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

Form 10-K

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

For the fiscal year ended December 31, 1998

OR

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

For the transition period from to

Commission File Number 1-5975

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

Delaware	61-0647538
(State of incorporation)	(I.R.S. Employer Identification Number)

500 West Main Street

Louisville, Kentucky	40202
(Address of principal executive offices)	(Zip Code)

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

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

Title of each class	Name of each exchange on which registered
Common Stock, $.16 2/3 par value	New York Stock Exchange

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

None

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by 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 [_]

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]

The aggregate market value of voting stock held by non-affiliates of the Registrant as of March 1, 1999 was $2,817,113,416 calculated using the average price on such date of $17.75. The number of shares outstanding of the Registrant's Common Stock as of March 1, 1999 was 167,575,889.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of Part II and Part IV incorporate herein by reference the Registrant's 1998 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 6, 1999.

The Exhibit Index begins on page 20.

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PART I

ITEM 1. BUSINESS

General

Humana Inc. is a Delaware corporation organized in 1961. Its principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202 and its telephone number at that address is (502) 580-1000. As used herein, the terms "the Company" or "Humana" include Humana Inc. and its subsidiaries. This Annual Report on Form 10-K contains both historical and forward-looking information. The forward-looking statements may be significantly impacted by risks and uncertainties and are made pursuant to the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. There can be no assurance that anticipated future results will be achieved because actual results may differ materially from those projected in the forward-looking statements. Readers are cautioned that a number of factors, which are described herein, could adversely affect the Company's ability to obtain these results. These include the effects of either federal or state health care reform or other legislation, changes in the Medicare reimbursement system, renewal of the Company's Medicare contracts with the federal government, renewal of the Company's contract with the federal government to administer the TRICARE program and renewal of the Company's Medicaid contracts with various state governments. Such factors also include the effects of other general business conditions, including but not limited to, the Company's ability to integrate its acquisitions, the Company's ability to appropriately address the "Year 2000" computer system issue, government regulation, competition, premium rate and yield changes, retrospective premium adjustments relating to federal government contracts, medical and pharmacy cost trends, changes in Commercial and Medicare HMO membership, operating subsidiary capital requirements, the ability of health care providers (including physician practice management companies) to comply with current contract terms, the effect of provider contract rate negotiations, 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 been a health services company that facilitates the delivery of health care services through networks of providers to its approximately 6.2 million medical members. The Company's products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracted providers. HMOs and PPOs control health care costs by various means, including pre-admission approval for hospital inpatient services, pre-authorization of outpatient surgical procedures and risk-sharing arrangements with providers. These providers may share medical cost risk or have other incentives to deliver quality medical services in a cost-effective manner. During 1998, the Company began an initiative to increase the amount of medical cost risk assumed by certain of its provider partners related primarily to its HMO products. As a result, at December 31, 1998, approximately 50 percent and 70 percent of its Commercial and Medicare HMO membership, respectively, were under various forms of risk-sharing arrangements. The Company also offers various specialty products to employers, including dental, group life and workers' compensation, and administrative services ("ASO") to those who self-insure their employee health plans.

The Company markets and distributes its products to three distinct customer groups and, therefore, reports operations in three business segments. Results of each segment are measured based on premium revenues and underwriting margin (premium revenues less medical expenses). The Company does not allocate assets or administrative costs to the segments and, therefore, does not measure results based on segment assets or pretax profits. Members from all three segments generally utilize the same medical provider networks, enabling the Company to obtain more favorable contract terms with providers. As a result, the profitability of each segment is somewhat interdependent.

In the Commercial segment, the Company markets and distributes its fully-insured HMO, PPO, specialty and ASO products to large group employers (over 100 employees) and small group employers. Premium revenue pricing to large group employers has historically been more competitive than that to small group

employers, resulting in less favorable underwriting margins for large groups. At December 31, 1998, the Company had a total of 3,261,500 fully-insured Commercial members and provided claims processing, utilization review and other administrative services to 646,200 ASO members.

In the Public Sector segment, the Company markets and distributes its Medicare and Medicaid products to individuals eligible for these government-sponsored programs. The products marketed to Medicare-eligible individuals are either HMO products ("Medicare HMO") or indemnity insurance policies that supplement Medicare benefits ("Medicare supplement"). At December 31, 1998, the Company had 502,000 Medicare HMO members and 56,600 Medicare supplement members. The Company facilitates the delivery of health care services to Medicaid-eligible individuals under contracts generally renewable annually with various states except for a two-year contract with the Commonwealth of Puerto Rico. The Puerto Rico contract, previously scheduled to expire on March 31, 1999, has been extended one month to April 30, 1999. The Company does not expect to be able to renew the contract in Puerto Rico under favorable terms and, therefore, has announced its intention to close this market when the contract expires. At December 31, 1998, the Company had 643,800 Medicaid members, approximately 442,000 of which were in Puerto Rico.

The Company's third segment is TRICARE. In this segment, the Company facilitates the delivery of health care services to the dependents of active military personnel and retired military personnel and their dependents located in the Southeastern United States. The Company is in the third year of its contract with the United States Department of Defense, which is renewable annually for up to two additional years. As encouraged by government regulation, TRICARE is managed by a separate management team and is more autonomous than the Company's Commercial and Public Sector segments, which generally share sales, marketing, customer service, medical management and claims processing functions of the Company. Three health benefit options are available to TRICARE beneficiaries. In addition to a traditional indemnity option, participants may enroll in an HMO-like plan with a point-of-service option or take advantage of reduced co-payments by using a network of preferred providers. The Company has subcontracted with third parties to provide certain administration and specialty services under the contract. At December 31, 1998, the Company had 1,085,700 TRICARE members.

On February 28, 1997, the Company acquired Health Direct, Inc. ("Health Direct") from Advocate Health Care for $23 million in cash. This transaction added approximately 50,000 medical members to the Company's Chicago, Illinois, membership.

On September 8, 1997, the Company acquired Physician Corporation of America ("PCA") for total consideration of $411 million in cash, consisting primarily of $7 per share for PCA's outstanding common stock and the assumption of $121 million in debt. The purchase was funded with borrowings under the Company's commercial paper program. PCA served approximately 1.1 million medical members and provided comprehensive health services through its HMOs in Florida, Texas and Puerto Rico. In addition, PCA provided workers' compensation third-party administrative management services. Prior to November 1996, PCA also was a direct writer of workers' compensation insurance in Florida.

On October 17, 1997, the Company acquired ChoiceCare Corporation ("ChoiceCare") for approximately $250 million in cash. The purchase was funded with borrowings under the Company's commercial paper program. ChoiceCare

provided health services products to approximately 250,000 medical members in the Greater Cincinnati, Ohio, area.

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. Effective April 1, 1997, the Company also completed the sale of its Alabama operations, exclusive of its small group business and Alabama TRICARE operations, to PrimeHealth of Alabama, Inc. On October 31, 1997, the Company also sold The Lexington Hospital in Lexington, Kentucky, to Jewish Hospital Healthcare Services, Inc. These sale transactions did not have a material impact on the Company's financial position, results of operations or cash flows.

Commercial Products

HMO

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

At December 31, 1998, the Company owned and operated 14 actively licensed HMOs, which contracted with approximately 78,300 physicians (including approximately 22,200 primary care physicians) and approximately 1,060 hospitals. In addition, the Company had approximately 8,100 contracts with other providers to provide services to HMO members.

An HMO member, typically through the member's employer, pays a monthly fee which generally covers, with minimal co-payments, health care services received from or approved by the member's primary care physician. For the year ended December 31, 1998, Commercial HMO premium revenues totaled approximately $2.3 billion or 24 percent of the Company's total premium revenues. Approximately $182 million of the Company's Commercial HMO premium revenues for the year ended December 31, 1998 were derived from contracts with the United States Office of Personnel Management ("OPM"), under which the Company facilitates the delivery of health care services to approximately 117,000 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.

PPO

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

At December 31, 1998, approximately 85,300 physicians and approximately 1,020 hospitals contracted directly with the Company to provide services to PPO members. The Company also had approximately 6,200 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 28 leased provider networks throughout the country.

For the year ended December 31, 1998, Commercial PPO premium revenues totaled approximately $2.7 billion or 28 percent of the Company's total premium revenues.

The Company expects that 1999 Commercial HMO and PPO premium rates will increase approximately 5 to 7 percent from 1998 levels. Over the last four years, changes in the Company's Commercial HMO and PPO premium rates have ranged between an approximate 2 percent decrease for the year ended December 31, 1995, to an approximate 4 percent increase for the year ended December 31, 1998, with an average increase of approximately 1 percent.

Medicare Products

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

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

Humana contracts with the federal government's Health Care Financing Administration ("HCFA") to facilitate the delivery of medical benefits in exchange for a fixed monthly payment per member to Medicare-eligible individuals residing in the geographic areas in which its HMOs operate. Individuals who elect to participate in these Medicare programs are relieved of the obligation to pay some or all of the deductible or coinsurance amounts but are generally required to use exclusively the services provided by the HMO and are required to pay a Part B premium to the Medicare program. In 1998, the enrollee paid the HMO a premium only in cases where the HMO facilitates the delivery of additional benefits and where competitive market conditions permit. At December 31, 1998, approximately 73,000 members in 16 markets were paying premiums which totaled approximately $22 million in 1998.

Medicare HMO

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

As of January 1, 1999, the Company facilitates the delivery of Medicare HMO services under 10 contracts with HCFA in 11 states. Management believes that additional Medicare HMO growth opportunities exist because only approximately 15 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 markets which meet the Company's long-term growth strategies.

At December 31, 1998, HCFA contracts covered approximately 502,000 Medicare HMO members for which the Company received premium revenues of approximately $2.9 billion or 30 percent of the Company's total premium revenues for 1998. At December 31, 1998, one such HCFA contract covered approximately 264,000 members in Florida and accounted for premium revenues of approximately $1.5 billion, which represented 52 percent of the Company's HCFA premium revenues or 16 percent of the Company's total premium revenues for 1998. 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.

As more fully discussed in the "Health Care Reform-National" section, the Balanced Budget Act of 1997 ("BBA") included provisions that altered the

methodology for payment effective January 1, 1998 in the Medicare program. The Company's 1999 average rate of statutory increase under the HCFA contracts is approximately 2 percent. Over the last five years, annual increases have ranged from as low as the January 1998 and 1999 increases of 2 percent to as high as 10 percent in January 1996, with an average of approximately 5 percent, including the January 1999 increase. Cost saving initiatives and continuation of risk-sharing strategies are necessary to mitigate the effect of lower Medicare reimbursement rates.

The loss of the Company's HCFA contracts or significant changes in the Medicare HMO program as a result of legislative action, including reductions in payments or increases in benefits without corresponding increases in payments, would have a material adverse effect on the 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, co-payments 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, 1998, the Company facilitated the delivery of Medicare supplement benefits for approximately 56,600 members. For the year ended December 31, 1998, Medicare supplement premium revenues totaled approximately $68 million or 1 percent of the Company's total premium revenues.

Medicaid Products

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

The Company also maintains a two-year contract with the Commonwealth of Puerto Rico to facilitate the delivery of health care services to Medicaid-eligible individuals. The Puerto Rico contract, previously scheduled to expire March 31, 1999, has been extended one month to April 30, 1999. The Company does not expect to be able to renew the contract with the Commonwealth of Puerto Rico under favorable terms and, therefore, has announced its intention to close this market when the contract expires. For the year ended December 31, 1998, premium revenues from the Company's Medicaid products totaled approximately $554 million or 6 percent of the Company's total premium revenues. It is anticipated that Medicaid premium revenues will approximate 3 percent of the Company's total 1999 premium revenues. At December 31, 1998, the Company had approximately 201,800 and 442,000 Medicaid members in four states and the Commonwealth of Puerto Rico, respectively.

TRICARE

In 1993, the Company established Humana Military Healthcare Services, Inc. (a wholly-owned subsidiary of the Company), to enter into contracts to facilitate the delivery of managed care services to the dependents of active military personnel and retired military personnel and their dependents. In

November 1995, the United States Department of Defense awarded the Company its first TRICARE contract covering approximately 1.1 million eligible beneficiaries in Florida, Georgia, South Carolina, Mississippi, Alabama, Tennessee and Eastern Louisiana.

On July 1, 1996, the Company began facilitating the delivery of managed health care services to these approximate 1.1 million eligible beneficiaries under a potential five-year contract (a one-year contract renewable annually for up to two additional years). The government exercised its option to extend the contract for one additional year effective July 1, 1998. The Company has subcontracted with third parties to provide certain administration and specialty services under the contract. Three health benefit options are available to TRICARE beneficiaries. In addition to a traditional indemnity option, participants may enroll in an HMO-like plan with a point-of-service option or take advantage of reduced co-payments by using a network of preferred providers. TRICARE premium revenues were approximately $800 million or 8 percent of the Company's total premium revenues for the year ended December 31, 1998.

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

Other Related Products

The Company offers various specialty products to employers, including dental, group life and workers' compensation, and administrative services ("ASO") to those who self-insure their employee health plans. Specialty and administrative services membership at December 31, 1998 totaled approximately 2.6 million members and 646,200 members, respectively. Specialty product premium revenues were approximately $239 million or 3 percent of the Company's total premiums for the year ended December 31, 1998.

The following table lists the Company's premium revenue for the year ended December 31, 1998, by product and segment:

PREMIUM REVENUE
(In millions)

	Commercial	Public Sector	TRICARE	Total	Percent of Total
HMO	$2,330	--	--	$2,330	24.3%
PPO	2,688	--	--	2,688	28.0
Medicare HMO	--	$2,918	--	2,918	30.4
Medicare supplement	--	68	--	68	0.7
Medicaid	--	554	--	554	5.8
TRICARE	--	--	$800	800	8.3
Specialty	239	--	--	239	2.5
Total	$5,257	$3,540	$800	$9,597	100.0%
Percent of total	54.8%	36.9%	8.3%	100.0%	

Provider Arrangements

In certain situations the Company's HMOs contract with individual or groups of primary care physicians, generally for an actuarially determined, fixed, per-member-per-month fee 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 specialty physicians and other providers for the provision of all covered managed health care services to HMO members. The capitation payment does not vary with the nature or extent of services to the member and is generally designed to shift a portion of the HMOs' financial risk to the primary care physician. The degree to which the Company uses capitation

arrangements varies by provider.

The Company also contracts with medical specialists and other providers to which a primary care physician may refer a member. The contracts with specialists may be capitation arrangements or may provide for payment on a fee-for-service basis based on negotiated fees. Typically, payments by the Company to these

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

The focal point for cost control in the Company's HMOs is the primary care physician who, under contract, provides services and controls utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. 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, 1998, approximately 35 percent of the Company's total medical costs were for services provided to its members in hospitals or related facilities.

The Company has certain other risk-sharing contracts whereby providers also assume a specified level of risk for covered managed care services to its members. Under these risk-sharing arrangements called global capitation contracts, providers are paid a monthly capitation payment per covered member to assume risk for all managed care services including professional and institutional (i.e. hospital) costs. The capitation payments are based on a specified percentage of premiums (typically 78 to 88 percent).

During 1998, the Company began an initiative to increase the amount of HMO product medical cost risk assumed by certain of its provider partners. As a result, at December 31, 1998, approximately 50 percent and 70 percent of its Commercial and Medicare HMO membership, respectively, were under some form of risk sharing arrangements. Under all of its risk-sharing arrangements, the Company remains financially responsible for the provision of covered medical services if its contractors fail to perform their obligations under the contract.

Prior to 1998, the Company employed physicians providing services to members in markets where it operated health centers or staff model HMOs. As part of its ongoing strategy of identifying and assessing non-strategic assets, the Company reached separate agreements during 1998 whereby certain provider groups or systems assumed the operations of most of Humana's health centers. The agreements relate to approximately 440 physicians formerly employed by Humana and approximately 361,000 members of the Company's health centers.

The Company continually contracts and seeks to renew contracts with providers at rates designed to ensure adequate profitability. To the extent the Company is unable to obtain such rates, its financial position, results of operations and cash flows could be adversely impacted. Currently, the Company is in negotiations with a major provider and is unable to predict the impact of these negotiations on future contract rates.

During 1998, the Company continued its Hospital Inpatient Management System ("HIMS") which allows specially trained physicians to manage the entire range of medical care while an HMO member is in the hospital, and coordinate the member's discharge and care after discharge. The Company also continues to implement several disease management programs in various markets. Under these arrangements, the Company provides financial incentives for contractors to

provide the full range of care to members with respect to a particular high risk or chronic disease in a quality, cost-effective manner. These programs include congestive heart failure, prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes and breast cancer screening.

Quality Assessment 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 for HMO participation, the Company performs or contracts for 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 board and 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 an initial evaluation of applicants for credentialing and reviews all providers on a periodic basis to monitor the appropriateness of members' care.

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"). In the states of Kansas and Florida, accreditation or external review by an accrediting organization is mandatory and generally required for licensure.

