bonds	313	1	(3)	311	331	9		340
Redeemable preferred stock	117		(1)	116	13			13
Marketable equity securities	79	2	(3)	78	57	1	(4)	54
Collateralized mortgage obligations	54	1		55	90	2		92
Other	23	6	(3)	26	16	1		17
	$1,266	$ 13	$ (17)	$1,262	$1,144	$ 20	$(8)	$1,156

Marketable securities classified as long-term assets at December 31, 1996 and 1995, included the following:

	1996				1995			
Dollars in millions	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Tax exempt municipal bonds	$ 77		$ (1)	$ 76	$ 65	$ 1	$(3)	$ 63
Redeemable preferred stocks	9			9	50			50
Marketable equity securities	5			5	8			8
Other	52	$ 1		53	59			59
	$143	$ 1	$ (1)	$ 143	$ 182	$ 1	$(3)	$ 180

The contractual maturities of debt securities available for sale at December 31, 1996, 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.

Dollars in millions	Amortized Cost	Fair Value
Due within one year	$ 117	$ 113
Due after one year through five years	438	437
Due after five years through ten years	261	264
Due after ten years	134	138
Not due at a single maturity date	375	370
	$1,325	$1,322

Gross realized gains and losses for the years ended December 31, 1996 and 1995, were immaterial. For the purpose of determining gross realized gains and losses, the cost of securities sold is based upon specific identification.

5. INCOME TAXES

The provision for income taxes consisted of the following:

	Years Ended December 31,		
Dollars in millions	1996	1995	1994
Current provision:			
Federal	$ 30	$ 78	$ 72
State	1	7	11
	31	85	83
Deferred provision (benefit):			
Federal	(23)	11	(2)
State	(2)	2	
	(25)	13	(2)
	$ 6	$ 98	$ 81

The income tax provision was different from the amount computed using the federal statutory income tax rate due to the following:

	Years Ended December 31,		
Dollars in millions	1996	1995	1994
Income tax provision at federal statutory rate	$ 6	$ 101	$ 90
State income taxes, net of federal benefit	1	7	7
Tax exempt investment income	(12)	(12)	(12)
Amortization	12	6	1
Other items, net	(1)	(4)	(5)
	$ 6	$ 98	$ 81

Cumulative temporary differences which gave rise to deferred tax assets and liabilities at December 31, 1996 and 1995, were as follows:

Dollars in millions	Assets (Liabilities) 1996	1995
Marketable securities	$ 2	$ (9)
Long-term assets	(41)	(35)
Medical costs payable	28	27
Liabilities for special charges	46	25
Professional liability risks	34	28
Other	42	41
	$ 111	$ 77

Management believes that the deferred tax assets ultimately will be realized based primarily on the existence of sufficient taxable income within the allowable carryback periods.

During 1994, the Company received $71 million in income tax refunds for the settlement of disputes with the Internal Revenue Service (the "IRS") related to the timing of medical claims deductions and the deductibility of intangible amortization for tax years 1988 through 1991. The Company had previously prepaid tax and interest for these issues for the 1988 and 1989 tax years to stop the accrual of interest expense on the disputed amounts. As a result of the settlement, the Company recognized a $29 million reduction of interest expense ($18 million after tax or $.11 per share) and a $10 million reduction of tax expense ($.06 per share), both of which represented the cumulative effect from 1988 to 1994 of amounts previously provided. During 1995, the Company made a $30 million payment to the IRS to stop the accrual of interest expense and resolve disputed amounts related to tax periods September 1, 1991, through December 31, 1993.

At December 31, 1996, the Company had net operating loss carryforwards of approximately $28 million related to prior acquisitions. These loss carryforwards, if unused to offset future taxable income of the acquired subsidiaries, will expire in 2002 through 2008.

