HUMANA INC
Form 10-Q
May 07, 2004
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

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

For the quarterly period ended March 31, 2004

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 or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**

500 West Main Street

Louisville, Kentucky 40202

(Address of principal executive offices, including zip code)

(502) 580-1000

(Registrant s telephone number, including area code)

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

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act). Yes x No ¨

Indicate the number of shares outstanding of each of the issuer s classes of common stock as of the latest practicable date.

Class of Common Stock	**Outstanding at April 30, 2004**
$0.16 2/3 par value	161,473,643 shares

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CONDENSED CONSOLIDATED BALANCE SHEETS

(Unaudited)

	March 31, 2004	December 31, 2003
	(in thousands, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 417,647	$ 931,404
Investment securities	2,115,784	1,676,642
Receivables, less allowance for doubtful accounts of $38,459 at March 31, 2004, and $40,400 at December 31, 2003:		
Premiums	511,931	452,404
Administrative services fees	16,627	13,583
Other	306,831	247,298
Total current assets	3,368,820	3,321,331
Property and equipment, net	397,212	416,472
Other assets:		
Long-term investment securities	311,409	319,167
Goodwill	776,874	776,874
Other	421,430	459,479
Total other assets	1,509,713	1,555,520
Total assets	$ 5,275,745	$ 5,293,323
LIABILITIES AND STOCKHOLDERS EQUITY		
Current liabilities:		
Medical and other expenses payable	$ 1,396,784	$ 1,272,156
Trade accounts payable and accrued expenses	422,568	440,340
Book overdraft	210,437	219,054
Unearned revenues	131,372	333,071
Total current liabilities	2,161,161	2,264,621
Long-term debt	646,897	642,638
Other long-term liabilities	558,741	550,115
Total liabilities	3,366,799	3,457,374
Commitments and contingencies		
Stockholders equity:		
Preferred stock, $1 par; 10,000,000 shares authorized, none issued		
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 174,559,254 shares issued at March 31, 2004, and 173,909,127 shares issued at December 31, 2003	29,093	28,984
Capital in excess of par value	986,369	974,975
Retained earnings	1,017,641	949,811

Accumulated other comprehensive income	24,641	16,909
Unearned stock compensation	(78)	(754)
Treasury stock, at cost, 12,739,251 shares at March 31, 2004, and 12,018,281 shares at December 31, 2003	(148,720)	(133,976)
Total stockholders equity	1,908,946	1,835,949
Total liabilities and stockholders equity	$ 5,275,745	$ 5,293,323

See accompanying notes to condensed consolidated financial statements.

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Humana Inc.

CONDENSED CONSOLIDATED STATEMENTS OF INCOME

(Unaudited)

	For the three months ended March 31,	
	2004	2003
	(in thousands, except per share results)	
Revenues:		
Premiums	$ 3,179,181	$ 2,842,949
Administrative services fees	78,237	61,136
Investment and other income	29,531	27,631
Total revenues	3,286,949	2,931,716
Operating expenses:		
Medical	2,683,516	2,371,434
Selling, general and administrative	469,629	464,278
Depreciation and amortization	26,312	44,667
Total operating expenses	3,179,457	2,880,379
Income from operations	107,492	51,337
Interest expense	4,719	3,935
Income before income taxes	102,773	47,402
Provision for income taxes	34,943	16,172
Net income	$ 67,830	$ 31,230
Basic earnings per common share	$ 0.42	$ 0.20
Diluted earnings per common share	$ 0.41	$ 0.19

See accompanying notes to condensed consolidated financial statements.

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CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(Unaudited)

	For the three months ended March 31,	
	2004	**2003**
	(in thousands)	
Cash flows from operating activities		
Net income	$ 67,830	$ 31,230
Adjustments to reconcile net income to net cash used in operating activities:		
Writedown of property and equipment		17,233
Depreciation and amortization	26,312	44,667
Provision for deferred income taxes	12,223	3,646
Changes in operating assets and liabilities:		
Receivables	(20,546)	(25,349)
Other assets	(15,472)	20,008
Medical and other expenses payable	124,628	83,912
Other liabilities	(32,431)	(66,539)
Unearned revenues	(201,699)	(218,153)
Other	(900)	1,115
Net cash used in operating activities	(40,055)	(108,230)
Cash flows from investing activities		
Purchases of property and equipment	(22,732)	(22,096)
Proceeds from sales of property and equipment	19,385	462
Purchases of investment securities	(1,491,272)	(1,545,241)
Maturities of investment securities	246,845	196,923
Proceeds from sales of investment securities	786,868	1,320,246
Net cash used in investing activities	(460,906)	(49,706)
Cash flows from financing activities		
Common stock repurchases	(12,836)	(20,817)
Change in book overdraft	(8,617)	(10,303)
Proceeds from stock option exercises and other	8,657	351
Net cash used in financing activities	(12,796)	(30,769)
Decrease in cash and cash equivalents	(513,757)	(188,705)
Cash and cash equivalents at beginning of period	931,404	721,357
Cash and cash equivalents at end of period	$ 417,647	$ 532,652
Supplemental cash flow disclosures:		
Interest payments	$ 6,581	$ 4,068
Income tax payments, net	$ 4,353	$ 3,716

See accompanying notes to condensed consolidated financial statements.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

Unaudited

(1) Basis of Presentation

The accompanying condensed consolidated financial statements are presented in accordance with generally accepted accounting principles for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the disclosures normally required by accounting principles generally accepted in the United States of America, or those normally made in an Annual Report on Form 10-K. References throughout this document to we, us, our, the Company, and Humana, mean Humana Inc. and all entities we own. For further information, the reader of this Form 10-Q should refer to our Form 10-K for the year ended December 31, 2003, that was filed with the Securities and Exchange Commission, or the SEC, on March 5, 2004.

The preparation of our condensed consolidated financial statements, in conformity with accounting principles generally accepted in the United States of America, requires us to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of medical expenses payable, the recognition of revenue related to our TRICARE contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. Although our estimates are based on knowledge of current events and anticipated future events, actual results may ultimately differ materially from those estimates. Refer to Critical Accounting Policies and Estimates in Humana s 2003 Annual Report on Form 10-K for information on accounting policies that the Company considers critical in preparing its Consolidated Financial Statements.

The financial information has been prepared in accordance with our customary accounting practices and has not been audited. In our opinion, the information presented reflects all adjustments necessary for a fair statement of interim results. All such adjustments are of a normal and recurring nature.