NCQA performs site reviews of standards for quality improvement, credentialing, utilization management, medical records, preventive health services and member rights and responsibilities. As of January 31, 1999, eight of Humana's HMOs have achieved full accreditation from NCQA. Humana Medical Plan, Inc., in its South Florida and Tampa Bay markets, Humana Health Plan, Inc., in its Chicago market, Humana Health Plan, Inc. and Humana Kansas City, Inc., in the Kansas City market, Humana Health Plan of Ohio, Inc. dba ChoiceCare in the Cincinnati market and Humana Health Plan, Inc., HMPK, Inc. and HPlan, Inc. in the Louisville market. In addition, Humana Medical Plan, Inc. in its North Florida (Jacksonville) and Central Florida (includes Daytona and Orlando areas) are fully accredited by NCQA pending limited merger reviews. The limited merger reviews will assess the integration of the fully accredited PCA Health Plans that Humana acquired during 1997. Humana also has an NCQA accreditation survey scheduled for the Texas market in July 1999. This survey will include Humana Health Plan of Texas, Inc., Humana HMO Texas, Inc. and PCA Health Plans of Texas, Inc., located in the San Antonio, Austin, Corpus Christi, Dallas and Houston markets.

JCAHO reviews rights, responsibilities and ethics, continuum of care, education and communication, leadership, management of information and human resources, and network performance. JCAHO also evaluates the mechanisms the organization has established to ensure continuous quality improvement. Humana Medical Plan, Inc., in Humana's Ft. Walton market received a three-year accreditation from JCAHO during 1998.

The Company's Y2K Readiness Disclosure Statement

The Company operates one of the largest managed care data centers in the nation. The primary computing facility is located in Louisville, Kentucky with a satellite operation in Green Bay, Wisconsin. In 1998, Humana's Information

Systems organization included 950 associates with an annual operating budget of $135 million. The Company's application systems are largely developed and maintained in-house by a staff of 400

application programmers who are versed in the use of state-of-the-art technology. All application systems are fully integrated and automatically pass data through various system processes. The information systems support marketing, sales, underwriting, contract administration, billing, financial, and other administrative functions as well as customer service, authorization and referral management, concurrent review, physician capitation and claims administration, provider management, quality management and utilization review.

The Company internally develops most of its own application systems software. All application systems must comply with strict standards for data integrity, file compatibility and architectural requirements. The Company maintains a central project coordination function and an architectural review function that ensure consistency across the application portfolio. The Company has subscribed to automated file processes and integrated data architectures for over twenty-five years.

The Year 2000 issue is the result of two potential malfunctions that may have an impact on the Company's systems and equipment. The first potential malfunction is the result of computers being programmed to use two rather than four digits to define the applicable year. The second potential malfunction arises where embedded microchips and micro-controllers have been designed using two rather than four digits to define the applicable year. As a result, certain of the Company's date-sensitive computer programs, building infrastructure components and medical devices, may recognize a date using "00" as the year 1900 rather than the year 2000. If uncorrected, the problem may result in computer system and program failures or equipment malfunctions that could result in a disruption of business operations (such as the payment of medical claims, premium billing and collection, and membership enrollment verification as well as the use of medical equipment such as heart defibrillators).

Humana's Information Systems organization operates in a centralized manner. The Company's data center and the majority of its programming and support staff are located at its corporate offices in Louisville, Kentucky. A Year 2000 project management office is in place to oversee the progress made in the assessment and correction of the Company's Year 2000 exposures.

In general, the Company's Year 2000 project consists of four phases--assessment, remediation, validation, and implementation--and is categorized into the following four components:

Information Technology (IT)--software essential for day-to-day operations including both internally developed software and third party software which interfaces therewith.

IT Infrastructure--mainframe, network, telecommunications interfaces and self-contained operating systems.

Third party business partners and intermediaries--entities on which the Company relies for transmission and receipt of claims, and encounter, membership and payment information, including federal and state governmental agencies such as the Health Care Financing Administration.

Non-IT Infrastructure--telecommunications equipment, elevators, public safety equipment (i.e., security and fire), medical equipment and HVAC systems.

The Company commenced the assessment of its Year 2000 exposures in 1996. Remediation efforts of internally developed software and third party software applications have also begun. The Company's plan is to have modified all critical mainframe systems and components in time for such systems and components to utilize the updated Year 2000 logic during the second quarter of 1999. Modifying all critical systems and components by the second quarter of 1999 will enable the majority of the modified programs to run in a production environment for a considerable period of time before encountering Year 2000 data. Of the Company's 98 mainframe systems identified in the assessment, 92 have been renovated, validated and are currently operating using the updated Year 2000 logic. During 1999, the remaining 6 systems will be modified, upgraded, or replaced and all systems will continue to be monitored and tested

to ensure that they will function properly after December 31, 1999. In addition, the Company is in the process of contacting vendors, third party

business partners and intermediaries in an effort to obtain the information necessary to address Year 2000 issues. The Company anticipates completing, in all material respects, its Year 2000 project by the end of the third quarter 1999. The Company's efforts are currently progressing on plan.

The Year 2000 project is currently estimated to have a minimum total cost of approximately $25 million. Project to date costs total $19.5 million, including $18.5 million during the year ended December 31, 1998. Year 2000 expenses represented less than 15 percent of the Information Systems budget during 1998. Year 2000 costs are expensed as incurred and funded through operating cash flow.

The extent and magnitude of the Year 2000 project, as it will affect the Company both before and for some period after January 1, 2000, are difficult to predict or quantify. As a result, the Company has recently undertaken the development of contingency plans in the event that its Year 2000 project is not completed in an accurate or timely manner. The Company has identified five major functional areas, covering 20 operational subdivisions, that will require contingency plans. The five major functional areas are: providers, service centers, suppliers and vendors, customers and brokers, and banking and finance. The Company is in the process of developing and refining alternative operating procedures for each functional area. Additionally, a tracking system is being developed to monitor the implementation of these procedures.

While the Company presently believes that the timely completion of its Year 2000 project will limit exposure so that the Year 2000 will not pose material operational problems, the Company does not control third party systems. Although the Company is contacting third parties, the Company has not received assurances that all third party interfaces will be converted in a timely manner. Additionally, if Year 2000 modifications or upgrades are not accomplished in a timely manner or proper contingency plans are not implemented, Year 2000 failures which may result could have a material adverse impact on the Company's results of operations or its financial position.

The costs of the Year 2000 project and the date on which the Company plans to complete Year 2000 modifications are based on management's best estimates, considering assumptions of future events including the continued availability of certain resources and other factors. There can be no guarantee that these estimates will be achieved and actual results could differ materially from plan. Specific factors that might cause such material differences include, but are not limited to, the availability and cost of personnel trained in this area, the ability to locate and correct all relevant computer codes, and the ability of the Company's significant suppliers, customers and others with which it conducts business, including federal and state governmental agencies, to identify and resolve their own Year 2000 issues.

Sales and Marketing

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

The Company uses various methods to market its Commercial and Public Sector products, including television, radio, telemarketing and mailings. At December 31, 1998, the Company used approximately 47,800 licensed independent brokers and agents and approximately 500 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, 1998, the Company used approximately 6,200 licensed independent brokers for referrals and approximately 1,100 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 500 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, 1998, by state and product:

MEDICAL MEMBERSHIP
(In thousands)

	Commercial				Public Sector						
	PPO	HMO	ASO	Total Commercial	Medicare HMO	Medicaid	Medicare Supplement	Total Public Sector	TRICARE	Total	Percent of Total
Florida	203.7	307.3	5.9	516.9	264.1	129.3	5.0	398.4	414.6	1,329.9	21.4%
Texas	314.1	318.8	18.4	651.3	79.2	38.4	5.7	123.3	0.0	774.6	12.5%
Illinois	255.5	292.2	75.8	623.5	70.4	13.7	0.1	84.2	0.0	707.7	11.4%
Puerto Rico	28.8	25.2	0.0	54.0	0.0	441.9	0.0	441.9	0.0	495.9	8.0%
Wisconsin	82.1	109.4	278.7	470.2	2.3	20.5	0.0	22.8	0.0	493.0	8.0%
Kentucky	207.4	101.3	18.3	327.0	13.1	0.0	30.1	43.2	0.0	370.2	6.0%
Georgia	88.1	7.3	13.4	108.8	0.0	0.0	3.2	3.2	258.8	370.8	6.0%
Ohio	100.1	219.0	49.0	368.1	15.2	0.0	0.0	15.2	0.0	383.3	6.2%
Missouri/ Kansas	41.1	101.3	14.5	156.9	24.6	0.0	5.7	30.3	0.0	187.2	3.0%
Indiana	91.0	0.0	27.5	118.5	0.0	0.0	0.0	0.0	0.0	118.5	1.9%
South Carolina	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	135.5	135.5	2.2%
Tennessee	68.4	0.0	16.2	84.6	33.1	0.0	0.0	33.1	70.1	187.8	3.0%
Other	294.5	4.9	128.5	427.9	0.0	0.0	6.8	6.8	206.7	641.4	10.4%
Total	1,774.8	1,486.7	646.2	3,907.7	502.0	643.8	56.6	1,202.4	1,085.7	6,195.8	100.0%

Risk Management

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

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

Competition

The managed health care industry is highly competitive and contracts for the sale of Commercial products are generally bid or renewed annually. The Company's competitors vary by local market and include 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 more 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 14 actively licensed HMO subsidiaries, nine are qualified under the Federal Health Maintenance Organization Act of 1973, as amended. To obtain federal qualification, an HMO must meet certain requirements, including conformance with benefit, rating and financial reporting standards. In certain markets, and for certain products, the Company operates HMOs that are not federally qualified because this provides greater flexibility with respect to product design and pricing than is possible for federally qualified HMOs.

Six subsidiaries (Humana Medical Plan, Inc., Humana Health Plan of Texas, Inc., Humana Health Plan, Inc., Humana Kansas City, Inc., Humana Health Plan of Ohio, Inc. and Humana Wisconsin Health Organization Insurance Corporation) are qualified under HCFA's Medicare+Choice program to sell Medicare HMO products in 11 states.

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

HCFA requires an independent review of medical records and quality of care and all denied claims and service complaints which are not resolved in favor of a member. All advertising and member communication materials require review and approval by HCFA.

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

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

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

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

The National Association of Insurance Commissioners has recommended that states adopt a risk-based capital ("RBC") formula for companies established as HMO entities. The RBC provisions may require new minimum capital and surplus

levels for some of the Company's HMO subsidiaries. The Company does not expect that the RBC provisions will have a material impact on its financial position, results of operations or cash flows.

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

Health Care Reform

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

National

In 1997, Congress passed the Balanced Budget Act, including the establishment of the Medicare+Choice program, which revised the structure of and reimbursement for private health plan options for Medicare enrollees. The BBA sought to expand the options available to Medicare enrollees by permitting HCFA to contract with many types of managed care plans, including provider sponsored organizations ("PSO"), and creating a new private fee-for-service option. Few PSOs have applied for participation in the Medicare+Choice programs. Federal reimbursement was also modified so that the premiums paid by HCFA will be adjusted to take into account, on an increasing basis, a blend of national and local health care cost factors, rather than only local costs--starting with a 10% national factor in 1998 and moving to a 50% national factor by 2003. In addition, starting in January 1999, the Company's Medicare reimbursement will be reduced through the assessment of .355 percent of premium (approximately $11 million), designed to fund a national senior education program. The 1998 assessment was .428 percent.

In addition, the BBA also required that HCFA modify Medicare reimbursement by developing health-risk premium adjustments to better estimate the actual cost for individual beneficiaries. In January 1999, HCFA released the preliminary Year 2000 premium rates and the risk adjusted payment amounts with a phased-in approach, moving to a 100% health-risk adjusted premium by the year 2004. Congress is evaluating the impact the methodology will have on Medicare+Choice plans relative to current and future enrollment. Congress also is evaluating the impact of other BBA provisions in light of the withdrawals of several health plans, including those operated by Humana, from certain Medicare markets characterized by high medical costs, inadequate reimbursement rates and/or unsatisfactory provider contract arrangements. The Company is in the process of preparing Medicare rate and benefit filings for Year 2000 and is considering benefit reductions, increased member premiums and out-of-pocket expenses to mitigate the effect of the lower Medicare reimbursement established by the BBA.

Other proposals under consideration by Congress include greater government oversight over private health insurance. In addition, the President and the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry have made recommendations for enhancing certain consumer health insurance rights. It is expected that both the House and the Senate will consider specific legislation authorizing certain patient protections in private health insurance during 1999.

State

A number of states have enacted some form of managed care reform. Issues relating to managed care consumer protection standards, including increased plan information disclosure, expedited grievance and

appeals procedures, third party review of certain medical decisions, health plan liability, access to specialists and confidentiality of medical records continue to be under discussion. Further, proposals that place restrictions on the selection and termination of participating health care providers also are receiving review. A few states are also expected to consider small group purchasing alliance legislation.

Management believes that managed care and health care in general will continue to be scrutinized and may lead to additional legislative health care reform initiatives. Management is unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws

or regulations affecting the Company's businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on the revenues, profitability and business prospects of the Company.

Other

Captive Insurance Company

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

Centralized Management Services

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

Employees

As of December 31, 1998, the Company had approximately 16,300 employees, including approximately 300 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 the Humana Building, located at 500 West Main Street, Louisville, Kentucky 40202.

The Company owns or leases medical centers ranging in size from approximately 1,500 to 80,000 square feet. Most of the medical centers are leased or subleased to providers within Humana's network. 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, 1998:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	6	82	3	22	113
Illinois	8	18	--	10	36
Puerto Rico	--	--	--	21	21
Texas	5	4	8	2	19
Kentucky	8	5	3	2	18
Missouri/Kansas	3	5	2	0	10
Wisconsin	--	--	1	8	9
California	--	--	--	7	7
Ohio	--	--	--	6	6
Other	1	3	1	46	51
Total	31	117	18	124	290

In addition, the Company owns buildings in Louisville, Kentucky, San Antonio, Texas, Green Bay, Wisconsin and Jacksonville, Florida, and leases facilities in Madison, Wisconsin, all of which are used for customer service and claims processing. The Louisville and Green Bay facilities also perform enrollment processing and other corporate functions.

ITEM 3. LEGAL PROCEEDINGS

A class action lawsuit styled Mary Forsyth, et al v. Humana Inc., et al, Case #CV-5-89-249-PMP (L.R.L.), was filed on March 29, 1989, in the United States District Court for the District of Nevada. On August 18, 1997, the Company filed a Petition for Writ of Certiorari in the United States Supreme Court ("Petition") requesting the Supreme Court to reverse the Ninth Circuit's decision to reinstate the claim under the Racketeer Influenced and Corrupt Organizations Act ("RICO") on behalf of a class of insureds who paid coinsurance at Humana hospitals (the "Co-Payer Class"). The petition was granted by the Supreme Court on June 22, 1998. Oral arguments on the Company's Petition were heard on November 30, 1998. In a decision issued on January 20, 1999, the Supreme Court upheld the decision of the Ninth Circuit and reinstated the RICO claim of the Co-Payer Class. The Ninth Circuit also reinstated an antitrust claim that had been dismissed by the District Court. The Company requested summary judgment in the District Court on that Claim on October 6, 1997. That request was denied on September 21, 1998. The Company has requested the District Court to reconsider its decision. The plaintiffs have filed their Fourth Amended Complaint and a motion for leave to file a Fifth Amended Complaint reasserting an ERISA claim and adding new RICO and antitrust claims. The company filed a motion to dismiss the Fourth Amended Complaint and a motion opposing the plaintiffs' request to file the Fifth Amended Complaint. The motions are pending before the District Court. The trial on the claims, which was scheduled to begin on February 23, 1998, has been postponed.

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. The defendants filed a motion to dismiss the case in October 1995. A hearing on this motion was held on January 26, 1999. The decision is still pending. The Company believes that the complaint is without merit.

Between November 19, 1997 and December 11, 1997, three related, purported class action complaints entitled (i) Medhat Reiser v. PCA, et al, Civil Action No. 97-3678 (S.D. Fla.) (Middlebrooks, J.), (ii) Janice Wells and Stewart Colton v. PCA, et al, Civil Action No. 97-3832 (King, J.), and (iii) David Applestein v. PCA, et al, Civil Action No. 97-4030 (Nesbitt, J.), were filed in the United States District Court for the Southern District of Florida by purported former stockholders of Physician Corporation of America ("PCA") against PCA and certain of its former directors and officers. By order entered February 13, 1998, the three actions were consolidated into a single action entitled In re Physician Corporation of America Securities Litigation, Civil Action No. 97-3678 (S.D. Fla.) (Middlebrooks, J.). The Reiser, Wells and Applestein complaints contain the same or substantially similar allegations; namely, that PCA and the individual defendants knowingly or recklessly made false and misleading statements in press releases and public filings with respect to the financial and regulatory difficulties of PCA's workers' compensation business. Count I of all three complaints is premised on alleged violations of Section 10(b) of the Securities Exchange Act of 1934 (the "1934 Act") and SEC Rule 10b-5, and Count II on alleged violations of Section 20(a) of the 1934 Act. All three complaints seek certification of a class of stockholders who purchased shares of PCA common stock from May 1996 through March 1997, as well as money damages plus prejudgment interest in an unspecified amount, and costs and expenses including attorneys fees. On February 19, 1999, the U.S. District Court denied PCA's motion to dismiss. The Company believes that the allegations in the above complaints are without merit and intends to pursue the defense of the consolidated action vigorously.

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 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.

Government regulators conduct reviews from time to time to audit compliance with government regulations and statutes, and those reviews may result in fines or other payments. Management does not believe that any pending and threatened legal actions and audits by agencies that regulate the Company will have a material adverse effect on the Company's financial position, results of operations or cash flows.

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

Not applicable.