6. LONG-TERM DEBT

The Company maintains a revolving credit agreement (the "Credit Agreement") which provides a revolving line of credit of up to $600 million. Principal amounts outstanding under the Credit Agreement bear interest depending on the ratio of debt to debt plus net worth at rates ranging from LIBOR plus 16 basis points to LIBOR plus 40 basis points. The Credit Agreement, under which there were no outstanding borrowings at December 31, 1996, contains customary covenants and events of default and expires in September 2000.

On April 16, 1996, the Company implemented a commercial paper program and began issuing debt securities thereunder. At December 31, 1996, borrowings under the commercial paper program totaled approximately $222 million. The average interest rate for 1996 borrowings was 5.6 percent. Borrowings under the commercial paper program have been classified as long-term debt based on management's ability and intent to refinance borrowings on a long-term basis. The commercial paper program is backed by the Credit Agreement.

7. PROFESSIONAL LIABILITY AND OTHER OBLIGATIONS

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 $31 million, $27 million, and $22 million for the years ended December 31, 1996, 1995 and 1994, respectively. The Subsidiary reinsures levels of coverage for losses in excess

of its retained limits with unrelated insurance carriers. Allowance for professional liability risks and the equivalent amounts of marketable securities related to the funding thereof included in the accompanying consolidated balance sheet were $95 million and $78 million at December 31, 1996 and 1995, respectively.

In addition to the long-term portion of the allowance for professional liability risks, professional liability and other obligations in the accompanying consolidated balance sheet consists primarily of liabilities for disability and other long-term insurance products and the Company's employee retirement and benefit plans. These liabilities totaled $61 million and $87 million at December 31, 1996 and 1995, respectively.

8. COMMON STOCKHOLDERS' EQUITY

As a result of state regulatory requirements, the Company must maintain certain levels of equity in its licensed subsidiaries. The Company's ability to make use of the equity of its subsidiaries is subject to these equity restrictions as well as regulatory approval.

In 1987, the Company adopted and in 1996 amended 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 $.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.

The Company has plans under which options to purchase common stock have been granted to officers, directors and key employees. Options are granted at 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, 1996, there were 15,431,887 shares reserved for employee and director stock option plans. At December 31, 1996, there were 4,510,000 shares of common stock available for future grants. In January 1997, a total of 2,130,000 options were granted.

The Company's option plan activity for the years ended December 31, 1996, 1995 and 1994, is summarized below:

	Shares Under Option	Exercise Price Per Share			Weighted Average Exercise Price
Balance, January 1, 1994	8,519,735	$ 4.32	to	$14.44	$ 7.40
Granted	419,500	16.94	to	17.94	17.67
Exercised	(931,701)	4.32	to	11.01	8.66
Canceled or lapsed	(337,333)	6.56	to	17.94	8.84
Balance, December 31, 1994	7,670,201	4.32	to	17.94	7.75
Granted	3,107,000	18.94	to	23.06	22.84
Exercised	(751,096)	4.32	to	11.90	8.35
Canceled or lapsed	(190,250)	6.56	to	23.06	13.11
Balance, December 31, 1995	9,835,855	4.32	to	23.06	12.37
Granted	1,888,500	15.63	to	27.56	19.74
Exercised	(454,044)	4.32	to	23.06	8.11
Canceled or lapsed	(348,424)	6.56	to	27.56	15.87
Balance, December 31, 1996	10,921,887	$ 4.32	to	$26.94	$13.71

A summary of stock options outstanding and exercisable at December 31, 1996 follows:

Range of Exercise Prices	Stock Options Outstanding: Shares	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Stock Options Exercisable: Shares	Weighted Average Exercise Price
$ 4.32 to $ 6.56	4,027,261	5.4 years	$ 6.54	2,436,011	$ 6.52
6.70 to 9.64	1,608,645	5.3 years	7.96	938,895	7.93
10.54 to 14.44	202,950	4.2 years	11.19	195,450	11.21
15.63 to 22.44	2,110,500	9.2 years	18.60	161,716	18.78
22.63 to 26.94	2,972,531	7.5 years	23.23	1,054,897	23.06
$ 4.32 to $26.94	10,921,887	6.7 years	$13.71	4,786,969	$11.05

As of December 31, 1995 and 1994, there were 2,079,980 and 1,304,201 options exercisable, respectively. The weighted average exercise price of options exercisable during 1995 and 1994 was $7.51 and $8.41, respectively.