(2) Significant Accounting Policies

Stock-Based Compensation

We have stock-based employee compensation plans, which are described more fully in Note 10 to the consolidated financial statements in Humana s 2003 Annual Report on Form 10-K. We account for our stock option plans under Accounting Principles Board Opinion No. 25, *Accounting for Stock Issued to Employees* and related interpretations, or APB No. 25. No employee compensation cost is reflected in net income related to fixed-based stock option awards because these options had an exercise price equal to the market value of the underlying common stock on the date of grant. Generally, if a fixed-based stock option award is subsequently modified, compensation expense, if any, is recorded for the amount that the market price of Humana common stock exceeds the option s exercise price on the date the option is modified. Compensation expense is recorded for restricted stock grants over their vesting periods based on fair value, which is equal to the market price of Humana common stock on the date of the grant.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Unaudited

The effect on net income and earnings per share if we had applied the fair value recognition provisions of Statement of Financial Accounting Standards No. 123, *Accounting for Stock-Based Compensation*, to our fixed-based stock option awards was as follows for the three months ended March 31, 2004 and 2003.

	2004	2003
	(in thousands, except per share results)	
Net income, as reported	$ 67,830	$ 31,230
Add: Stock-based employee compensation expense included in reported net income, net of related tax	782	1,403
Deduct: Total stock-based employee compensation expense determined under fair value based method for all awards, net of related tax	(3,038)	(2,396)
Adjusted net income	$ 65,574	$ 30,237
Earnings per share:		
Basic, as reported	$ 0.42	$ 0.20
Basic, pro forma	$ 0.40	$ 0.19
Diluted, as reported	$ 0.41	$ 0.19
Diluted, pro forma	$ 0.40	$ 0.19

New Accounting Standards

In January 2003, the Financial Accounting Standards Board (FASB) issued Interpretation No. 46, *Consolidation of Variable Interest Entities, an Interpretation of ARB 51*, or FIN 46. The primary objectives of FIN 46 are to provide guidance on the identification of entities for which control is achieved through means other than through voting rights (variable interest entities, or VIEs) and how to determine when and which business enterprise should consolidate the VIE (the primary beneficiary). In December 2003, the FASB issued FIN 46-R, *Consolidation of Variable Interest Entities an interpretation of ARB 51 (revised December 2003)*, which amended certain provisions of FIN 46 and delayed implementation for entities that are not considered special purpose entities until the first quarter of 2004. The adoption of FIN 46 or FIN 46-R did not have a material impact on our financial position, results of operations, or cash flows.

(3) Acquisition

On April 1, 2004, we acquired Ochsner Health Plan, or Ochsner, from Ochsner Clinic Foundation for $82.5 million in cash, subject to adjustment based upon completion of a final balance sheet necessary to determine, among other items, Ochsner s ultimate claims liability as of the purchase date using claims paid data during a 6-month run-out period. In addition, the purchase price includes provisions to pay additional consideration up to $45.0 million assuming certain earnings targets are met. Ochsner is a Louisiana health plan serving approximately 152,000 Commercial medical members, primarily in fully insured large group accounts, and approximately 33,000 members in the MedicareAdvantage program.

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(4) Long-lived Asset Impairment

A decision to eliminate the Jacksonville, Florida customer service center prompted a review for the possible impairment of long-lived assets associated with this center. Under a transition plan, we continued to use the long-lived assets of the Jacksonville customer service center until mid-2003, the completion date for consolidating this customer service center. The long-lived assets of this customer service center were supported by the future cash flows expected to result from members serviced by that center. Cash flows from members serviced by the service center represented the lowest level of independently identifiable cash flows. For example, cash flows from members located primarily in the state of Florida and serviced by the Jacksonville service center supported the Jacksonville center s long-lived assets until those members service was transitioned elsewhere.

Our impairment review during the first quarter of 2003 indicated that estimated undiscounted cash flows expected to result from the remaining use of the Jacksonville, Florida customer service center long-lived assets, primarily a building, were insufficient to recover their carrying value. Accordingly, we reduced the carrying value of these long-lived assets to their estimated fair value resulting in non-cash impairment expenses of $17.2 million ($10.5 million after tax) during the first quarter of 2003.

We used an independent third party appraisal to assist us in evaluating the fair value of the building. The non-cash impairment expenses are included with selling, general and administrative expenses in the accompanying condensed consolidated statements of income.

Based upon our decision to sell the building previously used in our Jacksonville customer service operations, we classified it as held for sale and ceased depreciating the building effective July 1, 2003. The impact of ceasing depreciation of the building was not material to our results of operations. During the first quarter of 2004, we completed the sale of the Jacksonville building, recording proceeds of $14.8 million and a loss of $0.2 million.

Accelerated Depreciation

After finalizing plans during the first quarter of 2003 to abandon software used in our operations by March 2003, we reduced the estimated useful life of the software effective January 1, 2003. Accordingly, we accelerated the depreciation of the remaining software balance of approximately $13.5 million ($8.3 million after tax) during the first quarter of 2003.

The allocation of the non-cash pretax expenses related to the writedown and accelerated depreciation of certain long-lived assets to our Commercial and Government segments was as follows for the three months ended March 31, 2003:

	2003		
	Commercial	Government	Total
		(in thousands)	
Line item affected:			
Selling, general and administrative	$ 4,325	$ 12,908	$ 17,233
Depreciation and amortization	13,527		13,527
Total pretax impact	$ 17,852	$ 12,908	$ 30,760

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Unaudited

(5) Other Intangible Assets

Other intangible assets primarily relate to acquired subscriber, provider, and government contracts, and the cost of acquired licenses and are included with other long-term assets on the condensed consolidated balances sheets. Amortization expense for other intangible assets was approximately $2.4 million for the three months ended March 31, 2004 and $3.9 million for the three months ended March 31, 2003. The following table presents our estimate of amortization expense for the remaining nine months of 2004, and for each of the five succeeding fiscal years:

	(in thousands)
For the nine month period ending December 31, 2004	$ 6,671
For the years ending December 31:	
2005	$ 5,440
2006	$ 352
2007	$ 352
2008	$ 227
2009	$ 215

The following table presents details of our other intangible assets included in other non-current assets in the accompanying condensed consolidated balance sheets at March 31, 2004 and December 31, 2003:

	March 31, 2004			December 31, 2003		
	Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
	(in thousands)					
Other intangible assets:						
Subscriber contracts	$ 85,496	$ 76,921	$ 8,575	$ 85,496	$ 75,194	$ 10,302
Provider contracts	12,128	8,683	3,445	12,128	8,075	4,053
Government contracts	11,820	11,820		11,820	11,820	
Licenses and other	5,065	1,430	3,635	5,065	1,376	3,689
Total other intangible assets	$ 114,509	$ 98,854	$ 15,655	$ 114,509	$ 96,465	$ 18,044

(6) Comprehensive Income

The following table presents details supporting the computation of comprehensive income for the three months ended March 31, 2004 and 2003:

	For the three months ended March 31,	
	2004	2003
	(in thousands)	
Net income	$ 67,830	$ 31,230
Net unrealized investment gains, net of tax	7,732	802
Comprehensive income, net of tax	$ 75,562	$ 32,032

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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(7) Earnings Per Common Share

We compute basic earnings per common share on the basis of the weighted average number of unrestricted common shares outstanding. Diluted earnings per common share is computed on the basis of the weighted average number of unrestricted common shares outstanding plus the dilutive effect of outstanding employee stock options and restricted shares using the treasury stock method. There were no adjustments required to be made to net income for purposes of computing basic or diluted earnings per common share.