EXECUTIVE OFFICERS OF THE COMPANY

Set forth below are names and ages of all of the current executive officers of the Company as of March 1, 1999, their positions, date of election to such position and the date first elected an officer of the Company:

Name	Age	Position	First Elected Officer
Gregory H. Wolf.....	42	President and Chief Executive Officer and Director	10/95(1)
Kenneth J. Fasola.....	39	Senior Vice President--Sales, Marketing and Business Development	05/96(2)
Michael B. McCallister..	46	Senior Vice President--Health System Management	09/89(3)
James E. Murray.....	45	Senior Vice President and Chief Financial Officer	08/90(4)
David R. Nelson.....	44	Vice President and Chief Actuary	09/96(5)
Bruce D. Perkins.....	44	Senior Vice President--National Contracting	09/94(6)
Jerry D. Reeves, M.D....	54	Senior Vice President and Chief Medical Officer	01/97(7)
Gregory K. Rotherham....	42	Vice President--Customer Service and Operations	09/96(8)
Kirk E. Rothrock.....	40	Senior Vice President--Specialty Products and Services and International Businesses	05/96(9)
George W. Vieth, Jr.....	43	Senior Vice President--Market Segment Management	12/95(10)

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(1) Mr. Wolf currently serves as President, Chief Executive Officer and Director of the Company having been elected to this position December 1997. Mr. Wolf previously served as President and Chief Operating Officer from September 1996 until December 1997 and served as Chief Operating Officer of the Company since July 1996. 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.

(2) Mr. Fasola currently serves as Senior Vice President--Sales, Marketing and Business Development and was elected to this position November 1998. Prior to that, Mr. Fasola served as Vice President--Sales & Marketing from May 1996 to November 1998. Mr. Fasola served in a similar capacity as Vice President and National Sales Manager of EHIC since 1989.

(3) Mr. McCallister currently serves as Senior Vice President--Health System Management and was elected to this position January 1998. Prior to that, Mr. McCallister served as Division I President from July 1996 to January 1998. Mr. McCallister joined the Company in June 1974 as a Financial Specialist and served in several positions throughout the Company.

(4) Mr. Murray currently serves as Senior Vice President and Chief Financial Officer and was elected to this position November 1998. Prior to this, Mr. Murray served as Chief Financial Officer from January 1997 to November 1998 and Vice President--Finance from August 1990 to January 1997. Mr. Murray joined the Company as Controller in October 1989.

(5) Mr. Nelson was elected to the above position in September 1996. Prior to that, Mr. Nelson was Vice President and Chief Actuary of EHIC since 1992.
(6) Mr. Perkins currently serves as Senior Vice President--National Contracting and was elected to this position January 1998. Prior to that, Mr. Perkins served as Senior Vice President--Provider Affairs and Reengineering from August 1996 to January 1998. He served as President of the South/West Division from May 1996 to August 1996 and Vice President--Region II from August 1994 to May 1996. Mr. Perkins joined the Company in May 1976.
(7) Dr. Reeves, a pediatric oncologist, joined the Company in January 1997 in the above position. Prior to that, 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 currently serves as Vice President--Customer Service and Operations and was elected to this position in October 1998. Prior to that, Mr. Rotherham served as Vice President & General Manager--Medstep from May 1998 through October 1998 and as Vice President--Marketing from September 1996 through May 1998. Mr. Rotherham also served in a similar capacity as Vice President for EHIC since 1994.
(9) Mr. Rothrock currently serves as Senior Vice President--Specialty Products & Services & International Businesses and was elected to this position November 1998. Prior to that, Mr. Rothrock served as Vice President--Specialty Products and Business Development from May 1996 to November 1998. 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 currently serves as Senior Vice President--Market Segment Management and was elected to this position November 1998. Prior to that, Mr. Vieth served as Vice President--Strategy and Systems Development from January 1998 through November 1998. Mr. Vieth also served as Vice President--Development and Planning from December 1995 through January 1998. Mr. Vieth joined the Company in November 1992 as Director of Development and Planning.

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

PART II

Information for Items 5 through 8 of this report, which appears in the 1998 Annual Report to Stockholders as indicated on the following table, is incorporated by reference herein in this report and filed as an exhibit hereto:

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 6, 1999 appearing under the caption "Election of Directors" 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 6, 1999, 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 6, 1999, 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 6, 1999 appearing under the caption "Certain Transactions with Management and Others" of such Proxy Statement.

PART IV

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

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

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

(2) Index to Consolidated Financial Statement Schedules:

Consolidated Schedules as of and for the years ended December 31, 1998, 1997 and 1996:

I Parent Company Financial Information

II Valuation and Qualifying Accounts

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

(3) Exhibits:

3(a) Restated Certificate of Incorporation filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the

amendment of January 9, 1992, and the correction of March 23, 1992. Exhibit 4(i) to the Company's Post-Effective Amendment to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994, is incorporated by reference herein.

(b) By-laws, as amended. Exhibit 3(b) to the Company's Annual Report for the fiscal year ended December 31, 1997, is incorporated by reference herein.

4(a) Form of Amended and Restated Rights Agreement dated February 14, 1996, between Humana Inc. and Mid-America Bank of Louisville and Trust Company. Exhibit 1.3 to the Registration Statement (File No. 1-5975) on Form 8-A/A dated February 14, 1996, is incorporated by reference herein.

(b) Amendment No. 2 to the Rights Agreement. Exhibit 4.3 to the Registration Statement (File No. 1-5975) on Form 8-A/A dated March 1, 1999, is incorporated by reference herein.

(c) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of the Company on a consolidated basis. Other long-term indebtedness of the Company is described in Note 6 of Notes to Consolidated Financial Statements in the Company's 1998 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.

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

10(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.

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

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

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

(l)* 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.

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

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

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

(p)* Employment Agreement--Gregory H. Wolf, dated December 1, 1997. Exhibit 10(o) to the Company's Annual Report on Form 10-K for the year ended December 31, 1997, is incorporated by reference herein.

(q)* Employment Agreement--Gregory H. Wolf, dated December 1, 1998, filed herewith.

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

(s)* 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.

(t)* 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.

(u)* 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.

(v) 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.

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

10(w) 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.

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

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

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

(aa) 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.

(bb) 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 1998 Annual Report to Stockholders, filed herewith. The Annual Report shall not be deemed to be filed with the Commission except to the extent that information is specifically incorporated by reference herein.

21 List of Subsidiaries, filed herewith.

23 Consent of PricewaterhouseCoopers LLP, filed herewith.

27 Financial Data Schedule, filed herewith.

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(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.

By: /s/ James E. Murray
James E. Murray
Chief Financial Officer

Date: March 31, 1999

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 31, 1999
/s/ David A. Jones David A. Jones	Chairman of the Board	March 31, 1999
/s/ David A. Jones, Jr. David A. Jones, Jr.	Vice Chairman of the Board	March 31, 1999
/s/ K. Frank Austen, M.D. K. Frank Austen, M.D.	Director	March 31, 1999
/s/ Michael E. Gellert Michael E. Gellert	Director	March 31, 1999
/s/ John R. Hall John R. Hall	Director	March 31, 1999
/s/ Irwin Lerner Irwin Lerner	Director	March 31, 1999
/s/ W. Ann Reynolds, Ph.D. W. Ann Reynolds, Ph.D.	Director	March 31, 1999
/s/ Gregory H. Wolf Gregory H. Wolf	Director, President and Chief Executive Officer	March 31, 1999

REPORT OF INDEPENDENT ACCOUNTANTS

To the Board of Directors
Humana Inc.

Our report on our audits of the consolidated financial statements of Humana Inc. dated February 9, 1999 has been incorporated by reference in this Form 10-K from page 53 of the 1998 Annual Report to Stockholders of Humana Inc. In connection with our audits of such financial statements, we have also audited the related financial statement schedules listed in the index in Item 14(a)(2) of this Form 10-K.

In our opinion, the financial statement schedules referred to above, when considered in relation to the basic financial statements taken as a whole present fairly, in all material respects, the information required to be included therein.

PricewaterhouseCoopers LLP

Louisville, Kentucky
February 9, 1999

HUMANA INC.

SCHEDULE I--PARENT COMPANY FINANCIAL INFORMATION (a)
CONDENSED BALANCE SHEETS
December 31, 1998 and 1997
(Dollars in millions, except per share amounts)

	December 31,	
	1998	1997
ASSETS		
Receivables from operating subsidiaries (b)	$ 168	$ 162
Other current assets	39	11
Property and equipment, net	181	167
Investments in subsidiaries	2,380	2,251
Other	35	60
TOTAL ASSETS	$2,803	$2,651
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities (c)	$ 513	$ 229
Long-term debt	573	889
Other	29	32
Total liabilities	1,115	1,150
Contingencies (b)		
Preferred stock, $1 par; authorized 10,000,000 shares; none issued	--	--
Common stock, $.16-2/3 par; authorized 300,000,000 shares; issued and outstanding 167,515,362 shares--1998, 164,058,225 shares--1997	28	27
Other stockholders' equity	1,660	1,474
Total stockholders' equity	1,688	1,501
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$2,803	$2,651

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(a) Parent company financial information has been derived from the consolidated financial statements of the Company and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with the consolidated financial statements of the Company.
(b) In the normal course of business, the parent company indemnifies certain of its subsidiaries for health plan obligations its subsidiaries may be unable to meet.
(c) At December 31, 1998 current liabilities include $250 million of debt classified as short-term.

HUMANA INC.

SCHEDULE I--PARENT COMPANY FINANCIAL INFORMATION (a)
CONDENSED STATEMENTS OF INCOME
For the Years Ended December 31, 1998, 1997 and 1996
(Dollars in millions)

	Years Ended December 31,		
	1998	1997 (b)	1996
Revenues:			
Management fees charged to operating subsidiaries	$297	$228	$170
Interest income	1	5	3
	298	233	173
Expenses:			
Selling, general and administrative	293	201	189
Depreciation and amortization	33	26	21
Interest expense	40	17	9
	366	244	219
Loss before income taxes and equity in income of subsidiaries	(68)	(11)	(46)
Income tax benefit	38	9	18
Loss before equity in income of subsidiaries	(30)	(2)	(28)
Equity in income of subsidiaries	159	175	40
Net income	$129	$173	$ 12

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(a) Parent company financial information has been derived from the consolidated financial statements of the Company and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with the consolidated financial statements of the Company.
(b) Includes the operations of Health Direct, Inc., Physician Corporation of America and ChoiceCare Corporation since their dates of acquisition, February 28, 1997, September 8, 1997 and October 17, 1997, respectively.

HUMANA INC.

SCHEDULE I--PARENT COMPANY FINANCIAL INFORMATION (a)
CONDENSED STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1998, 1997 and 1996
(Dollars in millions)

	Years Ended December 31,

	1998	1997	1996
Net cash provided by operating activities (b)...	$ 105	$ 191	$ 57
Cash flows from investing activities:			
Purchases of property and equipment.....	(43)	(38)	(32)
Purchases of marketable securities.....	(1)	(6)	(6)
Maturities and sales of marketable securities.....	7	1	5
Parent funding of operating subsidiaries.....	(59)	(209)	(46)
Acquisitions of health plans.....	--	(656)	--
Other.....	(11)	17	(8)
Net cash used in investing activities.....	(107)	(891)	(87)
Cash flows from financing activities:			
Issuance of long-term debt.....	123	300	--
Repayment of long-term debt.....	(330)	--	(250)
Net commercial paper borrowings.....	141	367	222
Other.....	68	33	58
Net cash provided by financing activities...	2	700	30
Change in cash and cash equivalents.....	--	--	--
Cash and cash equivalents at beginning of period.....	--	--	--
Cash and cash equivalents at end of period.....	$ --	$ --	$ --

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

(b) During the years ended December 31, 1998, 1997 and 1996, the Company received dividends from its operating subsidiaries totaling $93, $146 and $140, respectively.

HUMANA INC.

SCHEDULE II--VALUATION AND QUALIFYING ACCOUNTS
For the years ended December 31, 1998, 1997 and 1996
(Dollars in millions)

	Balance at Beginning of Period	Additions: Acquired Balances	Additions: Charged to Costs and Expenses	Additions: Charged to Other Accounts (a)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on premiums receivable:						
Year ended December 31, 1998.....	$48	--	$11	$14	$(11)	$62
Year ended December 31, 1997.....	38	$9	10	3	(12)	48
Year ended December 31, 1996.....	36	--	11	(1)	(8)	38

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(a) Represents retroactive membership adjustments recorded in premium income.

Exhibit 10(q)

EMPLOYMENT AGREEMENT

EMPLOYMENT AGREEMENT made as of December 1, 1998 by and between HUMANA INC. (hereinafter "Company"), a Delaware corporation having its principal place of business in Louisville, Kentucky, and Gregory H. Wolf (hereinafter "Employee"):

WITNESSETH:

WHEREAS, Employee desires to render faithful and efficient service to the Company; and

WHEREAS, the Company desires to receive the benefit of Employee's service; and

WHEREAS, Employee is willing to be employed by the Company; and

WHEREAS, both Company and Employee desire to formalize the conditions of Employee's employment by written agreement;

NOW, THEREFORE, in consideration of the premises and the mutual covenants hereinafter set forth, the parties agree as follows:

1. Office. The Company hereby employs Employee and as President and Chief Executive Officer and Employee hereby agrees to serve the Company in such capacity.

2. Term of Employment. Employee's employment shall be for the "Employment Period" with the initial term commencing on December 1, 1998 and extending through December 31, 2000. The initial term shall be automatically renewed and extended upon the expiration thereof for successive periods of one (1) year until such time as the Employment Period shall terminate pursuant to the terms of this Agreement, or until the Company on the one hand, or Employee on the other hand, shall terminate the Employment Period by giving written notice to the other party on or before sixty (60) days prior to the expiration date of the initial or any renewal term. The renewal and extension of this Agreement shall also be referred to as the "Employment Period." The effective date of Employee's termination of employment for whatever reason under this Agreement shall be the "Termination Date."

3. Responsibilities. During the Employment Period, Employee shall devote his entire business time and attention, except during reasonable vacation periods, to, and exert his best efforts to promote, the affairs of the Company, and shall render such services to the Company as may be required by the Board of Directors of the Company ("Board") consistent with his employment as Chief Executive Officer. Nothing herein contained shall preclude service by Employee on a reasonable number of boards of directors or trustees of other entities not engaged in any business competitive with the business of the Company, provided that Employee shall discuss any such board service in advance with the Company's Board.

4. Incapacity. If, during the Employment Period, Employee should be prevented from performing his duties or fulfilling his responsibilities by reason of any incapacity or disability for a continuous period of six (6) months, then the Company's Board, in its sole and absolute discretion, may, based on the opinion of a qualified physician, consider such incapacity or disability to be total and may on ninety (90) days written notice to Employee terminate the Employment Period. Benefits and payments shall be made under this Agreement following incapacity as if it were a termination without Good Cause in accordance with Section 8(a).

5. Death. The Employment Period shall automatically terminate upon the death of Employee, and payments will be made to the Employee's estate as if it was a termination without Good Cause in accordance with Section 8(a).

6. Compensation. During the Employment Period, Employee shall (i) receive a base salary (hereinafter "Annual Base Salary") that shall be an annual amount of not less than Eight Hundred Thousand Dollars ($800,000) payable in accordance with the payroll practices of the Company, and shall (ii) participate in an incentive plan providing for a target incentive compensation amount of not less than one hundred percent (100%) of his Annual Base Salary.

7. Benefit Plans and Programs. During the Employment Period, Employee shall be eligible for participation in all benefit plans and programs, including those for executive employees, made available by the Company to its respective employees.

8. Severance Payments.

(a) In the event that Employee's employment is terminated by (i) the Company while this Agreement is in effect without Good Cause as defined in Sections 8(c)(1), (2) or (3) hereof, (ii) by the Company for Good Cause as defined in Section 8(c)(4) hereof, (iii) because the Company terminates the Employment Period pursuant to Section 2 of this Employment Agreement, (iv) by reason of incapacity or disability in accordance with Section 4, or (v) by reason of death in accordance with Section 5:

(1) The Company shall pay to Employee or his estate, no later than thirty (30) calendar days after such Termination Date, an amount equal to any unpaid current Annual Base Salary accrued through the Termination Date, his bonus, calculated at one hundred percent (100%) of his Annual Base Salary prorated for the current fiscal year through the Termination Date, plus one (1) times the sum of his then current Annual Base Salary and bonus, calculated at one hundred percent (100%) of his Annual Base Salary. The Company shall continue to keep in full force and effect all plans or policies of medical, accident and life insurance benefits with respect to Employee and his dependents with the same level of coverage available to employees under the terms of those employee benefit plans for a period of twelve (12) months, upon the same terms, costs and otherwise to the same extent as such plans are in effect for employees of the Company who were similarly situated to Employee as of the Termination Date.

(2) All restricted shares previously awarded to Employee but not yet vested shall become vested and non-forfeitable as of the Termination Date.

(3) To the extent stock options granted to Employee have not become fully vested and exercisable as of the Termination Date, such options shall become fully vested and all vested stock options shall be exercisable for two (2) years commencing on the Termination Date.

(b) In the event that Employee's employment is terminated by the Company for Good Cause as defined in Sections 8(c)(1), (2) or (3):

(1) The Company shall pay to Employee, no later than thirty (30) calendar days after the Termination Date, an amount equal to his then current Annual Base Salary accrued but unpaid through the Termination Date; and Employee shall have a period of ninety (90) days after such Termination Date in which to exercise any exercisable vested stock options,

subject to the provisions of any applicable stock option agreement.

(2) Any restricted shares or stock options previously granted but still subject to restriction or unvested at the Termination Date shall be forfeited.