The Company has adopted the disclosure-only provisions of Statement of Financial Accounting Standards No. 123, "Accounting for Stock-Based Compensation," ("SFAS No. 123") but continues to apply Accounting Principles Board Opinion No. 25 and related interpretations in the accounting for its stock option plans. If the Company had adopted the expense recognition provisions of SFAS No. 123 for purposes of determining compensation expense related to stock options granted during the years ended December 31, 1996 and 1995, net income and earnings per common share would have been changed to the pro forma amounts shown below:

Dollars in millions, except per share results		Years Ended December 31, 1996	1995
Net income	As reported	$ 12	$ 190
	Pro forma	4	181
Earnings per common share	As reported	$ .07	$1.17
	Pro forma	.02	1.11

The fair value of each option granted during 1996 and 1995 was estimated on the date of grant using an option-pricing model (Black-Scholes) with the following weighted average assumptions: (i) no dividend yield, (ii) an expected volatility of 40.2 percent, (iii) a risk-free interest rate of 7.0 percent, and (iv) an expected option life of 5.8 years. Based upon the above assumptions, the weighted average fair value at grant date of options granted during 1996 and 1995 was $8.92 and $9.57, respectively. The effects of applying SFAS No. 123 in the pro forma disclosures are not likely to be representative of the effects on pro forma net income for future years because variables such as option grants, exercises, and stock price volatility included in the disclosures may not be indicative of future activity.

9. CONTINGENCIES

The Company's Medicare risk contracts with the federal government are renewed for a one-year term each December 31 unless terminated 90 days prior thereto. Current legislative proposals are being considered which include modification of future reimbursement rates under the Medicare program and which encourage the

use of managed health care for Medicare beneficiaries. 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. Additionally, the Company's CHAMPUS contract is a one year contract renewable annually for up to four additional years. 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.

During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe that any of these actions will have a material adverse effect on the Company's financial position, results of operations, or cash flows.

The Company remains contingently liable as guarantor for approximately $55 million of debt incurred prior to the March 1, 1993, separation of Humana's managed care and hospital businesses into two independent publicly-held companies.

10. ACQUISITIONS

On October 11, 1995, the Company acquired EMPHESYS Financial Group, Inc. ("EMPHESYS") for a total purchase price of approximately $650 million. The purchase was funded though available cash of $400 million and bank borrowings of $250 million under the Company's Credit Agreement. On November 30, 1995, the Company acquired certain primary care centers in South Florida and Tampa previously owned by Coastal Physician Group, Inc. for approximately $50 million. During the year ended December 31, 1994, the Company acquired two health plans for approximately $181 million.

The above acquisitions, and certain other minor acquisitions, were accounted for under the purchase method. In connection with these acquisitions, the Company allocated the acquisition costs to 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 sheet, include subscriber and provider contracts, and at December 31, 1996 and 1995, totaled $88 million and $124 million, respectively. Any remaining value not assigned to tangible or identifiable intangible assets was then allocated to cost in excess of net assets acquired. Cost in excess of net tangible and identifiable intangible assets acquired, recorded in connection with the acquisitions, was $387 million in 1995. Subscriber and provider contracts are amortized over their estimated useful lives (7 to 14 years) while cost in excess of net assets acquired is amortized over periods not exceeding 40 years.

The results of operations for the previously mentioned acquisitions have been included in the accompanying consolidated statement of income since the date of acquisition. The following unaudited pro forma consolidated results of operations give effect to those acquisitions as if they had occurred on January 1, 1994:

	Years Ended December 31,	
Dollars in millions, except per share results	1995	1994
Revenues	$5,968	$5,243
Net income	200	215
Earnings per common share	1.23	1.33

The unaudited pro forma information may not necessarily reflect future results of operations or what the results of operations would have been had the acquisitions actually been consummated on January 1, 1994.