The following table presents details supporting the computation of basic and diluted earnings per common share for the three months ended March 31, 2004 and 2003:

	For the three months ended March 31,	
	2004	2003
	(in thousands, except per share results)	
Net income available for common stockholders	$ 67,830	$ 31,230
Weighted average outstanding shares of common stock used to compute basic earnings per common share	161,966	157,739
Dilutive effect of:		
Employee stock options	2,333	359
Restricted stock	58	3,308
Shares used to compute diluted earnings per common share	164,357	161,406
Basic earnings per common share	$ 0.42	$ 0.20
Diluted earnings per common share	$ 0.41	$ 0.19

Stock options to purchase 123,899 shares and 6,773,524 shares for the three months ended March 31, 2004 and 2003, respectively were not dilutive and, therefore, were not included in the computations of diluted earnings per common share.

(8) Stock Repurchase Plan

In July 2003, the Board of Directors authorized the use of up to $100 million for the repurchase of our common shares exclusive of shares repurchased in connection with employee stock plans. The shares may be purchased from time to time at prevailing prices in the open market or in privately negotiated transactions. For the three months ended March 31, 2004, 686,000 common shares were acquired in open market

transactions at an aggregate cost of $13.9 million, or an average of $20.33 per share. As of May 6, 2004, $75.5 million of the July 2003 authorization remains available for share repurchases. See also the chart in Part II, Item 2 on page 34.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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(9) Long-term Debt

Long-term debt outstanding was as follows at March 31, 2004 and December 31, 2003:

	March 31, 2004	December 31, 2003
	(in thousands)	
6.30% senior, unsecured notes due 2018, net of unamortized discount of $823 at March 31, 2004 and $838 at December 31, 2003	$ 299,177	$ 299,162
7.25% senior, unsecured notes due 2006, net of unamortized discount of $340 at March 31, 2004 and $376 at December 31, 2003	299,660	299,624
Fair value of interest rate swap agreements	19,545	12,754
Deferred gain from interest rate swap exchange	23,750	26,175
Total senior notes	642,132	637,715
Other long-term borrowings	4,765	4,923
Total long-term debt	$ 646,897	$ 642,638

(10) Guarantees and Contingencies

Indemnifications and Guarantees

Our 5-year and 7-year airplane operating leases provide for a residual value payment of no more than $9.2 million at the end of the lease terms, which expire December 29, 2004 for the 5-year lease and January 1, 2010 for the 7-year lease. We have the right to exercise a purchase option with respect to the leased airplanes or the airplanes can be sold to a third party. If we decide not to exercise our purchase option at the end of the lease, we must pay the lessor a maximum amount of $4.4 million related to the 5-year lease and $4.8 million related to the 7-year lease. The amount will be reduced by the net sales proceeds of the airplanes to a third party.

Through indemnity agreements approved by the state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by Humana Inc., our parent company, in the event of insolvency for (1), member coverage for which premium payment has been made prior to insolvency; (2), benefits for members then hospitalized until discharged; and (3), payment to providers for services rendered prior to insolvency. Our parent also has guaranteed the obligations of our TRICARE subsidiaries.

In the ordinary course of business, we enter into contractual arrangements under which we may agree to indemnify a third party to such arrangement from any losses incurred relating to the services they perform on behalf of us, or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses. Historically, payments made related to these indemnifications have been immaterial.

Government Contracts

Our MedicareAdvantage contracts with the federal government are renewed for a one-year term each December 31 unless notice of termination is received at least 90 days prior thereto. In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act, or DIMA, was signed into law. DIMA includes provisions that require the 2004 stabilization funding to be directed toward increased reimbursement for providers, increased benefits or access for members, or decreased member premiums. CMS has approved all of our MedicareAdvantage plans filed in February 2004. CMS also announced Medicare rates for 2005. Given that risk adjusters have a 50 percent impact in 2005, our initial expectation is for 2005 net Medicare rate increases to be less than the program s overall average of 6.6 percent. We believe DIMA will open new opportunities for us. However, we do not believe that the benefit to our 2004 financial position, results of operations, or cash flows will be material.

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Our current TRICARE contracts with the Department of Defense will be in effect until June 30, 2004 for Regions 2 and 5 and until July 31, 2004 for Regions 3 and 4.

On August 21, 2003, the Department of Defense notified us that we were awarded the contract for the South Region, one of three newly-created regions under the government s revised TRICARE Program. The current TRICARE Regions 3 and 4 will become part of the new South Region along with Region 6, which is currently administered by another contractor. The current Regions 2 and 5 will become part of the North Region, which was awarded to another contractor.

Under the Department of Defense s current schedule for implementation of the new TRICARE contracts, Regions 2 and 5 will transition to the new North Region for the start of healthcare delivery on July 1, 2004. Regions 3 and 4 will become part of the new South Region for the start of healthcare delivery on August 1, 2004 and Region 6 will become part of our new South Region for the start of healthcare delivery on November 1, 2004.

In addition, retail pharmacy benefits for TRICARE beneficiaries will be administered separately under the new Department of Defense TRICARE Retail Pharmacy Program. On September 26, 2003, we were notified that we were not awarded the retail pharmacy contract and, later, that our protest of this award decision was not upheld.

We were also awarded the contract to administer TRICARE health benefits for participants in Puerto Rico. The ASO contract began on May 1, 2004 and includes a term of approximately four years, subject to annual renewal terms. While relatively small in potential annual revenues, we believe this opportunity further leverages our Puerto Rico operations.

We currently have Medicaid contracts with the Puerto Rico Health Insurance Administration through June 30, 2005, subject to each party agreeing upon annual rates. In July 2003, we signed amendments to the Puerto Rico Medicaid contracts regarding a premium rate increase for the annual period ending June 30, 2004. Our other Medicaid contracts are in Florida and Illinois, and are annual contracts. As of March 31, 2004, Puerto Rico accounted for approximately 84% of our total Medicaid membership.

Other than as described herein, the loss of any of our existing or pending government contracts or significant changes in these programs as a result of legislative action, including reductions in premium payments to us, or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our financial position, results of operations, and cash flows.

Legal Proceedings

Managed Care Industry Purported Class Action Litigation

We have been involved in several purported class action lawsuits that are part of a wave of generally similar actions that target the health care payer industry and particularly target managed care companies. These include a lawsuit against us and originally nine of our competitors that purports to be brought on behalf of physicians who have treated our members. As a result of action by the Judicial Panel on Multidistrict Litigation (JPML), the case was consolidated in the United States District Court for the Southern District of Florida, and has been styled *In re Managed Care Litigation*.