(c) Good Cause shall mean the Company's Board has determined in good faith, without being bound by the Company's progressive discipline policy for employees:

(1) that Employee has engaged in acts or omissions against the Company or any of its subsidiaries constituting dishonesty, intentional breach of fiduciary obligation or intentional wrongdoing or misfeasance; or

(2) that Employee has been arrested or indicted in a possible criminal violation involving fraud or dishonesty; or

(3) that Employee has intentionally and in bad faith acted in a manner which results in a material detriment to the assets, business or prospects of the Company or any of its subsidiaries; or

(4) that Employee has failed to perform on a prolonged basis, where such failure is considered to be substantial and where corporate performance expectations have been previously agreed upon with the Employee on an annual basis. Further, the failure to perform must be because of things considered to be within the reasonable control of the Employee, generally of an operating or strategic nature, and excluding performance primarily resulting from things clearly beyond the reasonable control of Employee, such as the following:

(A) a drop in the Company's stock share price as a result of an overall market correction,
(B) severe national economic conditions, or
(C) adverse problems intrinsic to the Company's industry.

(d) In the event that Employee's employment is terminated (i) because the Employee terminates the Employment Period pursuant to Section 2 of this Employment Agreement or (ii) because Employee voluntarily leaves the employ of the Company during the Employment Period, then the Company shall pay to Employee, no later than thirty (30) calendar days after such Termination Date, an amount equal to any unpaid current Annual Base Salary accrued through the Termination Date, plus one (1) times his then current Annual Base Salary. Any bonus finally determined to be payable at the end of the fiscal year in which the Termination Date is included shall be prorated for the period up to and including the Termination Date and shall be promptly paid to Employee at the same time any other similar bonuses are paid to any

other employee of the Company for such fiscal year. The Company shall continue to keep in full force and effect all plans or policies of medical, accident and life insurance benefits with respect to Employee and his dependents with the same level of coverage available to employees under the terms of those employee benefit plans for a period of twelve (12) months, upon the same terms, costs and otherwise to the same extent as such plans are in effect for employees of the Company who were similarly situated to Employee as of the Termination Date.

(e) Following the Employment Period, Employee shall be eligible for continuation of health and dental insurance coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) for eighteen (18) months. For the first twelve (12) months, Employee's cost will be an amount equal to the normal employee contribution. Thereafter, the cost will be an amount equal to the

COBRA cost of such coverage. During the first eighteen (18) months, Employee may elect any of the coverages available to Humana employees. Thereafter, Humana agrees that Employee may elect coverage under any of the insured products offered by Humana's health insurance or HMO subsidiaries for Employee, his spouse as of the date hereof ("Spouse"), and any eligible dependent until the later of Employee's age sixty-five (65) or eligibility for Medicare coverage (hereinafter "Extended Coverage"). At the earlier of Employee attaining Medicare eligibility or death, Employee's Spouse and any now current eligible dependent of Employee and Spouse will be eligible for Extended Coverage until the later of Spouse's age sixty-five (65) or Medicare coverage eligibility. If at any time during which the Extended Coverage is in effect Employee or his Spouse obtains Medicare or becomes eligible for other employee group health insurance coverage which does not exclude a pre-existing condition of Employee, Spouse or dependent, Humana's obligation will cease as to the one who has obtained Medicare or, in the case of other employee group health coverage, as to that person and their eligible dependents. Employee's premium for the Extended Coverage and Spouse's premium, if she retains Extended Coverage, will be amount equal to the COBRA cost of such coverage. If Humana hereafter adopts a retiree health insurance program and Humana still has obligations under this provision, Employee will be offered the option of participating in that program in lieu of the Extended Coverage described herein. The health and dental insurance benefits hereunder shall be administered in conjunction with any other similar benefits which the Employee has from the Company but in no case shall be duplicative.

9. Termination After A Change in Control. In the event of a "Change in Control" of the Company (as defined as of the date hereof in the Company's 1996 Stock Incentive Plan for Employees), if, within twenty-four (24) months following the closing of such a Change in Control (or at any time prior thereto but in contemplation thereof):

(i) There is a material reduction in the Employee's title, authority or responsibilities, including reporting responsibilities;

(ii) The Employee's Annual Base Salary is reduced;

(iii) The Employee's office at which he is to perform his duties is relocated to a location more than thirty (30) miles from the location at which the Employee performed his duties prior to the Change in Control;

(iv) The Company fails to continue in effect any incentive, bonus or other compensation plan in which the Employee participates, unless the Company substitutes a substantially equivalent benefit;

(v) The Company fails to continue in effect any employee benefit plan (including any medical, hospitalization, life insurance, dental or disability benefit plan in which the Employee participated) or any material fringe benefit or perquisite enjoyed by the Employee at the time of the Change in Control, unless the Company substitutes benefits which, in the aggregate, are substantially equivalent;

(vi) The Company breaches any material provision of this Employment Agreement; or

(vii) The Company fails to obtain a satisfactory agreement from any successor or assign of the Company to assume and agree to perform this Employment Agreement;

Then the Employee shall have the option to voluntarily terminate his employment and the Company shall:

(a) Pay the Employee his full base salary earned but not yet paid

through the Termination Date at the greater of the rate in effect at the time of the Change in Control or the Termination Date ("Higher Annual Base Salary"), plus any bonuses or incentive compensation which, pursuant to the terms of any compensation or benefit plan, have been earned and are payable as of the

Termination Date. For purposes of this Agreement, bonuses and incentive compensation shall be considered payable if all conditions for earning them have been met and any requirement that Employee be actively employed as of the date of payment shall be disregarded.

(b) Pay the Employee a lump sum in an amount equal to two and one-half (2 1/2) times the amount equal to the sum of (1) the Employee's Higher Annual Base Salary plus (2) the maximum target bonus or incentive compensation which could have been earned by the Employee calculated as if all relevant goals had been met during the then current fiscal year of the Company pursuant to the terms of the incentive compensation plan in which he participates. If there is no incentive compensation plan in effect as of the Termination Date, then for purposes of this Agreement it shall be assumed that the amount of incentive compensation to be paid to the Employee shall be the maximum target amount under any incentive compensation plan in which he participated at the date of the Change in Control or the most recent plan participated in, whichever would be greater.

(c) Maintain in full force and effect for the benefit of the Employee and the Employee's dependents and beneficiaries, at the Company's expense, all life insurance, health insurance, dental insurance, accidental death and dismemberment insurance and disability insurance under plans and programs in which the Employee and/or the Employee's dependents and beneficiaries participated immediately prior to the Termination Date, provided that continued participation is possible under the general terms and provisions of such plans and programs ("Extended Benefits"). The Extended Benefits shall be continued until the earlier of (A) the second (2nd) anniversary of the Termination Date, (B) the effective date of the Employee's coverage under equivalent benefits from a new employer (provided that no such equivalent benefits shall be considered effective unless and until all pre-existing condition limitations and waiting period restrictions have been waived or have otherwise lapsed), or (C) the death of the Employee. If participation in any such plan or program is barred, the Company shall arrange at its own expense to provide the Employee with benefits substantially similar to those which he was entitled to receive under such plans and programs. At the end of the period of coverage, the Employee shall have the right to have assigned to him, at no cost and with no apportionment of prepaid premiums, any assignable insurance policy relating specifically to him. Employee shall be entitled to continuation coverage as provided by COBRA at the conclusion of the coverage provided under this Section.

The amount of any payment or benefit provided for in this Section 9 shall be offset by any lump sum cash payments due the Employee upon termination under any other provisions of this Employment Agreement.

(d) To the extent that any amounts or payments in the nature of compensation [within the meaning of Section 280G of the Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder ("Section 280G")] to or for the benefit of the Employee under this Employment Agreement or otherwise (or any part of such amount or other payment) constitutes an "excess parachute payment" within the meaning of Section 280G and Section 4999 of the Internal Revenue Code, then the Company shall pay to Employee an additional sum such that, after all taxes applicable to the receipt of such amount have been subtracted therefrom, the remaining amount will equal the sum of the amount of tax imposed

with respect to the "excess parachute payment," plus any interest and penalties thereon (other than those caused solely by Employee's action or inaction). Therefore, the effect shall be to maintain the Employee in the same financial position that he would have been in had no tax under Section 280G been imposed.

10. Restrictive Covenants. Employee shall not during the Employment Period, directly or indirectly, alone or as a member of a partnership or association, or as an officer, director, advisor, consultant, agent or employee of any other company, be engaged in or concerned with any other duties or pursuits requiring his personal services except with the prior consent of the Company's Board. Nothing herein contained shall preclude the ownership by Employee of stocks or other investment securities.

11. Confidential Information and Trade Secrets.

(a) Employee recognizes that Employee's position with the Company requires considerable responsibility and trust, and, in reliance on Employee's loyalty, the Company may entrust Employee with highly sensitive confidential, restricted and proprietary information involving Trade Secrets and Confidential Information.

(b) For purposes of this Agreement, a "Trade Secret" is any scientific or technical information, design, process, procedure, formula or improvement that is valuable and not generally known to competitors of the Company. "Confidential Information" is any data or information, other than Trade Secrets, that is important, competitively sensitive, and not generally known by the public, including, but not limited to, the Company's business plans, business prospects, training manuals, product development plans, bidding and

pricing procedures, market strategies, internal performance statistics, financial data, confidential personnel information concerning employees of the Company, supplier data, operational or administrative plans, policy manuals, and terms and conditions of contracts and agreements. The terms "Trade Secret" and "Confidential Information" shall not apply to information which is (i) already in Employee's possession (unless such information was used in connection with formulating the Company's business plans, obtained by Employee from the Company or was obtained by Employee in the course of Employee's employment by the Company), or (ii) required to be disclosed by any applicable law.

(c) Except as required to perform Employee's duties hereunder, Employee will not use or disclose any Trade Secrets or Confidential Information of the Company during employment, at any time after termination of employment and prior to such time as they cease to be Trade Secrets or Confidential Information through no act of Employee in violation of this Section 11.

(d) Upon the request of Company and, in any event, upon the termination of employment hereunder, Employee shall surrender to the Company all memoranda, notes, records, plans, manuals or other documents pertaining to the Company's business or Employee's employment (including all copies thereof). Employee will also leave with the Company all materials involving Trade Secrets or Confidential Information of the Company. All such information and materials, whether or not made or developed by Employee, shall be the sole and exclusive property of the Company, and Employee hereby assigns to the Company all of Employee's right, title and interest in and to any and all of such information and materials.

12. Covenant Not To Compete. Employee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after ceasing employment with the Company for whatever reason, he shall not:

(a) Compete in any way with the Company without the Company's prior written consent.

(b) Interfere with the relationship of the Company and any employee, agent or representative.

(c) Divert, or attempt to cause the diversion from the Company, any business with which the Company has been actively engaged in during any part of the past two (2) year period preceding the Termination Date, nor interfere with

relationships of the Company with policyholders, dealers, distributors, marketers, sources of supply or customers.

Employee further specifically acknowledges that the geographic area to which the covenants contained in this Section 12 apply is the same geographic area in which the Company transacted its business during any part of the twelve (12) month period immediately prior to the Termination Date. The time period during which the prohibitions set forth in this Section 12 apply shall be tolled and suspended as to Employee for a period equal to the aggregate quantity of time during which Employee violates such prohibitions in any respect.

13. Specific Enforcement. Employee specifically acknowledges and agrees that the restrictions set forth in Sections 11 and 12 hereof are reasonable and necessary to protect the legitimate interest of the Company and that the Company would not have entered into this Agreement in the absence of such restrictions. Employee further acknowledges and agrees that any violation of the provisions of Sections 11 or 12 hereof will result in irreparable injury to the Company, that the remedy at law for any violation or threatened violation of such Sections will be inadequate and that in the event of any such breach, the Company, in addition to any other remedies or damages available to it at law or in equity, shall be entitled to temporary injunctive relief before trial from any court of competent jurisdiction as a matter of course, and to permanent injunctive relief without the necessity of proving actual damages.

14. Effect of Termination of the Employment Period. Upon the termination of the Employment Period, this Agreement shall terminate, and all of the parties' obligations hereunder shall forthwith terminate, except that rights and remedies accruing prior to such termination or arising out of this Agreement shall survive.

15. Notice. Any notice required to be given by the Company hereunder to Employee shall be in proper form and signed by an officer or Director of the Board of the Company. Until one party shall advise the other in writing to the contrary, notices shall be deemed delivered:

(a) To the Company if delivered to the Chairman of the Board of the Company, or if mailed, certified or registered mail postage prepaid, to Humana Inc., 500 West Main Street, Louisville, Kentucky 40202; Attention: Chairman of the Board, with a copy to the Company's General Counsel.

(b) To employee if delivered to Employee, or if mailed to him by certified or registered mail, postage prepaid, to Gregory H. Wolf, 211 Waterleaf Way, Louisville, Kentucky 40207.

16. Benefit. This Agreement shall bind and inure to the benefit of the Company and the Employee, their respective heirs, successors and assigns.

17. Severability. If a judicial determination is made that any of the

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provisions of this Employment Agreement constitutes an unreasonable or otherwise unenforceable restriction against Employee, such provision shall be rendered void only to the extent that such judicial determination finds such provisions to be unreasonable or otherwise unenforceable. In this regard, the parties hereto hereby agree that any judicial authority construing this Employment Agreement shall be empowered to sever any portion of the territory or prohibited business activity from the coverage of Sections 11 or 12 and to apply the provisions to the remaining portion of the territory or the remaining business activities not so severed by such judicial authority. Moreover, notwithstanding the fact that any provisions of this Employment Agreement are determined not to be specifically enforceable, the Company shall nevertheless be entitled to recover monetary damages as a result of the breach of such provision by Employee.

18. Other. This Employment Agreement shall, as of its effective date, replace and supercede the Employment Agreement dated December 1, 1997 between the parties.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

ATTEST:

BY:_____
Corporate Secretary

HUMANA INC.

BY:_____
David A. Jones
Chairman of the Board

WITNESS:

_____

"EMPLOYEE"

_____
Gregory H. Wolf

EXHIBIT 12

HUMANA INC.
RATIO OF EARNINGS TO FIXED CHARGES
FOR THE YEARS ENDED DECEMBER 31, 1998, 1997 AND 1996
(UNAUDITED)

(Dollars in millions)	YEARS ENDED DECEMBER 31,		
	1998	1997	1996
Earnings:			
Income before income taxes	$ 203	$ 270	$ 18
Fixed charges	58	29	19
	$ 261	$ 299	$ 37
Fixed charges:			
Interest charged to expense	$ 47	$ 20	$ 11
One-third of rent expense (a)	11	9	8
	$ 58	$ 29	$ 19
Ratio of earnings to fixed charges	4.5(a)	10.4	2.0(b)

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

(a) Exclusive of charges associated with certain market closures, merger dissolution and losses on disposals of non-strategic assets of $34 million pretax, premium deficiencies of $46 million pretax, a one-time incentive for non-officer employees of $16 million pretax and other cost of $36 million pretax, the ratio for the year ended December 31, 1998 would have been 6.8.

(b) Exclusive of charges related to closing of the Washington, D.C. market, severance and facility costs for workforce reductions and market closures and product discontinuance cost of $96 million pretax, premium deficiencies of $105 million pretax and litigation and certain other costs of $14 million pretax, the ratio for the year ended December 31, 1996 would have been 13.3.

EXHIBIT 13

Financial Section

Humana Inc.

Selected Financial Data

Humana Inc.

Dollars in millions, except per share results

For the years ended December 31,	1998 (a) (b)	1997 (c)	1996 (d) (e)	1995 (c)	1994 (f)
Summary of Operations					
Revenues:					
Premiums by segment:					
Commercial	$ 5,257	$ 4,387	$ 4,255	$ 2,883	$ 2,054
Public Sector:					
Medicare HMO	2,918	2,426	1,907	1,569	1,406
Medicaid and other	622	303	164	153	116
	3,540	2,729	2,071	1,722	1,522
TRICARE	800	764	351	-	-
Total premiums	9,597	7,880	6,677	4,605	3,576
Interest and other income	184	156	111	97	78
Total revenues	9,781	8,036	6,788	4,702	3,654
Income before income taxes	203	270	18	288	257
Net income	129	173	12	190	176
Earnings per common share	.77	1.06	.07	1.17	1.10
Earnings per common share - assuming dilution	.77	1.05	.07	1.16	1.07
Net cash provided by operations	76	289	341	150	298
Financial Position					
Cash and investments	$ 2,812	$ 2,798	$ 1,880	$ 1,696	$ 1,203
Total assets	5,496	5,600	3,306	3,056	1,957
Medical and other expenses payable	1,908	2,075	1,099	866	527
Debt and other long-term obligations	977	1,057	361	399	83
Stockholders' equity	1,688	1,501	1,292	1,287	1,058
Operating Data					
Medical expense ratio	83.8	82.8%	84.3%	81.7%	81.6%
Administrative expense ratio	15.2	15.5%	15.5%	13.9%	13.6%
Medical membership by segment:					
Commercial:					
Fully-insured	3,261,500	3,258,600	2,759,600	2,834,900	1,500,800
Administrative services	646,200	651,200	471,000	495,100	93,500
	3,907,700	3,909,800	3,230,600	3,330,000	1,594,300

Public Sector:					
Medicare HMO	502,000	480,800	364,500	310,400	287,400
Medicaid and other	700,400	704,000	152,900	164,000	159,200
	1,202,400	1,184,800	517,400	474,400	446,600
TRICARE	1,085,700	1,112,200	1,103,000	-	-
Total	6,195,800	6,206,800	4,851,000	3,804,400	2,040,900
Specialty membership:					
Dental	1,375,500	936,400	844,800	797,000	
Other	1,257,800	1,504,200	1,039,400	1,063,000	
Total	2,633,300	2,440,600	1,884,200	1,860,000	

(a) Includes charges associated with certain market closures, merger dissolution and losses on disposals of non-strategic assets of $34 million pretax, ($22 million after tax or $.13 per diluted share).