On December 30, 1996, the Company entered into a stock purchase agreement to acquire Health Direct, Inc. ("Health Direct") from Advocate Health Care ("Advocate") for $23 million. Health Direct provides managed health care services to approximately 50,000 members (including 24,000 employees of Advocate) in the metropolitan Chicago, Illinois area.

REPORT OF INDEPENDENT ACCOUNTANTS

To the Board of Directors
Humana Inc.

We have audited the accompanying consolidated balance sheet of Humana Inc. as of December 31, 1996 and 1995, and the related consolidated statements of income, common stockholders' equity and cash flows for each of the three years in the period ended December 31, 1996. 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 in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Humana Inc. as of December 31, 1996 and 1995, and the consolidated results of operations and cash flows for each of the three years in the period ended December 31, 1996, in conformity with generally accepted accounting principles.

COOPERS & LYBRAND L.L.P.
Louisville, Kentucky
February 11, 1997

QUARTERLY FINANCIAL INFORMATION (UNAUDITED)

Humana Inc.

A summary of the Company's quarterly results of operations follows:

Dollars in millions, except per share results	1996			
	First	Second (a)	Third	Fourth (b)
Revenues	$1,588	$1,605	$1,784	$1,811
Income (loss) before income taxes	81	(146)	48	35
Net income (loss)	53	(95)	32	22
Earnings (loss) per common share	.32	(.58)	.20	.13

Dollars in millions, except per share results	1995			
	First	Second	Third	Fourth (c)
Revenues	$1,048	$1,070	$1,094	$1,490
Income before income taxes	80	68	65	75
Net income	53	45	43	49
Earnings per common share	.32	.28	.27	.30

(a) Includes special charges of $200 million pretax ($130 million after tax or $.80 per share) related to the restructuring of the Washington, D.C., health plan, provision for expected future losses on insurance contracts, closing 13 service areas, discontinuing unprofitable products in three markets, and a litigation settlement.

(b) Includes a special charge of $15 million pretax ($10 million after tax or $.06 per share) related to planned workforce reductions.

(c) Includes the results of EMPHESYS Financial Group, Inc. since October 11, 1995, the date of acquisition.

W. ANN REYNOLDS, PH.D.
Chairwoman

MICHAEL E. GELLERT

JOHN R. HALL

DAVID A. JONES, JR.

NOMINATING COMMITTEE

JOHN R. HALL
Chairman

K. FRANK AUSTEN, M.D.

DAVID A. JONES, JR.

W. ANN REYNOLDS, PH.D.

SENIOR MANAGEMENT

DAVID A. JONES
Chairman of the Board and Chief Executive Officer

GREGORY H. WOLF
President and Chief Operating Officer

DAVID R. ASTAR
Vice President-Customer Service and Quality

KAREN A. COUGHLIN
Division II-President

KENNETH J. FASOLA
Vice President and National Sales Manager

ARTHUR P. HIPWELL
Senior Vice President and General Counsel

GAIL H. KNOPF
Vice President-Information Systems

MICHAEL B. MCCALLISTER
Division I-President

JAMES E. MURRAY
Chief Financial Officer

DAVID R. NELSON
Vice President-Risk Management and Chief Actuary

BRUCE D. PERKINS
Senior Vice President-Provider Affairs and Reengineering

JERRY D. REEVES, M.D.
Senior Vice President and Chief Medical Officer

GREGORY K. ROTHERHAM
Vice President-Marketing

KIRK E. ROTHROCK
Vice President-Specialty Products and Business Development

GEORGE W. VIETH, JR.
Vice President-Development and Planning

TOD J. ZACHARIAS
Vice President
Employers Health Insurance Company

OFFICERS

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Vice President - Tax

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Vice President

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Vice President and Treasurer

ROBERT A. HORRAR
Vice President-Human Resources

JOAN O. KROGER
Secretary

THOMAS J. LISTON
Vice President-Finance

HEIDI S. MARGULIS
Vice President-Government Affairs

SHERI E. MITCHELL
Vice President - Quality and Service Excellence

WALTER E. NEELY
Vice President and Associate General Counsel

R. EUGENE SHIELDS
Military Health Services Division-President

DAVID W. WILLE
Vice President

ADDITIONAL INFORMATION

TRANSFER AGENT
Bank of Louisville
Security Transfer Department

Post Office Box 1497
Louisville, Kentucky 40201
800-925-0810

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

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.