The plaintiffs assert that we and other defendants improperly paid providers claims and downcoded their claims by paying lesser amounts than they submitted. The complaint alleges, among other things, multiple violations under the Racketeer Influenced and Corrupt Organizations Act, or RICO, as well as various breaches of contract and violations of regulations governing the timeliness of claim payments. We moved to dismiss the complaint on September 8, 2000, and the other defendants filed similar motions thereafter. On March 2, 2001, the Court dismissed certain of the plaintiffs claims pursuant to the defendants several motions to dismiss. However, the Court allowed the plaintiffs to attempt to correct the deficiencies in their complaint with an amended pleading with respect to all of the allegations except a claim under the federal Medicare regulations, which was dismissed with prejudice. The Court also left undisturbed the plaintiffs claims for breach of contract. On March 26, 2001, the plaintiffs filed their amended complaint, which, among other things, added four state or county medical associations as additional plaintiffs. Two of those, the Denton County (Texas) Medical Society and the Texas Medical Association, purport to bring their actions against us, as well as against several other defendant companies. The Medical Association of Georgia and the California Medical Association purport to bring their actions against various other

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Unaudited

defendant companies. The associations seek injunctive relief only. The defendants filed a motion to dismiss the amended complaint on April 30, 2001.

On September 26, 2002, the Court granted the plaintiffs request to file a second amended complaint, adding additional plaintiffs, including the Florida Medical Association, which purports to bring its action against all defendants. On October 21, 2002, the defendants moved to dismiss the second amended complaint. On December 8, 2003, the Court denied the motion.

Also on September 26, 2002, the Court certified a global class consisting of all medical doctors who provided services to any person insured by any defendant from August 4, 1990, to September 26, 2002. The class includes two subclasses. A national subclass consists of medical doctors who provided services to any person insured by a defendant when the doctor has a claim against such defendant and is not required to arbitrate that claim. A California subclass consists of medical doctors who provided services to any person insured in California by any defendant when the doctor was not bound to arbitrate the claim.

On October 10, 2002, the defendants asked the Court of Appeals for the Eleventh Circuit to review the class certification decision. On November 20, 2002, the Court of Appeals agreed to review the class issue. The appellate court heard oral argument on September 11, 2003, but no ruling has been issued. Discovery is ongoing, and the Court has set a new trial date of March 15, 2005. Also, on January 15, 2004, the Court filed a notice with the JPML that would have permitted the JPML to decide whether the case should remain in Miami, Florida for trial or be separately remanded for trial to the courts in which the actions were filed prior to their transfer to and consolidation in Miami, Florida. In the case of the Company, that would be the United States District Court for the Western District of Kentucky. On April 12, 2004, the JPML ruled that the issue should only be decided after the Court of Appeals rules on the class certification motion. In the meantime, two of the defendants, Aetna Inc. and Cigna Corporation, have entered into settlement agreements which have been approved by the Court.

We intend to continue to defend this action vigorously.

Government Audits and Other Litigation and Proceedings

In July 2000, the Office of the Florida Attorney General initiated an investigation, apparently relating to some of the same matters that are involved in the managed care industry purported class action litigation described above. On September 21, 2001, the Texas Attorney General initiated a similar investigation. No actions have been filed against us by either state. These investigations are ongoing, and we have cooperated with the regulators in both states.

On May 31, 2000, we entered into a five-year Corporate Integrity Agreement, or CIA, with the Office of Inspector General, or OIG, of the Department of Health and Human Services. Under the CIA, we are obligated to, among other things, provide training, conduct periodic audits

and make periodic reports to the OIG.

In addition, our business practices are subject to review by various state insurance and health care regulatory authorities and federal regulatory authorities. There has been increased scrutiny by these regulators of the managed health care companies business practices, including claims payment practices and utilization management practices. We have been and continue to be subject to such reviews. Some of these have resulted in fines and could require changes in some of our practices and could also result in additional fines or other sanctions.

We also are involved in other lawsuits that arise in the ordinary course of our business operations, including claims of medical malpractice, bad faith, nonacceptance or termination of providers, improper rate setting, failure to disclose network discounts and various other provider arrangements, as well as challenges to subrogation practices. We also are subject to claims relating to performance of contractual obligations to providers, members, and others, including failure to properly pay claims and challenges to the use of certain software products in processing claims. Pending state and federal legislative activity may increase our exposure for any of these types of claims.

In addition, several courts, including several federal appellate courts, recently have issued decisions which have the effect of eroding the scope of ERISA preemption for employer-sponsored health plans, thereby exposing us to greater liability for medical negligence claims. This includes decisions which hold that plans may be liable for medical negligence claims in some situations based solely on medical necessity decisions made in the course of adjudicating claims. In addition, some courts have issued rulings which make it easier to hold plans liable for

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Unaudited

medical negligence on the part of network providers on the theory that providers are agents of the plans and that the plans are therefore vicariously liable for the injuries to members by providers.

Personal injury claims and claims for extracontractual damages arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

The likelihood or outcome of current or future suits, like the purported class action lawsuit described above, or governmental investigations, cannot be accurately predicted with certainty. In addition, the potential for increased liability for medical negligence arising from claims adjudication, along with the increased litigation that has accompanied the negative publicity and public perception of our industry, adds to this uncertainty. Therefore, such legal actions and government audits and investigations could have a material adverse effect on our financial position, results of operations, and cash flows.

(11) Segment Information

We manage our business with two segments: Commercial and Government. The Commercial segment consists of members enrolled in products marketed to employer groups and individuals, and includes three lines of business: fully insured medical, administrative services only, or ASO, and specialty. The Government segment consists of members enrolled in government-sponsored programs, and includes three lines of business: MedicareAdvantage (formerly Medicare+Choice), Medicaid, and TRICARE. We identified our segments in accordance with the aggregation provisions of Statement of Financial Accounting Standards No. 131, *Disclosures About Segments of an Enterprise and Related Information* which is consistent with information used by our Chief Executive Officer in managing our business. The segment information aggregates products with similar economic characteristics. These characteristics include the nature of customer groups and pricing, benefits and underwriting requirements.

The results of each segment are measured by income before income taxes. We allocate all selling, general and administrative expenses, investment and other income, interest expense, and goodwill, but no other assets or liabilities, to our segments. Members served by our two segments generally utilize the same medical provider networks, enabling us to obtain more favorable contract terms with providers. Our segments also share overhead costs and assets. As a result, the profitability of each segment is interdependent.