(b) Includes premium deficiencies of $46 million pretax ($29 million after tax or $.17 per diluted share), a one-time incentive for non-officer employees of $16 million pretax ($10 million after tax or $.06 per diluted share) and other costs of $36 million pretax ($23 million after tax or $.14 per diluted share).

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

(d) Includes charges related to the closing of the Washington, D.C., market, severance and facility costs for workforce reductions and market closures and product discontinuance costs of $96 million pretax ($63 million after tax or $.38 per diluted share).

(e) Includes premium deficiencies of $105 million pretax ($68 million after tax or $.41 per diluted share), litigation and certain other costs of $14 million pretax ($9 million after tax or $.06 per diluted share).

(f) Includes nonrecurring income of $11 million pretax ($17 million after tax or $.10 per diluted 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.

Management's Discussion and Analysis of Financial Condition and Results of Operations

Humana Inc.

The consolidated financial statements of Humana Inc. (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 because actual results may differ materially from those projected in the forward-looking statements. Readers are cautioned that a number of factors, which are described herein and in the Company's Annual Report on Form 10-K for the year ended December 31, 1998, could adversely affect the Company's ability to obtain these results. These include the effects of either federal or state health care reform or other legislation, changes in the Medicare reimbursement system, renewal of the Company's Medicare contracts with the federal government, renewal of the Company's contract with the federal government to administer the TRICARE program and renewal of the Company's Medicaid contracts with various state governments. Such factors also include the effects of other general business conditions, including but not limited to, the Company's ability to integrate its acquisitions, the Company's ability to appropriately address the "Year 2000" computer system issue, government regulation, competition, premium rate and yield changes, retrospective premium adjustments relating to federal government contracts, medical and pharmacy cost trends, changes in Commercial and Medicare HMO membership, operating subsidiary capital requirements, the ability of health care providers (including physician practice management companies) to comply with current contract terms, the effect of provider contract rate negotiations, general economic conditions and the retention of key employees. In addition, past financial performance is not necessarily a reliable indicator of future performance and investors should not use historical performance to anticipate results or future period trends.

Introduction

The Company is a health services company that facilitates the delivery of health care services through networks of providers to its approximately 6.2 million medical members. The Company's products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracted providers. HMOs and PPOs control health care costs by various means, including pre-admission approval for hospital inpatient services, pre-authorization of outpatient surgical procedures, and risk-sharing arrangements with providers. These providers may share medical cost risk or have other incentives to deliver quality medical services in a cost-effective manner. During 1998, the Company began an initiative to increase the amount of medical cost risk assumed by certain of its provider partners related primarily to its HMO products. As a result, at December 31, 1998, approximately 50 percent and 70 percent of its Commercial and Medicare HMO membership, respectively, were under various forms of risk-sharing arrangements. The Company also offers various specialty products to employers, including dental, group life and workers' compensation, and administrative services ("ASO") to those who self-insure their employee health plans. In total, the Company's products are licensed in 47 states, the District of Columbia and Puerto Rico, with approximately 21 percent of its membership in the state of Florida.

The Company markets and distributes its products to three distinct customer groups and, therefore, reports operations in three business segments. Results of each segment are measured based on premium revenues and underwriting margin (premium revenues less medical expenses). The Company does not allocate assets or administrative costs to the segments and, therefore, does not measure results based on segment assets or pretax profits. Members from all three segments generally utilize the same medical provider networks, enabling the Company to obtain more favorable contract terms with providers. As a result, the profitability of each segment is somewhat interdependent.

In the Commercial segment, the Company markets and distributes its fully-insured HMO, PPO, specialty and ASO products to large group employers (over 100 employees) and small group employers. Premium revenue pricing to large group employers has historically been more competitive than that to small group employers,

resulting in less favorable underwriting margins for large groups. In the Public Sector segment, the Company markets and distributes its Medicare and Medicaid products to individuals eligible for these government-sponsored programs. The Medicare HMO product provides health care services that include all Medicare benefits and, in certain circumstances, additional services. The Company's third segment is TRICARE. In this segment, the Company facilitates health care services for the dependents of active military personnel and retired military personnel and their dependents located in the Southeastern United States. The Company is in the third year of its contract with the United States Department of Defense, which is renewable annually for up to two additional years. As encouraged by government regulation, TRICARE is managed by a separate management team and is more autonomous than the Company's Commercial and Public Sector segments, which generally share sales, marketing, customer service, medical management and claims processing functions of the Company.

On February 28, 1997, the Company acquired Health Direct, Inc. ("Health Direct") from Advocate Health Care for $23 million in cash. This transaction, which was recorded using the purchase method of accounting, added approximately 50,000 medical members to the Company's Chicago, Illinois, membership.

On September 8, 1997, the Company acquired Physician Corporation of America ("PCA") for total consideration of $411 million in cash, consisting primarily of $7 per share for PCA's outstanding common stock and the assumption of $121 million in debt. The purchase was funded with borrowings under the Company's commercial paper program. PCA served approximately 1.1 million medical members

and provided comprehensive health services through its HMOs in Florida, Texas and Puerto Rico. In addition, PCA provided workers' compensation third-party administrative management services. Prior to November 1996, PCA also was a direct writer of workers' compensation insurance in Florida. Long-term medical and other expenses payable in the accompanying consolidated balance sheets includes the long-term portion of workers' compensation liabilities related to this business. This transaction was recorded using the purchase method of accounting.

On October 17, 1997, the Company acquired ChoiceCare Corporation ("ChoiceCare") for approximately $250 million in cash. The purchase was funded with borrowings under the Company's commercial paper program. ChoiceCare provided health services products to approximately 250,000 medical members in the Greater Cincinnati, Ohio, area. This transaction was recorded using the purchase method of accounting.

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. Effective April 1, 1997, the Company also completed the sale of its Alabama operations, exclusive of its small group business and Alabama TRICARE operations, to PrimeHealth of Alabama, Inc. On October 31, 1997, the Company also sold The Lexington Hospital in Lexington, Kentucky, to Jewish Hospital Healthcare Services, Inc. These sale transactions did not have a material impact on the Company's financial position, results of operations or cash flows.

Asset Write-Downs and Other Charges

On August 10, 1998, the Company and United HealthCare Corporation ("United") announced their mutual agreement to terminate the previously announced Agreement and Plan of Merger, dated May 27, 1998. The merger, among other things, was expected to improve the operating results of certain of the Company's products and markets. Following the merger's termination, the Company conducted a strategic evaluation of each of its markets and product offerings. As a result of this strategic evaluation, which included assessing the Company's competitive market positions and profit potential, the Company recognized charges of $34 million during the third quarter of 1998. The charges included severance and lease termination costs associated with closing five markets (Sarasota and Treasure Coast, Florida, Springfield and Jefferson City, Missouri and Puerto Rico) and discontinuing products ($5 million), write-downs of certain receivables and property and equipment associated with closing markets ($10 million), losses on disposals of non-strategic assets ($12 million) and merger dissolution costs ($7 million). Charges for estimated employee severance costs were based on the

Company's employee benefit plan arrangements. Significant market closure activities are expected to be completed by the end of the second quarter of 1999 as membership lapses or existing contracts expire.

In 1996, the Company recorded asset write-downs and other charges of $96 million. These charges included write-downs of long-lived assets associated with the Company's Washington, D.C., health plan ($70 million), severance and lease termination costs for workforce reductions undertaken during 1997 ($15 million) and market closure and product discontinuance costs ($11 million). Substantially all amounts related to the cash portion of these charges were paid before the end of 1997.

Premium Deficiencies and Other Costs

In addition to the charges discussed above, as a result of management's regular assessment of the profitability of its contracts for providing health care services to its members, the Company recorded provisions for probable future

losses (premium deficiencies) of $46 million and $105 million in 1998 and 1996, respectively. These premium deficiencies have been included in medical expenses in the accompanying consolidated statements of income.

After evaluating the recoverability of receivables from certain physician practice management companies, a write-down of $27 million was recorded in 1998 medical expenses in the accompanying consolidated statements of income. In addition, as a result of the dissolved merger with United, a one-time incentive for each non-officer employee ($16 million) and other costs ($9 million) were recorded during 1998. The one-time non-officer employee incentive and other costs have been included in selling, general and administrative expenses in the accompanying consolidated statements of income.

During 1996, the Company recorded provisions for litigation and certain other costs of $14 million which has been included in selling, general and administrative expenses in the accompanying consolidated statements of income.

Comparison of Results of Operations

In order to enhance comparability, and to present an estimated baseline against which historical and prospective periods should be measured, the following discussions comparing the results for the years ended December 31, 1998, 1997 and 1996 exclude the impact of the asset write-downs and other charges, premium deficiencies, and other costs described previously.

Years Ended December 31, 1998 and 1997

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

The Company's 1998 premium revenues increased 22 percent to a record $9.6 billion, from $7.9 billion for the year ended December 31, 1997. This increase was attributable to the current year effect of 1997 acquisitions, Commercial and Medicare HMO same-plan membership growth and increased premium rates for the Company's Commercial products. PCA and ChoiceCare premium revenues contributed approximately $1.6 billion, a $1.1 billion increase over 1997. Same-plan membership growth contributed $120 million and Commercial premium increases added approximately $186 million, as same-plan Commercial premium yields increased 4.8 percent. Changes in Medicare HMO premium yield had little effect on premium revenues as same-plan yields declined .4 percent in 1998. The Medicare 2 percent statutory rate increase for 1998 was offset by membership growth in geographic areas with lower reimbursement rates.

During 1998, the Company's medical expense ratio increased to 83.0 percent from 82.8 percent for the year ended December 31, 1997. The year to year increase was the result of the higher medical expense ratio of acquired plans being included for a full year during 1998. The same-plan medical expense ratio improved 20 basis points to 82.2 percent from 82.4 percent in 1997, the result of the aforementioned premium rate increases, provider risk-sharing initiatives and improved claim payment accuracy. These improvements were partially offset by increased year-over-year pharmacy costs of 16 percent and 9 percent for the Company's Commercial and Medicare HMO products, respectively. As more fully described above, the medical expense ratio discussion excludes the impact of premium deficiencies ($46 million) and the write-down of physician practice management receivables ($27 million). The inclusion of these two items

increases the 1998 medical expense ratio from 83.0 percent to 83.8 percent.

The Company's administrative cost ratio was 14.9 percent and 15.5 percent for the years ended December 31, 1998 and 1997, respectively. This improvement was the result of efforts to streamline the organization, as well as synergy savings from the 1997 acquisitions. Although further synergy savings are expected from these acquisitions, planned spending during 1999 for information systems and customer service enhancements will likely offset the beneficial effect of these savings. This administrative expense ratio discussion excludes the impact of the one-time non-officer employees incentive ($16 million) and other costs ($9 million) described above. The inclusion of these two items increases the 1998 administrative expense ratio from 14.9 percent to 15.2 percent.

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

Business Segment Information for the Years Ended December 31, 1998 and 1997

Commercial premium revenues increased 20 percent in 1998 to $5.3 billion, from $4.4 billion in 1997. The PCA and ChoiceCare acquisitions contributed $575 million of this increase, while increased premium yields contributed the remainder. Commercial membership remained stable in 1998, the result of the Company's commitment to price its Commercial products commensurate with the underlying risk. For 1999, Commercial premium yield increases are expected to approximate 5 to 7 percent, while membership is expected to increase approximately 5 percent. Public Sector premium revenues increased 30 percent to $3.5 billion in 1998, the result of the 1997 acquisitions and 4.4 percent same-plan membership growth in the Medicare HMO product. During 1998, the Company slowed its Medicare HMO membership growth in newer, more costly markets. In addition, the September 1998 announcement to close two markets by December 31, 1998, resulted in the decrease of 16,000 members. Medicare HMO premium yields are expected to increase approximately 2 percent in 1999, while membership is expected to increase approximately 5 percent. Also during 1999, Medicaid membership is expected to decline approximately 442,000 members, the result of the expiration of the Puerto Rico Medicaid contract. TRICARE revenues increased 4.7 percent in 1998 on stable membership, due to contract modifications.

The following table depicts segment medical membership balances and activity as of and for the years ended December 31, 1998 and 1997:

	1998			1997		
In Thousands	Commercial	Public Sector	TRICARE	Commercial	Public Sector	TRICARE
Beginning medical membership	3,910	1,185	1,112	3,231	517	1,103
Sales	822	359	-	703	254	-
Cancellations	(824)	(342)	-	(635)	(222)	-
Acquisitions	-	-	-	735	659	-
Dispositions	-	-	-	(124)	(23)	-
TRICARE change	-	-	(26)	-	-	9
Ending medical membership	3,908	1,202	1,086	3,910	1,185	1,112

The Commercial segment medical expense ratio improved 100 basis points to 82.3 percent in 1998, due to increased premium yields and risk-sharing initiatives previously mentioned. During 1999, the Company believes its Commercial segment medical expense ratio will be benefitted by its continued focus on pricing its Commercial products at rates commensurate with the risk assumed and its control of claims cost trends, including its contractual relationships with providers. The Company believes that the industry's 1999 Commercial premium pricing environment will facilitate its Commercial premium rate increases. The Public Sector medical expense ratio increased to 84.8 percent in 1998 from 82.3 percent in 1997, primarily from lower Medicare HMO reimbursement rates, the 1997 growth of Medicare HMO membership in new, more costly markets outside the Company's base markets and increasing Medicaid costs in Puerto Rico. Although the expiration of the Puerto Rico Medicaid contract will improve the Public Sector medical expense ratio, for the Public Sector medical expense ratio to remain stable, the Company must continue to control its Medicare HMO medical costs during 1999 in line with the anticipated 2 percent premium yield increases. TRICARE's medical expense ratio improved 110 basis points in 1998 to 80.1 percent, the result of continuing utilization management, improved networks and contract price modifications. As previously described, this medical expense ratio discussion excludes the impact of premium deficiencies ($46 million) and the write-down of physician practice management receivables ($27 million). The inclusion of these two items increases the 1998 Commercial and Public Sector medical expense ratios to 82.9 percent and 86.0 percent, respectively.

Years Ended December 31, 1997 and 1996

Income before income taxes totaled $270 million for the year ended December 31, 1997, compared to $234 million for the year ended December 31, 1996. Net income was $173 million or $1.05 per diluted share in 1997, compared to $152 million or $.92 per diluted share in 1996. The earnings increase was primarily a result of increasing Commercial premium yields, improved hospital utilization and providing a full year of health care services under the TRICARE contract, which commenced during the third quarter of 1996. These favorable items were partially offset by higher than anticipated medical costs in the Company's new Medicare HMO markets and increased pharmacy costs system-wide. The acquisitions of PCA and ChoiceCare did not significantly impact 1997 earnings.

The Company's premium revenues increased 18 percent to $7.9 billion for the year ended December 31, 1997, from $6.7 billion for the year ended December 31, 1996. The premium revenue increase was primarily attributable to the full year impact of the TRICARE contract, the acquisitions of PCA and ChoiceCare and increased premium yields. TRICARE premium revenues increased $413 million in 1997 and the PCA and ChoiceCare acquisitions contributed premium revenues of approximately $512 million since their dates of acquisition. Premium rate changes contributed the remaining increase, as same-plan Commercial and Medicare HMO premium yields increased 4.2 percent and 4.3 percent, respectively.

During 1997, the Company's medical expense ratio increased to 82.8 percent from 82.7 percent for the year ended December 31, 1996 as a result of the PCA and ChoiceCare acquisitions. Excluding the effect of these acquisitions, the Company's medical expense ratio improved to 82.4 percent, reflecting the aforementioned premium yield increases, favorable physician cost trends (compared to premium yield increases) in the Company's Commercial products and an overall improvement in hospital utilization. These medical cost improvements were partially offset by higher than anticipated medical costs in the Company's new Medicare HMO markets (where a larger portion of membership growth was taking place) and increased pharmacy costs system-wide. As more fully described previously, the medical expense ratio discussion excludes the impact of the premium deficiencies recorded in 1996 of $105 million. The inclusion of these premium deficiencies increases the 1996 medical expense ratio from 82.7 percent to 84.2 percent.

The Company's administrative cost ratio was 15.5 percent and 15.3 percent for the years ended December 31, 1997 and 1996, respectively. Although investment spending in such areas as customer service, information systems and Medicare HMO product growth initiatives resulted in this year-over-year increase, efforts to rationalize the Company's staffing levels and streamline the organizational structure resulted in sequential quarterly improvements in the administrative cost ratio throughout 1997. The administrative expense ratio discussion excludes the impact of provisions in 1996 for litigation and certain other costs ($14 million) described previously. The inclusion of these costs increases the 1996 administrative expense ratio from 15.3 percent to 15.6 percent.

Interest income totaled $131 million for the year ended December 31, 1997, compared to $101 million for the year ended December 31, 1996. The increase is primarily attributable to a larger investment portfolio resulting from the addition of TRICARE, PCA and ChoiceCare. The tax equivalent yield on invested assets approximated 7.5 percent and 8 percent for the years ended December 31, 1997 and 1996, respectively. Tax equivalent yield is the rate earned on invested assets, excluding unrealized gains and losses, adjusted for the benefit of nontaxable investment income. The weighted average investment life decreased to 2.6 years at December 31, 1997, from 3.1 years at December 31, 1996.