1996	HIGH	LOW
First Quarter	28-3/4	24
Second Quarter	26-1/2	17-5/8
Third Quarter	21-1/4	15-5/8
Fourth Quarter	21-1/4	17-3/4

1995	HIGH	LOW
First Quarter	26-1/2	21-7/8
Second Quarter	27-1/8	17-3/8
Third Quarter	20-3/8	17-1/2
Fourth Quarter	28	18-5/8

CORPORATE HEADQUARTERS
Humana Inc.
The Humana Building
500 West Main Street
Louisville, Kentucky 40202
(502) 580-1000
(800) 486-2620

ANNUAL MEETING
The Company's Annual Meeting of Stockholders will be held on Thursday, May 8, 1997, at 10:00 a.m. in the Auditorium on the 25th floor of the Humana Building.

HUMANA INC. EXHIBIT 21
SUBSIDIARY LIST

ALABAMA
- -------

1. Humana Health Plan of Alabama, Inc.

CALIFORNIA
- ----------

1. Centerstone Insurance and Financial Services
2. HMO California

DELAWARE
- --------

1. EMPHESYS Financial Group, Inc.
2. Health Value Management, Inc.
3. HUMNOV, Inc.
4. Humana Compensation Management Source, Inc.
5. Humana HealthChicago, Inc. - Doing Business As:
   a. HC Services
   b. Goldcare 65
6. Humana Inc. - Doing Business As:
   a. H.A.C. Inc.
7. Humana Military Healthcare Services, Inc. - Doing Business As:
   a. Humana Military Health Services, Inc.
8. Humrealty, Inc.

FLORIDA
- -------

1. Delray Beach Health Management Associates, Inc.
2. Health Inclusive Plan of Florida, Inc.
3. Humana Health Care Plans - Davie, Inc.
4. Humana Health Care Plans - Palm Springs, Inc.
5. Humana Health Care Plans - Rolling Hills, Inc.
6. Humana Health Care Plans - South Pembroke Pines, Inc.
7. Humana Health Care Plans - West Palm Beach, Inc.
8. Humana Internal Medicine Associates, Inc. - Doing Business As:
   a. Humana Health Care Plans-Hialeah
   b. Humana Health Care Plans-South Miami
   c. Humana Health Care Plans-Miami
   d. Humana Health Care Plans-Miami Beach
   e. Humana Health Care Plans-Royal Oaks
   f. Humana Health Care Plans-Miami Springs
   g. Humana Health Care Plans-Midway
9. Humana Internal Medicine Associates of the Palm Beaches, Inc. - Doing Business As:
   a. Humana Health Care Plans-Lake Worth
   b. Humana Health Care Plans-Flagler
   c. Humana Health Care Plans-Riverbridge
   d. Humana Health Care Plans-Palm Beach

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FLORIDA Cont.
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10. Humana Health Insurance Company of Florida, Inc.
11. Humana Medical Plan, Inc. - Doing Business As:
    a. Advanced Orthopaedics
    b. Apopka Health Care
    c. Atlantic Family Practice
    d. Casselberry Health Care
    e. Coastal Pediatrics
    f. Community Medical Associates
    g. Daytona Gastroenterology
    h. Deland Family Health Care
    i. Edgewood Health Care

     j. Flagler Family Practice
     k. Internal Medicine of Daytona Beach
     l. Ormond Primary Care
     m. Palm Coast Family Health Care
     n. Personal Care Physicians of Apopka
     o. Personal Care Physicians of Casselberry
     p. Personal Care Physicians of Orlando
     q. Personal Care Physicians of St. Mary
     r. Professional Dermatology
     s. Rosemont Health Care
     t. Sugar Mill Medical Associates
     u. Suncoast Medical Associates
     v. Urological Associates-Ormond Beach
12. Lakeside Medical Center Management, Inc. - Doing Business As:
     a. University Medical Center