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Humana Inc.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Unaudited

Our segment results for the three months ended March 31, 2004 and 2003 are as follows:

	Commercial Segment	
	For the three months ended March 31,	
	2004	2003
	(in thousands)	
Revenues:		
Premiums:		
Fully insured		
HMO	$ 672,964	$ 735,590
PPO	944,156	801,363
Total fully insured	1,617,120	1,536,953
Specialty	85,971	78,603
Total premiums	1,703,091	1,615,556
Administrative services fees	41,696	29,590
Investment and other income	23,638	21,853
Total revenues	1,768,425	1,666,999
Operating expenses:		
Medical	1,422,777	1,313,580
Selling, general and administrative	286,727	280,362
Depreciation and amortization	16,065	32,755
Total operating expenses	1,725,569	1,626,697
Income from operations	42,856	40,302
Interest expense	3,770	3,063
Income before income taxes	$ 39,086	$ 37,239

	Government Segment
	For the three months

	ended March 31,	
	2004	2003
	(in thousands)	
Revenues:		
Premiums:		
MedicareAdvantage	$ 706,318	$ 635,842
TRICARE	648,993	470,321
Medicaid	120,779	121,230
Total premiums	1,476,090	1,227,393
Administrative services fees	36,541	31,546
Investment and other income	5,893	5,778
Total revenues	1,518,524	1,264,717
Operating expenses:		
Medical	1,260,739	1,057,854
Selling, general and administrative	182,902	183,916
Depreciation and amortization	10,247	11,912
Total operating expenses	1,453,888	1,253,682
Income from operations	64,636	11,035
Interest expense	949	872
Income before income taxes	$ 63,687	$ 10,163

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Humana Inc.

MANAGEMENT S DISCUSSION AND ANALYSIS OF

FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The condensed consolidated financial statements of Humana Inc. in this document present the Company s financial position, results of operations and cash flows, and should be read in conjunction with the following discussion and analysis. References to we, us, our, Company, and Humana mean Humana Inc. and its subsidiaries. This discussion includes forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. When used in this filing and in future filings with the Securities and Exchange Commission, in our press releases, investor presentations, and in oral statements made by or with the approval of one of our executive officers, the words or phrases like expects, anticipates, intends, likely will result, estimates, projects or variations of such words and similar expressions are intended to identify such forward looking statements. These forward looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including, among other things, information set forth in the Cautionary Statements section of this document. In light of these risks, uncertainties and assumptions, the forward looking events discussed in this document might not occur. There may also be other risks that we are unable to predict at this time. Any of these risks and uncertainties may cause actual results to differ materially from the results discussed in the forward looking statements.

Overview

Headquartered in Louisville, Kentucky, Humana Inc. is one of the nation s largest publicly traded health benefits companies, based on our 2003 revenues of $12.2 billion. We offer coordinated health insurance coverage and related services through a variety of traditional and Internet-based plans for employer groups, government-sponsored programs, and individuals. As of March 31, 2004, we had approximately 7.0 million members in our medical insurance programs, as well as approximately 1.7 million members in our specialty products programs.

We manage our business with two segments: Commercial and Government. The Commercial segment consists of members enrolled in products marketed to employer groups and individuals, and includes three lines of business: fully insured medical, administrative services only, or ASO, and specialty. The Government segment consists of members enrolled in government-sponsored programs, and includes three lines of business: MedicareAdvantage, TRICARE, and Medicaid. We identified our segments in accordance with the aggregation provisions of Statement of Financial Accounting Standards No. 131, *Disclosures About Segments of an Enterprise and Related Information* which is consistent with information used by our Chief Executive Officer in managing our business. The segment information aggregates products with similar economic characteristics. These characteristics include the nature of customer groups and pricing, benefits and underwriting requirements.

The results of each segment are measured by income before income taxes. We allocate all selling, general and administrative expenses, investment and other income, interest expense, and goodwill, but no other assets or liabilities, to our segments. Members served by our two segments generally utilize the same medical provider networks, enabling us to obtain more favorable contract terms with providers. Our segments also share overhead costs and assets. As a result, the profitability of each segment is interdependent.

Our strategy to increase Commercial segment profitability focuses on providing solutions for employers to the rising cost of health care through the use of innovative and consumer-choice product designs which are supported by service excellence and industry-leading electronic capabilities, including education, tools and technologies provided primarily through the Internet. To that end, we have developed an innovative suite of products styled as Smart products. We believe that these Smart products offer the best solution for many employers to the problem of fast rising health care costs for their employees. Membership in our Smart products exceeds 220,000 members at March 31, 2004. We believe that growth in these products, which may be competitively priced to produce higher margins, is a key component, among other items, for our

continuing improvement in the Commercial segment.

Other important elements which impact our Commercial segment profitability are the competitive pricing environment and market conditions. With respect to pricing, there is a complex balancing act between sustaining or increasing underwriting margins versus achieving enrollment growth. With respect to market conditions, there is the impact of economies of scale on administrative overhead. As a result of the decline in preference for tightly managed HMO products and intensive utilization review procedures, medical costs have become increasingly comparable among the larger competitors. Consequently, product design and consumer involvement have become the more important drivers of medical services consumption. Administrative expense efficiency is becoming a

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primary driver of commercial margin sustainability. In line with that philosophy, we continue to rationalize our administrative expense structure, realize administrative expense savings through technology tools, and look at acquisition opportunities that align with our geographic presence and Commercial strategy.

On April 1, 2004, we completed the acquisition of Ochsner Health Plan, enhancing our presence in the Southern United States, an area growing in population and commercial activity. In addition to creating a new Humana market in New Orleans, Louisiana, the Ochsner Health Plan acquisition is expected to facilitate sales opportunities in our existing Houston, Texas market and we believe will make us more attractive to national accounts.

In our Government segment, we continue to work on transitioning our TRICARE business in the interim period before the commencement of the new South contract which is scheduled to begin August 1, 2004 as it relates to our current Regions 3 and 4 contracts and November 1, 2004 as it relates to the current Region 6 contract. In addition, our TRICARE unit was awarded the contract to administer health benefits for participants in Puerto Rico. The ASO contract began May 1, 2004 and includes a term of approximately four years, subject to annual renewal terms. While relatively small in potential annual revenues, we believe this opportunity further leverages our Puerto Rico operations.

We believe the new Medicare legislation demonstrates the federal government s financial commitment to the private payor program and the commitment to providing health benefits and options to seniors. The first quarter of 2004 was the third consecutive quarter in which our Medicare membership increased. On April 1, 2004, we added 33,000 Medicare members through the Ochsner acquisition. Thus we are forecasting membership to grow to between 370,000 and 390,000 by the end of 2004.