Business Segment Information for the Years Ended December 31, 1997 and 1996

Commercial segment premiums increased 3 percent for the year ended December 31, 1997, from $4.3 billion to $4.4 billion. The increase was the result of the 1997 acquisitions and increased premium yields, partially offset by same-plan fully-insured membership reductions. Same-plan fully-insured membership declined 62,500 members, the result of a premium pricing discipline begun during the second half of 1996. Commercial same-plan ASO membership increased 130,000 or 28 percent during 1997. Public Sector premiums increased 32 percent for the year ended December 31, 1997, from $2.1 billion to $2.7 billion. The increase was the result of the aforementioned acquisitions, same-plan Medicare HMO membership growth in new markets and same-plan Medicare HMO premium yields of 4.4 percent. Same-plan Public Sector membership increased 31,500 or 6 percent in 1997, the result of Medicare HMO product growth of 19 percent, largely offset by a decline in membership for other Public Sector products. TRICARE premium revenues totaled approximately $764 million for the year ended December 31, 1997, compared to approximately $351 million for the period July 1 through December 31, 1996.

The following table depicts segment medical membership balances and activity as of and for the years ended December 31, 1997 and 1996, including the effect of the PCA and ChoiceCare acquisitions:

	1997			1996		
In Thousands	Commercial	Public Sector	TRICARE	Commercial	Public Sector	TRICARE
Beginning medical membership	3,231	517	1,103	3,330	474	-
Sales	703	254	-	587	196	1083
Cancellations	(635)	(222)	-	(686)	(153)	-
Acquisitions	735	659	-	-	-	-
Dispositions	(124)	(23)	-	-	-	-
TRICARE change	-	-	9	-	-	20
Ending medical membership	3,910	1,185	1,112	3,231	517	1,103

The Commercial medical expense ratio improved 50 basis points in 1997 to 83.3 percent. The improvement resulted from same-plan premium yield increases and favorable physician cost trends (compared to premium yield increases), partially offset by the higher medical expense ratio of the acquired plans. The Public Sector medical expense ratio increased from 80.3 percent in 1996 to 82.3 percent in 1997, resulting from higher than anticipated costs in the Company's new Medicare HMO markets. The TRICARE medical expense ratio improved from 83.6 percent during 1996 to 81.2 percent in 1997. This medical expense ratio discussion excludes the impact of premium deficiencies ($105 million). The inclusion of this item increases the 1996 Commercial medical expense ratio to 86.3 percent.

Liquidity

During 1998, cash provided by the Company's operations was $76 million, compared to cash provided by operations in 1997 and 1996 of $289 million and $341 million, respectively. Cash flow in 1998 was negatively impacted by the 1997 PCA acquisition, including paydowns of medical claims backlogs, cash advances to providers and severance payments. Also during 1998, the Company made cash payments of $134 million related to the closed block of PCA workers' compensation business. The 1997 decline in net cash provided by operations was the result of changes in operating assets and liabilities, increased TRICARE receivables and more timely medical claims processing.

Cash provided by investing activities totaled $7 million in 1998, compared to cash used for investing activities of $664 million in 1997. The use of cash for investing activities during 1997 was primarily the result of the PCA and ChoiceCare acquisitions. Cash provided by financing activities was $51 million in 1998 compared to $679 million in 1997. Cash provided in 1998 was the result of the timing of book overdrafts, while in 1997 cash provided by financing activities was the result of borrowings to finance acquisitions.

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

The Company maintains a revolving credit agreement ("Credit Agreement") which provides additional liquidity under a line of credit of up to $1.5 billion. Borrowings under this Credit Agreement were $93 million and $300 million at December 31, 1998 and 1997, respectively. The Company also maintains a commercial paper program and issues debt securities thereunder. The commercial paper program is backed by the Credit Agreement. Commercial paper borrowings averaged $659 million in 1998 at a weighted average interest rate of 5.9 percent. Commercial paper borrowings outstanding at December 31, 1998 and 1997 was $730 million and $589 million, respectively.

The Company intends to repay approximately $250 million of its outstanding debt with the proceeds of operating subsidiary dividends expected to be received during 1999. All borrowings under both the Credit Agreement and commercial paper program, except the planned 1999 repayments, have been classified as long-term debt based on management's ability and intent to refinance borrowings on a long-term basis.

Management believes that existing working capital, future operating cash flows and funds available under the existing revolving 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 to fund capital requirements.

Risk Sensitive Financial Instruments and Positions

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

The Company has evaluated the interest income and debt expense impact resulting from a hypothetical change in interest rates of 100, 200 and 300 basis points over the next 12-month period, as reflected in the table below. In the past 10 years, annual changes in commercial paper rates have never exceeded 300 basis points, changed between 200 and 300 basis points twice, and changed between 100 and 200 basis points twice. The modeling technique used to calculate the pro forma net change considered the cash flows related to fixed income investments and debt, including the repayment of $250 million of debt in 1999, which are subject to interest rate changes during a prospective 12-month period.

Dollars in millions	Increase (decrease) in earnings given an interest rate decrease of X basis points			Increase (decrease) in earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
1998						
Fixed income portfolio	$(11.9)	$ (7.9)	$(4.0)	$ 4.0	$ 8.0	$ 12.0
Debt	5.7	3.8	1.9	(1.9)	(3.8)	(5.7)
Total	$ (6.2)	$ (4.1)	$(2.1)	$ 2.1	$ 4.2	$ 6.3
1997						
Fixed income portfolio	$(15.1)	$(10.0)	$(5.0)	$ 4.9	$ 9.9	$ 14.8
Debt	12.3	8.2	4.1	(4.1)	(8.2)	(12.3)
Total	$ (2.8)	$ (1.8)	$ (.9)	$ .8	$ 1.7	$ 2.5

Humana Inc.

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

Dollars in millions	Decrease in valuation of security given an X% decrease in each equity security's value			Fair value as of December 31,	Increase in valuation of security given an X% increase in each equity security's value		
	(30%)	(20%)	(10%)		10%	20%	30%
1998							
Common equity securities	$(18.6)	$(12.4)	$(6.2)	$62.1	$6.2	$12.4	$18.6
1997							
Common equity securities	$(15.5)	$(10.4)	$(5.2)	$51.8	$5.2	$10.4	$15.5

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

Capital Resources

The Company's ongoing capital expenditures relate primarily to administrative facilities and information systems necessary for activities such as claims processing, billing and collections, medical utilization review and customer service. Total capital expenditures, excluding acquisitions, were $104 million, $73 million and $72 million for the years ended December 31, 1998, 1997 and 1996, respectively. Capital expenditures during 1998 included the $32 million purchase and renovation of a regional customer service center in Jacksonville, Florida.

Excluding acquisitions, planned capital spending in 1999 will approximate $80 to $90 million for the expansion and improvement of administrative facilities and 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 products are generally approved by the respective state insurance commissioners, while

increases in premiums for Medicaid and Medicare HMO products are established by various state governments and the Health Care Financing Administration. Premium rates under the TRICARE contract with the United States Department of Defense may be adjusted on a year by year basis to reflect inflation, changes in the workload volumes of military medical facilities and contract modifications.

The Company's 1999 average rate of statutory increase under the Medicare contracts is approximately 2 percent. Over the last five years, annual increases have ranged from as low as the January 1998 increase of 2 percent to as high as 9 percent in January 1996, with an average of approximately 5 percent. The Company's Medicare contracts with the federal government are renewed for a one-year term each December 31 unless terminated 90 days prior thereto.

Legislative proposals are being considered which may revise the Medicare program's current support of the use of managed health care for Medicare beneficiaries and the future reimbursement rates thereunder. Management is unable to predict the outcome of these proposals or the impact they may have on the Company's financial position, results of operations or cash flows. The Company's Medicaid contracts are generally annual contracts with various states except for the two-year contract with the Commonwealth of Puerto Rico. The Puerto Rico contract, previously scheduled to expire March 31, 1999, has been extended one month to April 30, 1999. The Company does not expect to be able to renew the contract in Puerto Rico under favorable terms and, therefore, has announced its intention to close this market when the contract expires. Additionally, the Company's TRICARE contract is a one-year contract renewable annually for up to two additional years. The loss of these contracts (other than the contract in Puerto Rico) or significant changes in these programs as a result of legislative action, including reductions in payments or increases in benefits without corresponding increases in payments, would have a material adverse effect on the revenues, profitability and business prospects of the Company.

In addition, the Company continually contracts and seeks to renew contracts with providers at rates designed to ensure adequate profitability. To the extent the Company is unable to obtain such rates, its financial position, results of operations and cash flows could be adversely impacted. Currently, the Company is in renegotiations with a major provider and is unable to predict the impact of these negotiations on future rates.

The Company's Y2K Readiness Disclosure Statement

The Company operates one of the largest managed care data centers in the nation. The primary computing facility is located in Louisville, Kentucky with a satellite operation in Green Bay, Wisconsin. In 1998, Humana's Information Systems organization included 950 associates with an annual operating budget of $135 million. The Company's application systems are largely developed and maintained in-house by a staff of 400 application programmers who are versed in the use of state-of-the-art technology. All application systems are fully integrated and automatically pass data through various system processes. The information systems support marketing, sales, underwriting, contract administration, billing, financial, and other administrative functions as well as customer service, authorization and referral management, concurrent review, physician capitation and claims administration, provider management, quality management and utilization review.

The Company internally develops most of its own application systems software. All application systems must comply with strict standards for data integrity, file compatibility and architectural requirements. The Company maintains a central project coordination function and an architectural review function that ensure consistency across the application portfolio. The Company has subscribed to automated file processes and integrated data architectures for over twenty-five years.

The Year 2000 issue is the result of two potential malfunctions that may have an impact on the Company's systems and equipment. The first potential malfunction is the result of computers being programmed to use two rather than four digits to define the applicable year. The second potential malfunction arises where embedded microchips and micro-controllers have been designed using two rather than four digits to define the applicable year. As a result, certain of the Company's date-sensitive computer programs, building infrastructure components and medical devices, may recognize a date using "00" as the year 1900 rather than the year 2000. If uncorrected, the problem may result in computer system and program failures or equipment malfunctions that could result in a disruption of business operations (such as the payment of medical claims, premium billing and collection, and membership enrollment verification as well as the use of medical equipment such as heart defibrillators).

Humana's Information Systems organization operates in a centralized manner. The Company's data center and the majority of its programming and support staff are located at its corporate offices in Louisville, Kentucky. A Year 2000 project management office is in place to oversee the progress made in the assessment and correction of the Company's Year 2000 exposures.

In general, the Company's Year 2000 project consists of four phases -- assessment, remediation, validation, and implementation -- and is categorized into the following four components:

Information Technology (IT) - software essential for day-to-day operations including both internally developed software and third party software which interfaces therewith.

IT Infrastructure - mainframe, network, telecommunications interfaces and self-contained operating systems.

Third party business partners and intermediaries - entities on which the Company relies for transmission and receipt of claims, and encounter, membership and payment information, including federal and state governmental agencies such as the Health Care Financing Administration.

Non-IT Infrastructure - telecommunications equipment, elevators, public safety equipment (i.e., security and fire), medical equipment and HVAC systems.

The Company commenced the assessment of its Year 2000 exposures in 1996. Remediation efforts of internally developed software and third party software applications have also begun. The Company's plan is to have modified all critical mainframe systems and components in time for such systems and components to utilize the updated Year 2000 logic during the second quarter of 1999. Modifying all critical systems and components by the second quarter of 1999 will enable the majority of the modified programs to run in a production environment for a considerable period of time before encountering Year 2000 data. Of the Company's 98 mainframe systems identified in the assessment, 92 have been renovated, validated and are currently operating using the updated Year 2000 logic. During 1999, the remaining 6 systems will be modified, upgraded, or replaced and all systems will continue to be monitored and tested to ensure that they will function properly after December 31, 1999. In addition, the Company is in the process of contacting vendors, third party business partners and intermediaries in an effort to obtain the information necessary to address Year 2000 issues. The Company anticipates completing, in all material respects, its Year 2000 project by the end of the third quarter 1999. The Company's efforts are currently progressing on plan.

The Year 2000 project is currently estimated to have a minimum total cost of approximately $25 million. Project to date costs total $19.5 million, including

$18.5 million during the year ended December 31, 1998. Year 2000 expenses represented less than 15 percent of the Information Systems budget during 1998. Year 2000 costs are expensed as incurred and funded through operating cash flow.

The extent and magnitude of the Year 2000 project, as it will affect the Company both before and for some period after January 1, 2000, are difficult to predict or quantify. As a result, the Company has recently undertaken the development of contingency plans in the event that its Year 2000 project is not completed in an accurate or timely manner. The Company has identified five major functional areas, covering 20 operational subdivisions, that will require contingency plans. The five major functional areas are: providers, service centers, suppliers and vendors, customers and brokers, and banking and finance. The Company is in the process of developing and refining alternative operating procedures for each functional area. Additionally, a tracking system is being developed to monitor the implementation of these procedures.

While the Company presently believes that the timely completion of its Year 2000 project will limit exposure so that the Year 2000 will not pose material operational problems, the Company does not control third party systems. Although the Company is contacting third parties, the Company has not received assurances that all third party interfaces will be converted in a timely manner. Additionally, if Year 2000 modifications or upgrades are not accomplished in a timely manner or proper contingency plans are not implemented, Year 2000 failures which may result could have a material adverse impact on the Company's results of operations or its financial position.

The costs of the Year 2000 project and the date on which the Company plans to complete Year 2000 modifications are based on management's best estimates, considering assumptions of future events including the continued availability of certain resources and other factors. There can be no guarantee that these estimates will be achieved and actual results could differ materially from plan. Specific factors that might cause such material differences include, but are not limited to, the availability and cost of personnel trained in this area, the ability to locate and correct all relevant computer codes, and the ability of the Company's significant suppliers, customers and others with which it conducts business, including federal and state governmental agencies, to identify and resolve their own Year 2000 issues.

Impact of Recently Issued Accounting Pronouncements

In June 1998, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS 133"). In general, SFAS 133 requires that all derivatives be recognized as either assets or liabilities in the balance sheet at their face value, and sets forth the manner in which gains or losses thereon are to be recorded. The treatment of such gains and losses is dependent upon the type of exposure, if any, for which the derivative is designated as a hedge. This statement is effective for periods beginning after June 15, 1999. Management of the Company anticipates that, due to its limited use of derivative instruments, the adoption of SFAS 133 will not have a significant effect on the Company's results of operations or its financial position.

Other Information

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

Consolidated Balance Sheets

Humana Inc.

Dollars in millions, except per share amounts

December 31,	1998	1997
Assets		
Current assets:		
Cash and cash equivalents	$ 913	$ 779
Marketable securities	1,594	1,507
Premiums receivable, less allowance for doubtful accounts of $62 in 1998 and $48 in 1997	276	351
Deferred income taxes	129	164
Other	207	231
Total current assets	3,119	3,032
Property and equipment, net	433	420
Other assets:		
Long-term marketable securities	305	512
Cost in excess of net assets acquired	1,188	1,224
Deferred income taxes	64	60
Other	387	352
Total other assets	1,944	2,148
Total Assets	$5,496	$5,600
Liabilities and Stockholders' Equity		
Current liabilities:		
Medical and other expenses payable	$1,470	$1,478
Trade accounts payable and accrued expenses	395	511
Book overdraft	234	152
Unearned premium revenues	294	304
Short-term debt	250	-
Total current liabilities	2,643	2,445
Long-term medical and other expenses payable	438	597
Long-term debt	573	889
Professional liability and other obligations	154	168
Total liabilities	3,808	4,099
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; authorized 10,000,000 shares; none issued	-	-
Common stock, $.16 2/3 par; authorized 300,000,000 shares; issued and outstanding 167,515,362 shares - 1998 and 164,058,225 shares - 1997	28	27
Capital in excess of par value	894	841
Retained earnings	753	624
Accumulated other comprehensive income	13	9
Total stockholders' equity	1,688	1,501
Total Liabilities and Stockholders' Equity	5,496	$5,600

The accompanying notes are an integral part of the consolidated financial

statements.

Consolidated Statements of Income

Humana Inc.

Dollars in millions, except per share results

Years ended December 31,	1998	1997	1996
Revenues:			
Premiums	$9,597	$7,880	$6,677
Interest and other income	184	156	111
Total revenues	9,781	8,036	6,788
Operating expenses:			
Medical	8,041	6,522	5,625
Selling, general and administrative	1,328	1,116	940
Depreciation and amortization	128	108	98
Asset write-downs and other charges	34	-	96
Total operating expenses	9,531	7,746	6,759
Income from operations	250	290	29
Interest expense	47	20	11
Income before income taxes	203	270	18
Provision for income taxes	74	97	6
Net income	$ 129	$ 173	$ 12
Earnings per common share	$ .77	$ 1.06	$.07
Earnings per common share - assuming dilution	$ .77	$ 1.05	$.07

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

Consolidated Statements of Stockholders' Equity

Humana Inc.