GEORGIA
- -------

1.   Humana Employers Health Plan of Georgia, Inc.
2.   Humana Health Plan of Georgia, Inc.

ILLINOIS
- --------

1.   Health Direct, Inc. - Doing Business As:
     a. Behavioral Health Direct
2.   Health Direct Insurance, Inc.
3.   Humana HealthChicago Insurance Company
4.   The Dental Concern, Ltd. - Doing Business As:
     a. TDC

KENTUCKY
- --------

1.   HMPK, INC.
2.   HPLAN, INC.
3.   Humana Broadway Corp.
4.   Humana Health Plan, Inc. - Doing Business As:
     a. Bluegrass Family Practice
     b. Central Kentucky Family Practice
     c. Franklin Medical Center
     d. Humana MedFirst
     e. Humana Health Care Plans of Indiana
     f. Madison Family and Industrial Medicine

(KY - Cont. Next Page)

KENTUCKY Cont.
- --------------

5.   Humco, Inc. - Doing Business As:
     a. Eagle Creek Medical Plaza
     b. Humana Hospital - Lexington
6.   The Dental Concern, Inc.
7.   The Dental Concern Insurance Company

LOUISIANA
- ---------

1.   Humana Health Plan of Louisiana, Inc.

MISSOURI
- --------

1.   Humana Kansas City, Inc. - Doing Business As:
     a. Humana Prime Health Plan
2.   Humana Insurance Company - Doing Business As:
     a. Dental Care Affiliates
     b. Managed Prescription Services
     c. Managed Prescription Services
     d. Managed Prescription Services, Inc.
3.   Humana/Med-Pay, Inc.

NEVADA
- ------

1. Humana Health Insurance of Nevada, Inc.

OHIO
- ----

1. Humana Health Plan of Ohio, Inc.

TEXAS
- -----

1. Humana HMO Texas, Inc.
2. Humana Health Plan of Texas, Inc. - Doing Business As:
   a. Humana Health Plan of Corpus Christi
   b. Humana Health Plan of Dallas
   c. Humana Health Plan of Houston
   d. Humana Health Plan of San Antonio
   e. Humana Regional Service Center
   f. Leon Valley Health Center
   g. MedCentre Plaza Health Center
   h. Nacogdoches Family Medical Center
   i. Perrin Oaks Health Center
   j. Val Verde Health Center
   k. West Lakes Health Center
   l. Wurzbach Family Medical Center

UTAH
- ----

1. Humana Health Plan of Utah, Inc.

VERMONT
- -------

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

VIRGINIA
- --------

1. Humana Group Health Plan, Inc.

WASHINGTON
- ----------

1. Humana Health Plan of Washington, 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. The Barrington Group, LTD
8. Wisconsin Employers Group, Inc.

Exhibit 23

CONSENT OF INDEPENDENT ACCOUNTANTS

We consent to the incorporation by reference in the registration statements of Humana Inc. on Form S-8 (Registration No. 2-39061, No. 2-79239, No. 2-96154, No. 33-33072, No. 33-49305, No. 33-52593 and No. 33-54455), of our report dated February 11, 1997, on our audits of the consolidated financial statements of Humana Inc. as of December 31, 1996 and 1995, and for each of the three years in the period ended December 31, 1996, which report is included in this Annual Report on Form 10-K.

COOPERS & LYBRAND L.L.P.
Louisville, Kentucky
February 11, 1997

<ARTICLE> 5
<LEGEND> This schedule contains summary financial information extracted from Humana Inc.'s Form 10-K for the twelve months ended December 31, 1996, and is qualified in its entirety by reference to such financial statement.
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