Our revenues for the first quarter of 2004 increased 12.1% to $3.3 billion compared to $2.9 billion in the same period a year ago. Medical membership at March 31, 2004 totaled 7.0 million, an increase of 5.9% over the 6.6 million medical members as of March 31, 2003. Higher revenues resulted primarily from an increase in TRICARE s base contract price which became effective in July 2003 and an increase in fully insured commercial per member premiums. In addition to our Smart products, our Individual product sales have also been accelerating with membership over the past year increasing from less than 10,000 at the end of March 31, 2003 to approximately 75,000 at March 31, 2004. Our Commercial ASO products were another area of appreciable membership growth, with nearly one million ASO members, up more than 50% over the prior year s quarter.

Increased earnings contributed to the improvement in operating cash flows. Net cash used in our operations of $40.1 million during the first quarter of 2004 and $108.2 million during the same period a year ago was caused by the timing of our monthly payments from CMS. The early receipt of the January CMS payment in December resulted in a total of only two CMS payments during the quarter. During the first quarter of 2004, we repurchased 686,000 shares in the open market at aggregate cost of $13.9 million, or an average of $20.33 and invested $22.7 million in capital expenditures.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, and the primary factors that accounted for those changes, as well as how certain critical accounting principles and estimates impact our financial statements.

Acquisition

On April 1, 2004, we acquired Ochsner Health Plan, or Ochsner, from Ochsner Clinic Foundation for $82.5 million in cash, subject to adjustment based upon completion of a final balance sheet necessary to determine, among other items, Ochsner s ultimate claims liability as of the purchase date using claims paid data during a 6-month run-out period. In addition, the purchase price includes provisions to pay additional consideration up to $45.0 million assuming certain earnings targets are met. Ochsner is a Louisiana health plan serving approximately 152,000 Commercial medical members, primarily in fully insured large group accounts, and approximately 33,000 members in the MedicareAdvantage program.

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Comparison of Results of Operations

The following discussion primarily deals with our results of operations for the three months ended March 31, 2004, or the 2004 quarter, and the three months ended March 31, 2003, or the 2003 quarter.

The following table presents certain financial data for our two segments:

	For the three months ended March 31,		Change	
	2004	2003	Dollars	Percentage
	(in thousands, except ratios)			
Premium revenues:				
Fully insured	$ 1,617,120	$ 1,536,953	$ 80,167	5.2%
Specialty	85,971	78,603	7,368	9.4%
Total Commercial	1,703,091	1,615,556	87,535	5.4%
MedicareAdvantage	706,318	635,842	70,476	11.1%
TRICARE	648,993	470,321	178,672	38.0%
Medicaid	120,779	121,230	(451)	(0.4)%
Total Government	1,476,090	1,227,393	248,697	20.3%
Total	$ 3,179,181	$ 2,842,949	$ 336,232	11.8%
Administrative services fees:				
Commercial	41,696	$ 29,590	$ 12,106	40.9%
Government	36,541	31,546	4,995	15.8%
Total	$ 78,237	$ 61,136	$ 17,101	28.0%
Income before income taxes:				
Commercial	$ 39,086	$ 37,239	$ 1,847	5.0%
Government	63,687	10,163	53,524	526.7%
Total	$ 102,773	$ 47,402	$ 55,371	116.8%
Medical expense ratios:				
Commercial	83.5%	81.3%		2.2
Government	85.4%	86.2%		(0.8)
Total	84.4%	83.4%		1.0
SG&A expense ratios:				
Commercial	16.4%	17.0%		(0.6)

Government	12.1%	14.6%	(2.5)
Total	14.4%	16.0%	(1.6)

Medical membership was as follows at March 31, 2004 and 2003:

			Change	
	2004	2003	Members	Percentage
Commercial segment medical members:				
Fully insured	2,298,600	2,348,800	(50,200)	(2.1)%
ASO	997,000	654,600	342,400	52.3%
Total Commercial	3,295,600	3,003,400	292,200	9.7%
Government segment medical members:				
MedicareAdvantage	333,200	327,100	6,100	1.9%
TRICARE	1,860,100	1,752,500	107,600	6.1%
TRICARE ASO	1,057,900	1,050,800	7,100	0.7%
Medicaid	468,200	491,400	(23,200)	(4.7)%
Total Government	3,719,400	3,621,800	97,600	2.7%
Total medical membership	7,015,000	6,625,200	389,800	5.9%

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Overview

Net income was $67.8 million, or $0.41 per diluted share in the 2004 quarter compared to $31.2 million, or $0.19 per diluted share in the 2003 quarter. The increase in net income primarily was due to improved profits in the Government segment. The 2003 quarter results included expenses for asset impairments and other unusual items.

Premium Revenues and Medical Membership

Premium revenues increased 11.8% to $3.18 billion for the 2004 quarter, compared to $2.84 billion for the 2003 quarter. Higher premium revenues resulted primarily from an increase in TRICARE premiums and an increase in fully insured commercial per member premiums. Items impacting per member premiums include changes in premium and government reimbursement rates, as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Commercial segment premium revenues increased 5.4% to $1.70 billion for the 2004 quarter, compared to $1.62 billion for the 2003 quarter. This increase resulted from increases in per member premiums in the 7% to 9% range on our fully insured commercial business. Our fully insured commercial medical membership decreased 2.1%, or 50,200 members, to 2,298,600 at March 31, 2004 compared to 2,348,800 at March 31, 2003. We expect fully insured commercial per member premiums to increase in the 7.5% to 9.5% range for the remainder of 2004. Also, we expect Commercial segment medical membership, both fully insured and ASO to grow at a rate of 6% to 8% from December 31, 2003 to December 31, 2004, with the attrition in fully insured business somewhat offsetting the growth in ASO accounts.

Government segment premium revenues increased 20.3% to $1.48 billion for the 2004 quarter, compared to $1.23 billion for the 2003 quarter. This increase was primarily attributable to our TRICARE business. TRICARE premium revenues grew 38.0% to $649.0 million due to the increase in our base contract monthly revenue which became effective in July 2003. MedicareAdvantage membership was 333,200 at March 31, 2004, compared to 327,100 at March 31, 2003, an increase of 6,100 members, or 1.9%. Per member premiums for our MedicareAdvantage business increased in the 8% to 10% range for the 2004 quarter. We expect per member premiums for our MedicareAdvantage business to increase in the 9% to 11% range for 2004 with membership, including the Ochsner acquisition, growing to between 370,000 and 390,000 by December 31, 2004.

Administrative Services Fees

Our administrative services fees for the 2004 quarter were $78.2 million, an increase of $17.1 million from $61.1 million for the 2003 quarter. For the Commercial segment, administrative services fees increased $12.1 million, or 40.9%, to $41.7 million. This increase corresponds to the higher level of ASO membership at March 31, 2004, which was 997,000 members, compared to 654,600 at March 31, 2003. Administrative fees for the Government segment increased $5.0 million when comparing the 2004 quarter to the 2003 quarter. This increase resulted from contractual adjustments related to TRICARE for Life, a program for seniors where we provide medical benefit administrative services.