In millions

	Common Stock Shares	Common Stock Amount	Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
Balances, January 1, 1996	162	$27	$815	$439	$ 6	$1,287

Comprehensive loss:						
Net income		-	-	12	-	12
Other comprehensive loss:						
Net unrealized investment loss, net of $(8) tax		-	-	-	(14)	(14)
Comprehensive loss						(2)
Other	1	-	7	-	-	7
Balances, December 31, 1996	163	27	822	451	(8)	1,292
Comprehensive income:						
Net income		-	-	173	-	173
Other comprehensive income:						
Net unrealized investment gain, net of $10 tax		-	-	-	17	17
Comprehensive income						190
Other	1	-	19	-	-	19
Balances, December 31, 1997	164	27	841	624	9	1,501
Comprehensive income:						
Net income		-	-	129	-	129
Other comprehensive income:						
Net unrealized investment gain, net of $2 tax		-	-	-	4	4
Comprehensive income						133
Other	4	1	53	-	-	54
Balances, December 31, 1998	168	$28	$894	$753	$13	$1,688

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

Consolidated Statements of Cash Flows

Humana Inc.

Dollars in millions

Years Ended December 31,	1998	1997	1996
Cash flows from operating activities			
Net income	$ 129	$ 173	$ 12
Adjustments to reconcile net income to net cash provided by operating activities:			
Asset write-downs and losses on sales of assets	17	-	70
Depreciation and amortization	128	108	98
Deferred income taxes	26	40	(25)
Changes in operating assets and liabilities:			
Premiums receivable	45	(102)	(81)
Other assets	32	(47)	(31)
Medical and other expenses payable	(22)	(118)	215
Workers' compensation liabilities	(134)	(31)	-
Other liabilities	(135)	57	84
Unearned premium revenues	(10)	203	(3)
Other	-	6	2
Net cash provided by operating activities	76	289	341
Cash flows from investing activities			
Acquisitions of health plan assets, net of cash acquired	-	(669)	(6)
Purchases of property and equipment	(104)	(73)	(72)
Dispositions of property and equipment	12	15	5
Purchases of marketable securities	(1,037)	(608)	(440)
Maturities and sales of marketable securities	1,174	648	356
Other	(38)	23	(17)

Net cash provided by (used in) investing activities	7	(664)	(174)
Cash flows from financing activities			
Issuance of long-term debt	123	300	-
Repayment of long-term debt	(330)	-	(250)
Net commercial paper borrowings	141	367	222
Change in book overdraft	82	(1)	(25)
Other	35	13	1
Net cash provided by (used in) financing activities	51	679	(52)
Increase in cash and cash equivalents	134	304	115
Cash and cash equivalents at beginning of period	779	475	360
Cash and cash equivalents at end of period	$913	$779	$475
Supplemental cash flow disclosure:			
Interest payments	$ 49	$ 15	$ 11
Income tax payments	69	8	39

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. ("the Company") is a health services company that facilitates the delivery of health care services through networks of providers. The Company's products are marketed primarily through health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs") that encourage or require the use of contracted providers. HMOs and PPOs control health care costs by various means, including pre-admission approval for hospital inpatient services, pre-authorization of outpatient surgical procedures, and risk-sharing arrangements with providers. These providers may share medical cost risk or have other incentives to deliver quality medical services in a cost-effective manner. The Company also offers various specialty products to employers, including dental, group life and workers' compensation, and administrative services ("ASO") to those who self-insure their employee health plans. In total, the Company's products are licensed in 47 states, the District of Columbia and Puerto Rico, with approximately 21 percent of its membership in the state of Florida.

The Company markets and distributes its products to three distinct customer groups and, therefore, reports operations in three business segments. Results of each segment are measured based on premium revenues and underwriting margin (premium revenues less medical expenses). The Company does not allocate assets or administrative costs to the segments and, therefore, does not measure results based on segment assets or pretax profits. Members from all three segments generally utilize the same medical provider networks, enabling the Company to obtain more favorable contract terms with providers. As a result, the profitability of each segment is somewhat interdependent.

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

Marketable Securities

At December 31, 1998 and 1997, 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 capital spending, professional liability, long-term insurance product requirements and payment of long-term workers' compensation claims are classified as long-term assets. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity until realized.

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

Long-Lived Assets

Property and equipment is carried at cost and comprises the following at December 31, 1998 and 1997:

Dollars in millions	1998	1997
Land	$ 33	$ 33
Buildings	355	302
Equipment	400	393
	788	728
Accumulated depreciation	(355)	(308)
	$ 433	$ 420

Depreciation is computed using the straight-line method over estimated useful lives ranging from three to 10 years for equipment and 20 years for buildings. Depreciation expense was $75 million, $66 million and $59 million for the years ended December 31, 1998, 1997 and 1996, respectively.

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. Accumulated amortization totaled $69 million and $37 million at December 31, 1998 and 1997, respectively.

The carrying values of all long-lived assets are periodically reviewed by management for impairment, based upon undiscounted future cash flows, and appropriate losses are recognized whenever the carrying value of an asset may not be recoverable.

Revenue and Medical Cost Recognition

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

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

The Company assesses the profitability of its contracts for providing health care services to its members when current operating results or forecasts indicate probable future losses. The Company records a premium deficiency in current operations to the extent that the sum of expected health care costs, claim adjustment expenses and maintenance costs exceeds related future premiums. Anticipated investment income is not considered for purposes of computing the premium deficiency. During the years ended December 31, 1998 and 1996, the Company recorded premium deficiencies approximating $46 million and $105 million, respectively.

Management believes the Company's medical and other expenses payable are adequate to cover future claims payments required, however, such estimates are subject to changes in assumptions, and, therefore, the actual liability could differ from amounts provided.

Book Overdraft

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

Stock Options

The Company has adopted the disclosure-only provisions of Statement of Financial Accounting Standards No. 123, "Accounting for Stock-Based Compensation" ("SFAS 123") and continues to apply Accounting Principles Board.

Opinion No. 25 and related interpretations in the accounting for its stock option plans. No compensation expense has been recognized in connection with the granting of stock options. See Note 8 for discussion of stock options and the disclosures required by SFAS 123.

Earnings Per Common Share

Detail supporting the computation of earnings per common share and earnings per common share-assuming dilution follows:

Dollars in millions, except per share results

Year Ended December 31, 1998	Net Income	Shares	Per Share Results
Earnings per common share	$ 129	166,471,824	$ .77
Effect of dilutive stock options		1,792,756	
Earnings per common share - assuming dilution	$ 129	168,264,580	$ .77
Year Ended December 31, 1997			
Earnings per common share	$ 173	163,406,460	$1.06

Effect of dilutive stock options		2,436,019	
Earnings per common share - assuming dilution	$ 173	165,842,479	$1.05

Year Ended December 31, 1996			
Earnings per common share	$ 12	162,531,524	$ .07
Effect of dilutive stock options		2,747,294	
Earnings per common share - assuming dilution	$ 12	165,278,818	$ .07

Options to purchase 1,562,949, 2,414,148 and 1,580,891 shares for the years ended December 31, 1998, 1997 and 1996, respectively, were not included in the computation of earnings per common share-assuming dilution because the options' exercise prices were greater than the average market price of the common shares during the periods.

Reclassifications

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

Adoption of Recent Accounting Pronouncements

In 1998, the Company adopted Statement of Financial Accounting Standards No. 130, "Reporting Comprehensive Income" ("SFAS 130"). SFAS 130 establishes standards for reporting and display of changes in equity from non-owner sources in the financial statements. Non-owner changes in stockholders' equity consists of unrealized investment gains or losses on marketable securities and, as permitted under the provisions of SFAS 130, are presented in the Consolidated Statements of Stockholders' Equity. The adoption of SFAS 130 did not affect results of operations or financial position but did affect disclosure of comprehensive income.

In 1998, the Company adopted Statement of Financial Accounting Standards No. 131, "Disclosures About Segments of an Enterprise and Related Information" ("SFAS 131"). SFAS 131 establishes new requirements for the reporting of segment information under a new framework referred to as the management approach. The management approach designates the internal organization that is used by management for making operating decisions and assessing performance as the source of the Company's reportable segments. The adoption of SFAS 131 did not affect results of operations or financial position but did affect disclosure of segment information.

In 1998, the Company also adopted Statement of Position 98-1, "Accounting for the Costs of Computer Software Developed or Obtained for Internal Use" ("SOP 98-1"), issued by the AICPA's Accounting Standards Executive Committee in March 1998. SOP 98-1 specifies the costs to be capitalized in connection with obtaining or developing computer software to be used solely to meet the Company's internal needs. Computer software costs capitalized in 1998 were approximately $9 million.

3. Asset Write-Downs and Other Charges

In 1998, the Company recorded asset write-downs and other charges of $34 million. The charges included severance and lease termination costs associated with closing five markets (Sarasota and Treasure Coast, Florida, Springfield and Jefferson City, Missouri and Puerto Rico) and discontinuing products ($5 million), write-downs of receivables and certain property and equipment associated with closing markets ($10 million), losses on disposals of non-strategic assets ($12 million) and merger dissolution costs ($7 million). Charges for estimated employee severance costs were based on the Company's employee benefit plan arrangements. Significant market closure activities are expected to be completed by the end of the second quarter of 1999 as membership lapses or existing contracts expire. Total premium revenues and underwriting profits associated with market closures and discontinued products approximated $665 million and $50 million, respectively, for the year ended December 31,

1998.

Activity related to these charges for the year ended December 31, 1998 follows (in millions):

Provision for asset write-downs and other charges	$ 34
Usage (non-cash)	(17)
Usage (cash)	(10)
Balance remaining at December 31, 1998	$ 7

In 1996, the Company recorded asset write-downs and other charges of $96 million. These charges included write-downs of long-lived assets associated with the Company's Washington, D.C., health plan which was sold in 1997 ($70 million), severance and lease termination costs for workforce reductions undertaken during 1997 ($15 million) and market closure and product discontinuance costs ($11 million). Substantially all amounts related to the cash portion of these charges were paid before the end of 1997.

4. Marketable Securities

Marketable securities classified as current assets at December 31, 1998 and 1997 included the following:

	1998				1997			
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 obligations	$ 165	$ 4	$ -	$ 169	$ 178	$ 1	$ -	$ 179
Tax exempt municipal bonds	845	6	-	851	723	5	(2)	726
Corporate bonds	250	8	-	258	282	6	-	288
Redeemable preferred stocks	124	1	-	125	113	1	(2)	112
Marketable equity securities	129	2	(2)	129	114	5	(1)	118
Other	59	3	-	62	80	4	-	84
	$1,572	$24	$(2)	$1,594	$1,490	$22	$ (5)	$1,507

Marketable securities classified as long-term assets at December 31, 1998 and 1997 included the following:

	1998				1997			
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 obligations	$ 5	$ -	$ -	$ 5	$ 146	$ -	$ -	$ 146
Tax exempt municipal bonds	234	4	(1)	237	284	3	(2)	285
Redeemable preferred stocks	31	-	-	31	16	-	-	16
Marketable equity securities	2	-	-	2	19	1	-	20
Other	30	-	-	30	45	-	-	45
	$ 302	$ 4	$(1)	$ 305	$ 510	$ 4	$ (2)	$ 512

The contractual maturities of debt securities available for sale at December 31, 1998, 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	$ 178	$ 180

Due after one year through five years	579	590
Due after five years through ten years	410	420
Due after ten years	220	224
Not due at a single maturity date	356	354
	$1,743	$1,768

Realized gains and losses for the years ended December 31, 1998, 1997 and 1996 were approximately $21 million, $10 million and $2 million, respectively.

5. Income Taxes

The provision for income taxes consisted of the following:

	Years Ended December 31,		
Dollars in millions	1998	1997	1996
Current provision:			
Federal	$ 39	$ 51	$ 30
State	9	6	1
	48	57	31
Deferred provision (benefit):			
Federal	24	36	(23)
State	2	4	(2)
	26	40	(25)
	$ 74	$ 97	$ 6

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

	Years Ended December 31,		
Dollars in millions	1998	1997	1996
Income tax provision at federal statutory rate	$ 71	$ 95	$ 6
State income taxes, net of federal benefit	8	10	1
Tax exempt investment income	(18)	(13)	(12)
Amortization	17	10	12
Other items, net	(4)	(5)	(1)
	$ 74	$ 97	$ 6

Cumulative temporary differences which gave rise to deferred tax assets and liabilities at December 31, 1998 and 1997 were as follows:

	Assets (Liabilities)	
Dollars in millions	1998	1997
Marketable securities	$ (8)	$ (6)
Long-term assets	(46)	(42)
Medical and other expenses payable	95	126
Liabilities for charges	16	14
Professional liability risks	7	11
Net operating loss carryforwards	58	77
Other	71	44
	$ 193	$ 224

At December 31, 1998, the Company has available tax net operating loss carryforwards of approximately $150 million related to prior acquisitions. These loss carryforwards, if unused to offset future taxable income of the acquired subsidiaries, will expire in 2002 through 2012.

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

6. Long-Term Debt

The Company maintains a revolving credit agreement ("Credit Agreement") which provides a line of credit of up to $1.5 billion. Principal amounts outstanding under the Credit Agreement bear interest at either a fixed rate or a floating rate, ranging from LIBOR plus 12 basis points to LIBOR plus 30 basis points, depending on the ratio of debt to debt plus net worth. The Credit Agreement contains customary covenants and events of default and expires in August 2002. The Company also maintains and issues debt securities under a commercial paper program, which is backed by the Credit Agreement.

The Company intends to repay approximately $250 million of its outstanding debt with the proceeds from operating subsidiary dividends expected to be received during 1999. All borrowings under both the Credit Agreement and commercial paper program, except $250 million, have been classified as long-term debt based on management's ability and intent to refinance borrowings on a long-term basis.

Borrowings and the weighted average interest rate on those borrowings as of December 31, 1998 and 1997 were as follows:

	1998		1997	
Dollars in millions	Amount	Weighted Average Interest Rate	Amount	Weighted Average Interest Rate
Credit Agreement	$ 93	5.9%	$ 300	6.2%
Commercial paper program	730	5.9%	589	5.9%
Total debt	823		889	
Less: short-term debt	250		-	
Total long-term debt	$ 573		$ 889	

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 $27 million, $32 million and $31 million for the years ended December 31, 1998, 1997 and 1996, 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 and reinsurance recoverables related to the funding thereof included in the accompanying consolidated balance sheets were $123 million and $111 million at December 31, 1998 and 1997, 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 sheets consist primarily of liabilities for disability and other long-term insurance products, leases and the Company's employee retirement and benefit plans. These liabilities totaled $53 million and $77 million at December 31, 1998 and 1997, respectively.

8. Stockholders' Equity

The Company has adopted a stockholders' rights plan designed to deter takeover initiatives not considered to be in the best interests of the Company's stockholders. The rights are redeemable by action of the Company's Board of Directors at a price of $.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 restricted stock awards and options to purchase common stock have been granted to officers, directors and key employees. In 1998, the Company awarded 400,000 shares at $14.38 of performance-based restricted stock to officers and key employees. The shares vest in equal one-third installments beginning January 1, 2000, provided the Company meets certain earnings goals. Unearned compensation under the restricted stock awards plan is amortized over the vesting period. Compensation expense recognized related to the restricted stock award plans was $3 million in 1998.

Options are granted at the 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 10 years after grant. At December 31, 1998, there were 15,883,609 shares reserved for employee and director stock option plans. At December 31, 1998, there were 4,043,385 shares of common stock available for future grants. In January 1999, a total of 1,861,500 options were granted and 6,000 shares were awarded to directors in lieu of director fees.

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

The Company's option plan activity for the years ended December 31, 1998, 1997 and 1996 is summarized below:

	Shares Under Option	Exercise Price Per Share			Weighted Average Exercise Price
Balance, January 1, 1996	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
Granted	2,819,000	18.31	to	23.69	19.79
Exercised	(1,247,793)	4.32	to	23.06	8.67
Canceled or lapsed	(270,830)	6.56	to	23.06	17.32
Balance, December 31, 1997	12,222,264	5.80	to	26.94	15.54
Granted	6,403,788	15.59	to	26.22	17.04
Exercised	(3,067,202)	5.80	to	26.31	11.72
Canceled or lapsed	(6,753,198)	6.56	to	26.31	20.03
Balance, December 31, 1998	8,805,652	$ 6.56	to	$ 26.94	$ 14.52

A summary of stock options outstanding and exercisable at December 31, 1998 follows:

Range of Exercise Prices			Stock Options Outstanding			Stock Options Exercisable	
			Shares	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Shares	Weighted Average Exercise Price
$ 6.56	to	$ 9.64	2,032,160	4.0 years	$ 6.97	2,032,160	$ 6.97
10.54	to	14.44	104,700	2.7 years	11.38	104,700	11.38
15.59	to	19.31	6,036,658	7.8 years	16.29	1,112,551	18.40
20.16	to	22.97	304,800	7.8 years	21.16	81,402	22.20
23.06	to	26.94	327,334	4.9 years	23.50	305,668	23.46
$ 6.56	to	$ 26.94	8,805,652	6.7 years	$ 14.52	3,636,481	$ 12.32

As of December 31, 1997 and 1996, there were 6,215,776 and 4,786,969 options exercisable, respectively. The weighted average exercise price of options exercisable during 1997 and 1996 was $13.32 and $11.05, respectively.