Investment and Other Income

Investment and other income totaled $29.5 million for the 2004 quarter, an increase of $1.9 million from $27.6 million for the 2003 quarter. This increase primarily resulted from an increase in the average invested balance.

Medical Expense

Total medical expenses as a percentage of premium revenues, or medical expense ratio (MER), for the 2004 quarter were 84.4%, increasing 100 basis points from 83.4% for the 2003 quarter.

The Commercial segment s MER for the 2004 quarter was 83.5%, increasing 220 basis points from the 2003 quarter of 81.3%. This increase is primarily due to an additional day of medical expense as a result of leap year in the 2004 quarter, a large account with approximately 90,000 members whose MER deteriorated significantly from the 2003 quarter, and a more competitive pricing environment.

The Government segment s MER for the 2004 quarter was 85.4%, decreasing 80 basis points from the 2003 quarter of 86.2%. The decrease was primarily due to higher base revenues from the July 2003 price increase on our TRICARE contracts.

SG&A Expense

Total selling, general and administrative, or SG&A, expenses as a percentage of premium revenues and administrative services fees, or SG&A expense ratio, for the 2004 quarter was 14.4%, decreasing 160 basis points

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from the 2003 quarter of 16.0%. This decrease is the result of operational efficiencies gained from completing the consolidation of seven service centers into four and workforce reductions in 2003 and 2002.

The Commercial segment SG&A expense ratio decreased 60 basis points to 16.4% and is expected to be in the range of 15.5% to 16.5% for the remainder of 2004. The Government segment SG&A expense ratio decreased 250 basis points to 12.1% and is expected to be in the range of 11% to 12% for 2004.

Depreciation and amortization for the 2004 quarter totaled $26.3 million compared to $44.7 million for the 2003 quarter, a decrease of $18.4 million, or 41.1%. The decrease resulted from accelerated depreciation of software of $13.5 million included in the 2003 quarter and lower amortization of other intangible assets as costs associated with the government contract acquired with the TRICARE 2 and 5 transaction became fully amortized in the second quarter of 2003.

Interest Expense

Interest expense was $4.7 million for the 2004 quarter, compared to $3.9 million for the 2003 quarter, an increase of $0.8 million. This increase primarily resulted from higher average outstanding debt, due to the issuance of $300 million senior notes in August 2003, offset by lower interest rates.

Income Taxes

On an interim basis, the provision for income taxes is provided for at the anticipated effective tax rate for the year. Our effective tax rate for the 2004 quarter was approximately 34.0%, consistent with the 2003 quarter.

Membership

The following table presents our medical and specialty membership at March 31, 2004, and at the end of each quarter in 2003:

	2004	2003			
	March 31	March 31	June 30	Sept. 30	Dec. 31
Medical Membership:					
Commercial segment:					
Fully insured	2,298,600	2,348,800	2,350,400	2,324,600	2,352,800
ASO	997,000	654,600	670,300	711,800	712,400

Total Commercial	3,295,600	3,003,400	3,020,700	3,036,400	3,065,200
Government segment:					
MedicareAdvantage	333,200	327,100	324,200	324,600	328,600
TRICARE	1,860,100	1,752,500	1,750,800	1,746,300	1,849,700
TRICARE ASO	1,057,900	1,050,800	1,052,500	1,057,000	1,057,200
Medicaid	468,200	491,400	492,700	460,800	468,900
Total Government	3,719,400	3,621,800	3,620,200	3,588,700	3,704,400
Total medical members	7,015,000	6,625,200	6,640,900	6,625,100	6,769,600
Specialty Membership:					
Commercial segment	1,703,200	1,650,100	1,642,000	1,639,100	1,668,100

Liquidity

Cash and cash equivalents decreased to $417.6 million at March 31, 2004 from $931.4 million at December 31, 2003. The primary reason for the decrease in cash and cash equivalents during the 2004 quarter was the timing of the MedicareAdvantage premium receipts and the purchase of investment securities.

The timing of MedicareAdvantage premium receipts may significantly impact our cash flows from operations in a particular period as the MedicareAdvantage premium receipt is payable to us on the first day of each month. When the first day of a month falls on a weekend or holiday, we receive this payment at the end of the previous month. Since this amount is significant, the timing of its receipt can cause a material fluctuation in our operating cash flows from period to period. The MedicareAdvantage premium receipts for January 2004 of $211.9 million and January 2003 of $205.8 million were received early in December 2003 and December 2002, respectively because January 1 is a holiday. This timing accounts for a significant portion of the unearned revenues balance on our condensed consolidated balance sheets at December 31, 2003.

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The change in cash and cash equivalents for the three months ended March 31, 2004 and 2003 is summarized as follows:

	2004	2003
	(in thousands)	
Net cash used in operating activities	$ (40,055)	$ (108,230)
Net cash used in investing activities	(460,906)	(49,706)
Net cash used in financing activities	(12,796)	(30,769)
Decrease in cash and cash equivalents	$ (513,757)	$ (188,705)

The primary drivers of operating cash flow in our business are premium collections and medical claim payments. Because premiums generally are collected in advance of claims payments by a period up to several months in many instances, our business should normally produce strong cash flows during a period of increasing enrollment. Conversely, cash flows would be negatively impacted during a period of shrinking enrollment. The exception to this general rule is the collection of certain TRICARE receivables, some of which takes place at least six months after the end of a contract year. Other activities that impact our cash flows are the collection of ASO fees and investment income and the payment of operating expenses, interest expense and taxes.

Increased earnings contributed to the improvement in operating cash flows during the 2004 quarter compared to the 2003 quarter. Our operating cash flows were not substantially impacted by a change in the timing of non-MedicareAdvantage premium and ASO fee collections or medical claim payments, as both amounts generally increased with inflation and membership growth. The following table details the increase in our receivables:

	March 31, 2004	December 31, 2003	Change
		(in thousands)	
TRICARE:			
Base receivable	$ 260,174	$ 266,656	$ (6,482)
Bid price adjustments (BPAs)	112,845	92,875	19,970
Change orders	1,362	7,073	(5,711)
	374,381	366,604	7,777
Less: long-term portion of BPAs		(38,794)	38,794
TRICARE subtotal	374,381	327,810	46,571
Commercial and other	192,636	178,577	14,059
Allowance for doubtful accounts	(38,459)	(40,400)	1,941
Total net receivables	$ 528,558	$ 465,987	$ 62,571

TRICARE base receivables are collected monthly in the ordinary course of business. The risk sharing provisions of the TRICARE contracts increased BPA receivables and increases in premium and ASO fee revenues contributed to higher Commercial and other receivables during the 2004 quarter.

The timing of payments for claims can significantly impact comparisons of our operating cash flows between years. The following table presents the estimated valuation and number of unprocessed claims on hand, performance metrics we regularly review. Claims on hand represent the estimated number of provider requests for reimbursement that have been received but not yet processed.