If the Company had adopted the expense recognition provisions of SFAS 123 for purposes of determining compensation expense related to stock options granted during the years ended December 31, 1998, 1997 and 1996, 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, 1998	1997	1996
Net income	As reported	$ 129	$ 173	$ 12
	Pro forma	116	159	4
Earnings per common share	As reported	$ .77	$1.06	$.07
	Pro forma	.69	.97	.02
Earnings per common share - assuming dilution	As reported	$ .77	$1.05	$.07
	Pro forma	.69	.96	.02

The fair value of each option granted during 1998, 1997 and 1996 was estimated on the date of grant using the Black-Scholes pricing model with the following weighted average assumptions:

	1998	1997	1996
Dividend yield	None	None	None
Expected volatility	40.9%	38.5%	40.2%
Risk-free interest rate	4.9%	6.1%	7.0%
Expected option life (years)	6.8	5.4	5.8
Weighted average fair value at grant date	$8.59	$8.88	$8.92

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

9. Commitments and Contingencies

The Company's Medicare contracts with the federal government are renewed for a one-year term each December 31 unless terminated 90 days prior thereto. Legislative proposals are being considered which may revise the Medicare program's current support of the use of managed health care for Medicare beneficiaries and the future reimbursement rates thereunder. Management is unable to predict the outcome of these proposals or the impact they may have on the Company's financial position, results of operations or cash flows. The Company's Medicaid contracts are generally annual contracts with various states except for the two-year contract with the Commonwealth of Puerto Rico. The Puerto Rico contract, previously scheduled to expire March 31, 1999, has been extended one month to April 30, 1999. The Company does not expect to be able to renew the contract in Puerto Rico under favorable terms and, therefore, has announced its intention to close this market when the contract expires. Additionally, the Company's TRICARE contract is a one-year contract renewable annually for up to two additional years. The loss of these contracts (other than the contract in Puerto Rico) or significant changes in these programs as a result of legislative action, including reductions in payments or increases in benefits without corresponding increases in payments, would have a material adverse effect on the revenues, profitability and business prospects of the Company. In addition, the Company continually contracts and seeks to renew contracts with providers at rates designed to ensure adequate profitability. To the extent the Company is unable to obtain such rates, its financial position, results of operations and cash flows could be adversely impacted. Currently, the Company is in renegotiations with a major provider and is unable to predict the impact of these negotiations on future contract rates.

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

10. Acquisitions

On October 17, 1997, the Company acquired ChoiceCare Corporation ("ChoiceCare") for approximately $250 million in cash. The purchase was funded with borrowings under the Company's commercial paper program. ChoiceCare

provided health services products to members in the Greater Cincinnati, Ohio, area.

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

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

The above acquisitions were accounted for under the purchase method of accounting. In connection with these acquisitions, the Company allocated the acquisition costs to tangible and identifiable intangible assets based upon their fair values. Identifiable intangible assets, which are included in other long-term assets in the accompanying consolidated balance sheets, primarily relate to subscriber and provider contracts. Any remaining value not assigned to 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 $754 million in 1997. Subscriber and provider contracts are amortized over their estimated useful lives (seven 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 statements 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 at the beginning of the year preceding the year of acquisition:

	Years Ended December 31,	
Dollars in millions, except per share results	1997	1996
Revenues	$9,272	$8,581
Net income (loss)	64	(271)
Earnings (loss) per common share	$ .39	$(1.67)
Earnings (loss) per common share - assuming dilution	.39	(1.67)

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 at the beginning of the year preceding the year of acquisition.

11. Segment Information

The Company markets and distributes its products to three distinct customer groups and, therefore, reports operations in three business segments. Results of each segment are measured based on premium revenues and underwriting margin (premium revenues less medical expenses). The Company does not allocate assets or administrative costs to the segments and, therefore, does not measure results based on segment assets or pretax profits. Members from all three segments generally utilize the same medical provider networks, enabling the Company to obtain more favorable contract terms with providers. As a result, the profitability of each segment is somewhat interdependent. The accounting policies of each segment are similar and are described in Note 2 to the consolidated financial statements.

Commercial Segment

Facilitates delivery of health care services to the employees of Commercial enterprises with which the Company has negotiated actuarially determined premium rates.

Public Sector Segment

Facilitates delivery of health care services to Medicaid- and Medicare-eligible individuals at premium rates generally established by the various state governments and the Health Care Financing Administration.

TRICARE Segment

Facilitates delivery of health care services for the dependents of active military personnel and retired military personnel and their dependents located in the Southeastern United States, under a managed care support contract awarded through a competitive bid process conducted by the United States Department of Defense.

The segment results are as follows:

Dollars in millions	1998	1997	1996
Premium revenues:			
Commercial	$ 5,257	$ 4,387	$4,255
Public Sector	3,540	2,729	2,071
TRICARE	800	764	351
Total for reportable segments	9,597	7,880	6,677
Non-allocated revenues - interest and other income	184	156	111
Total consolidated revenues	$ 9,781	$ 8,036	$6,788
Underwriting margin:			
Commercial	$ 900	$ 732	$ 585
Public Sector	497	482	409
TRICARE	159	144	58
Total for reportable segments	1,556	1,358	1,052
Other, non-allocated revenue and expense:			
Interest and other income	184	156	111
Selling, general and administrative expenses	(1,328)	(1,116)	(940)
Depreciation and amortization	(128)	(108)	(98)
Asset write-downs and other charges	(34)	-	(96)
Interest expense	(47)	(20)	(11)
Total consolidated income before income tax	$ 203	$ 270	$ 18

The Company's product offerings include managed health care products and specialty products. Managed health care products facilitate the delivery of health care services through networks of providers and consist primarily of HMO, PPO and Medicare HMO products. Managed health care product premiums were approximately $9,358 million, $7,650 million and $6,483 million for the years ended December 31, 1998, 1997 and 1996, respectively. The Company markets various specialty products to its Commercial segment including dental, group life, workers' compensation and ASO. Specialty product premiums were approximately $239 million, $230 million, and $194 million for the years ended December 31, 1998, 1997 and 1996, respectively.

Premium revenues derived from contracts with the federal government in 1998, 1997 and 1996 represent approximately 41 percent, 43 percent and 38 percent, respectively, of total premium revenues.

Report of Independent Accountants

To the Board of Directors
Humana Inc.

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of income, stockholders' equity and cash flows present fairly, in all material respects, the consolidated financial position of Humana Inc. and its subsidiaries at December 31, 1998 and 1997, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 1998, in conformity with generally accepted accounting principles. These financial statements are the responsibility of the Company's management; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with generally accepted auditing standards which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for the opinion expressed above.

PricewaterhouseCoopers LLP
Louisville, Kentucky
February 9, 1999

Quarterly Financial Information (Unaudited)

Humana Inc.

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

Dollars in millions, except per share results	1998			
	First	Second	Third (a) (b)	Fourth
Revenues	$2,402	$2,446	$2,464	$2,469
Income (loss) before income taxes	79	82	(47)	89
Net income (loss)	50	52	(30)	57
Earnings (loss) per common share	.30	.31	(.18)	.34
Earnings (loss) per common share - assuming dilution	.30	.31	(.18)	.34

Dollars in millions, except per share results	1997 (c)			
	First	Second	Third	Fourth
Revenues	$1,832	$1,836	$1,968	$2,400
Income before income taxes	60	65	69	76
Net income	39	42	44	48
Earnings per common share	.24	.26	.27	.29
Earnings per common share - assuming dilution	.24	.25	.27	.29

(a) Includes charges associated with certain market closures, merger dissolution and losses on disposals of non-strategic assets of $34 million pretax ($22 million after tax or $.13 per diluted share).
(b) Includes premium deficiencies of $46 million pretax ($29 million after tax or $.17 per diluted share), a one-time incentive for non-officer employees of $16 million pretax ($10 million after tax or $.06 per diluted share) and other costs of $36 million pretax ($23 million after tax or $.14 per diluted share).
(c) Includes the operations of Health Direct, Inc., Physician Corporation of America and ChoiceCare Corporation since their dates of acquisition, February 28, 1997, September 8, 1997 and October 17, 1997, respectively.

Board of Directors

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

David A. Jones
Chairman of the Board, Humana Inc.

Michael E. Gellert
General Partner, Windcrest Partners, private investment partnership

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

W. Ann Reynolds, Ph.D.
President, University of Alabama at Birmingham

Gregory H. Wolf
President and Chief Executive Officer, Humana Inc.

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

Irwin Lerner
Retired Chairman of the Board and Executive Committee, Hoffmann-La Roche Inc.

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David A. Jones, Jr.
Gregory H. Wolf

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Investment Committee
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Nominating and Corporate Governance Committee
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Organization and Compensation Committee
Irwin Lerner, Chairman
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Michael E. Gellert
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President and Chief Executive Officer

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Regional Vice President

George G. Bauernfeind
Vice President - Tax

R. Joseph Berding
Regional Vice President

Jeffrey B. Bringardner
Vice President - National and Major Accounts

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Regional Vice President

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Vice President - Commercial Large Group Segment

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Vice President - Investment Management and Treasurer

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Vice President - Dental

Lois E. Gargotto
Vice President - Systems Development

David K. George
Vice President - Medicare Sales

David M. Krebs
Vice President - Finance and Controller

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Vice President - Women's Health

Joan O. Lenahan
Corporate Secretary

Thomas J. Liston
Vice President - Corporate Development

Heidi S. Margulis
Vice President - Government Affairs

Carol J. McCall
Vice President - Pharmacy Operations

Michael B. McCallister
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Vice President - Accreditation and Compliance

James E. Murray
Senior Vice President and Chief Financial Officer

Walter E. Neely
Vice President and Associate General Counsel

David R. Nelson
Vice President and Chief Actuary

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Vice President - Underwriting

Mark W. Owen
Vice President - Public Sector Programs

John R. Pegues
Vice President - Strategy and Corporate Development

Kathleen Pellegrino
Vice President and Associate General Counsel

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Senior Vice President - National Contracting

Jerry D. Reeves, M.D.
Senior Vice President and Chief Medical Officer

Thomas C. Rekart
Vice President - Operations Services

Gregory K. Rotherham
Vice President - Customer Service Operations

Kirk E. Rothrock
Senior Vice President - Specialty Products and Services and International Businesses

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Regional Vice President

L. Bryan Shaul
Vice President - Mergers and Acquisitions

R. Eugene Shields
President - Humana Military Healthcare Services

John T. Terry
Vice President - Telemarketing Sales

Diana L. Tortelli
Vice President - Commercial Sales

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Vice President and Medical Director, Population Health Improvement

George W. Vieth, Jr.
Senior Vice President - Market Segment Management

Melissa L. Weaver, M.D.
Vice President - Health Resource Effectiveness and Corporate Medical Director

David W. Wille
Vice President - Actuarial Services

Tod J. Zacharias
Vice President - Commercial Small Group Segment

Thomas G. Zielinski
Vice President - Wisconsin Service Center Operations

Additional Information

Transfer Agent

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

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.

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

1997	High	Low
First Quarter	23	17-3/4
Second Quarter	24-1/4	20-1/8
Third Quarter	24-15/16	22-13/16
Fourth Quarter	24-5/8	18-7/8

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 6, 1999, 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.
2. QuestCare, Inc.

CALIFORNIA
- ----------
1. Centerstone Insurance and Financial Services (Marketpoint is a Division of CFS) - Doing Business As:
   a. Centerstone Insurance Agency and Financial Services, Inc.
   b. West Coast Multiple Servs, Inc.

DELAWARE
- --------
1. Centerstone Holding Corporation
2. EMPHESYS Financial Group, Inc.
3. Health Value Management, Inc.
4. Humana Compensation Management Source, Inc.
5. Humana HealthChicago, Inc
6. Humana Inc. - Doing Business As:
   a. H.A.C. Inc.
   b. Humana of Delaware, Inc.
7. Humana Military Healthcare Services, Inc. - Doing Business As:
   a. Humana Military Health Services, Inc.
8. Humrealty, Inc.
9. Medstep, Inc.
10. Physician Corporation of America

FLORIDA
- -------
1. Delray Beach Health Management Associates, Inc. - Doing Business As:
   a. Humana Health Care Plans-Delray
2. Family Health Plan Administrators, Inc.
3. Health Inclusive Plan of Florida, Inc. - Doing Business As:
   a. Humana Health Care Plans-Century Village Palm Beach
4. Humana Health Care Plans - Davie, Inc. f/k/a Coastal Physician Group of South Davie, Inc.
5. Humana Health Care Plans - Palm Springs, Inc. f/k/a Coastal Managed Care of Lake Worth, Inc.
6. Humana Health Care Plans - Rolling Hills, Inc. f/k/a Coastal Physician Group of North Davie, Inc.
7. Humana Health Care Plans - South Pembroke Pines, Inc. f/k/a Coastal Physician Group of Pembroke Pines, Inc.
8. Humana Health Care Plans - West Palm Beach, Inc. f/k/a Coastal Managed Care of West Palm Beach, Inc.
9. Humana Internal Medicine Associates, Inc. f/k/a Coastal Internal Medicine Associates of Dade, Inc. - Doing Business As:
   a. Humana Health Care Plans-Hialeah f/k/a Coastal Internal Medicine Associates of Hialeah
   b. Humana Health Care Plans-South Miami f/k/a Coastal Internal Medicine Associates of Larkin
   c. Humana Health Care Plans-Miami f/k/a Coastal Internal Medicine Associates of Miami
   d. Humana Health Care Plans-Miami Beach f/k/a Coastal Internal Medicine Associates of Miami Beach
   e. Humana Health Care Plans-Royal Oaks f/k/a Coastal Internal Medicine Associates of Miami Lakes
   f. Humana Health Care Plans-Miami Springs f/k/a Coastal Internal Medicine Associates of Miami Springs
   g. Humana Health Care Plans-Midway f/k/a Coastal Internal Medicine Associates of Midway
   h. Humana Health Care Plans-Boca Raton
   i. Humana Health Care Plans-Delray Harbor
   j. Humana Health Care Plans-Lantana
   k. Humana Health Care Plans-Palm Beach Gardens
   l. Humana Health Care Plans-Tamarac
   m. Humana Health Care Plans-West Boca

(FL-Cont. Next Page)

FLORIDA Cont.
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10. Humana Internal Medicine Associates of the Palm Beaches, Inc. f/k/a Coastal Internal Medicine Associates of the Palm Beaches, Inc.

    Doing Business As:

    a. Humana Health Care Plans-Lake Worth f/k/a Coastal Internal Medicine Associates of JFK Circle
    b. Humana Health Care Plans-Flagler f/k/a Coastal Internal Medicine Associates of North Dixie Highway
    c. Humana Health Care Plans-Riverbridge f/k/a Coastal Internal Medicine Associates at Riverbridge
    d. Humana Health Care Plans-Palm Beach f/k/a Coastal Internal Medicine Associates of South Dixie Highway
    e. Humana Health Care Plans-Boynton Beach

11. Humana Health Insurance Company of Florida, Inc.
12. Humana Medical Plan, Inc. - Doing Business As:
    a. Coastal Pediatrics-Daytona
    b. Coastal Pediatrics-Port Orange
    c. Coastal Pediatric-Ormond
    d. Daytona Gastroenterology
    e. Flagler Family Practice
    f. Florida Dermatology Center
    g. Humana Medical Plan-West Palm Beach
    h. Internal Medicine of Daytona
    i. Orange Park Family Health Care
    j. St. Augustine Family Health Center
    k. Suncoast Medical Associates
13. Humana Workers' Compensation Services, Inc. - Doing Business As:
    a. Humana Workers' Compensation Insurance Services
14. Lakeside Medical Center Management, Inc. - Doing Business As:
    a. University Medical Center
15. PCA Options, Inc.
16. PCA Property & Casualty Insurance Co.

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

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

KENTUCKY
- --------
1. HMPK, INC.
2. HPLAN, INC.
3. Humana Health Plan, Inc. - Doing Business As:
    a. Central Kentucky Family Practice
    b. Franklin Medical Center
    c. Humana Health Care Plans of Indiana
    d. Madison Family and Industrial Medicine (KY)
    e. Humana Health Care Plans-Somerset (KY)
4. Humco, Inc. (shell corporation-keep active until 12/31/99 per Escrow Agmt.)
5. The Dental Concern, Inc. (f/k/a Randmark, Inc.) - Doing Business As:
    a. The Dental Concern/KY, Inc. (IN)
    b. The Dental Concern/KY, Inc. (MO)
6. The Dental Concern Insurance Company

LOUISIANA
- ---------
1. Humana Workers' Compensation Services 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 (GA)

NEVADA
- ------
1. Humana Health Insurance of Nevada, Inc.

OHIO
- ----
1. Humana Health Plan of Ohio, Inc. f/k/a ChoiceCare Health Plans, Inc. - Doing Business As:

    a. ChoiceCare/Humana (IL, IN, KY, OH)

OKLAHOMA
- --------
1. Commonwealth Management, Inc.

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

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

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

VIRGINIA
- --------
1. Humana Group Health Plan, Inc. (Note: Assets sold to Kaiser Permanente 1/31/97)

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

FOREIGN
- -------

BERMUDA
- -------
1. Hallmark RE Ltd.

EXHIBIT 23

CONSENT OF INDEPENDENT ACCOUNTANTS

We 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, No. 33-54455, No. 33-04435 and No. 333-57095) of our report dated February 9, 1999, on our audits of the consolidated financial statements of Humana Inc. as of December 31, 1998 and 1997 and for each of the three years in the period ended December 31, 1998, which report is incorporated by reference in this Annual Report on Form 10-K. We further consent to the incorporation by reference of our report on our audits of the financial statement schedules of Humana Inc. as of December 31, 1998 and 1997 and for each of the three years in the period ended December 31, 1998, which report is included in this Annual Report on Form 10-K.

PricewaterhouseCoopers LLP
Louisville, Kentucky
February 9, 1999

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THIS SCHEDULE CONTAINS SUMMARY FINANCIAL INFORMATION EXTRACTED FROM HUMANA INC.'S FORM 10-K FOR THE TWELVE MONTHS ENDED DECEMBER 31, 1998, AND IS QUALIFIED IN ITS REFERENCE TO SUCH FINANCIAL STATEMENT.
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