	Estimated Valuation	Claims on Hand	Number of Days Claims On-hand
	(dollars in thousands)		
December 31, 2000	$ 257,400	1,157,900	11.0
December 31, 2001	$ 125,400	518,100	5.0
December 31, 2002	$ 92,300	424,200	4.5
December 31, 2003	$ 109,700	443,000	4.9
March 31, 2004	$ 94,800	400,900	3.9

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Medical and other expenses payable increased during the 2004 quarter due primarily to medical claims inflation. The detail of medical and other expenses payable was as follows at March 31, 2004 and December 31, 2003:

	March 31, 2004	December 31, 2003	Change
		(in thousands)	
IBNR (1)	$ 1,143,807	$ 1,034,858	$ 108,949
Unprocessed claim inventories (2)	94,800	109,700	(14,900)
Processed claim inventories (3)	81,705	74,262	7,443
Payable to pharmacy benefit administrator and other (4)	76,472	53,336	23,136
Total medical and other expenses payable	$ 1,396,784	$ 1,272,156	$ 124,628

(1) IBNR represents an estimate of medical expenses payable for claims incurred but not reported (IBNR) at the balance sheet date. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).

(2) Unprocessed claim inventories represent the estimated valuation of claims received but not yet fully processed. Further detail regarding unprocessed claim inventories is provided above.

(3) Processed claim inventories represent the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling.

(4) The balance due to our pharmacy benefit administrator fluctuates due to bi-weekly payments and the month-end cutoff and other medical expenses payable.

Cash Flow from Investing Activities

During the 2004 quarter, we reinvested a portion of our cash and cash equivalents in investment securities, primarily short-duration fixed income securities, totaling $457.6 million. Our ongoing capital expenditures primarily relate to our technology initiatives and administrative facilities necessary for activities such as claims processing, billing and collections, medical utilization review, and customer service. Total capital expenditures, excluding acquisitions, were $22.7 million for the 2004 quarter and $22.1 million for the 2003 quarter. Excluding acquisitions, we expect our total capital expenditures in 2004 to be approximately $100 million, most of which will be used for our technology initiatives and improvement of administrative facilities. Proceeds from the sale of the Jacksonville service center building increased investing cash flows $14.8 million.

Cash Flow from Financing Activities

The cash used in financing activities in the 2004 quarter resulted primarily from common stock repurchases and change in the book overdraft, partially offset by proceeds from stock option exercises.

Stock Repurchase Plan

In July 2003, the Board of Directors authorized the use of up to $100 million for the repurchase of our common shares exclusive of shares repurchased in connection with employee stock plans. The shares may be purchased from time to time at prevailing prices in the open market or in privately negotiated transactions. For the three months ended March 31, 2004, 686,000 common shares were acquired in open market transactions at an aggregate cost of $13.9 million, or an average of $20.33. As of May 6, 2004, $75.5 million of the July 2003 authorization remains available for share repurchases. See also the chart in Part II, Item 2 on page 34.

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Long-term Debt

Long-term debt outstanding was as follows at March 31, 2004 and December 31, 2003:

	March 31, 2004	December 31, 2003
	(in thousands)	
6.30% senior, unsecured notes due 2018, net of unamortized discount of $823 at March 31, 2004 and $838 at December 31, 2003	$ 299,177	$ 299,162
7.25% senior, unsecured notes due 2006, net of unamortized discount of $340 at March 31, 2004 and $376 at December 31, 2003	299,660	299,624
Fair value of interest rate swap agreements	19,545	12,754
Deferred gain from interest rate swap exchange	23,750	26,175
Total senior notes	642,132	637,715
Other long-term borrowings	4,765	4,923
Total long-term debt	$ 646,897	$ 642,638

Senior Notes

In order to term-out our short-term debt and take advantage of historically low interest rates, we issued $300 million 6.30% senior notes due August 1, 2018 on August 5, 2003. Our net proceeds, reduced for the cost of the offering, were approximately $295.8 million. The net proceeds were used for general corporate purposes, including the funding of our short term cash needs.

In order to hedge the risk of changes in the fair value of our $300 million 6.30% senior notes and our $300 million 7.25% senior notes attributable to fluctuations in interest rates, we entered into interest rate swap agreements. Interest rate swap agreements, which are considered derivatives, are contracts that exchange interest payments on a specified principal amount, or notional amount, for a specified period. The interest rate swap agreements have the same critical terms as our 6.30% senior notes and our 7.25% senior notes. Changes in the fair value of the 6.30% or 7.25% senior notes and the swap agreements due to changing interest rates are assumed to offset each other completely, resulting in no impact to earnings from hedge ineffectiveness. Our swap agreements are recognized in our condensed consolidated balance sheet at fair value with an equal and offsetting adjustment to the carrying value of our senior notes. The fair value of our interest rate swap agreements are estimated based on quoted market prices of comparable agreements, and reflect the amounts we would receive (or pay) to terminate the agreements at the reporting date.

In June 2003, we recorded a deferred gain and received proceeds of $31.6 million in exchange for new swap agreements discussed above related to our 7.25% senior notes. The corresponding deferred swap gain of $31.6 million is being amortized to reduce interest expense over the remaining term of the 7.25% senior notes. The carrying value of our 7.25% senior notes has been increased $23.8 million by the remaining deferred swap gain balance at March 31, 2004.

Our interest rate swap agreements exchange the fixed interest rate under our 6.30% and 7.25% senior notes for a variable interest rate. At March 31, 2004, the effective interest rate was 1.99% for the 6.30% senior notes and 2.98% for the 7.25% senior notes, including the amortization of the deferred swap gain. The $300 million swap agreements for the 6.30% senior notes mature on August 1, 2018, and the $300 million swap agreements for the 7.25% senior notes mature on August 1, 2006, and each has the same critical terms as the related senior notes.

At March 31, 2004, the $19.5 million fair value of our swap agreements is included in other long-term assets. Likewise, the carrying value of our senior notes has been increased $19.5 million to reflect its fair value. The counterparties to our swap agreements are major financial institutions with which we also have other financial relationships.

Credit Agreements

We maintain two unsecured revolving credit agreements consisting of a $265 million, 4-year revolving credit agreement and a $265 million, 364-day revolving credit agreement with a one-year term-out option. A one-year term-out option converts the outstanding borrowings, if any, under the credit agreement to a one-year term loan

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upon expiration. The 4-year revolving credit agreement expires in October 2005. In October 2003, we renewed the 364-day revolving credit agreement which expires in October 2004, unless extended.

There were no balances outstanding under either agreement at March 31, 2004. Under these agreements, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion of both agreements bears interest at either a fixed rate or floating rate based on LIBOR plus a spread. The spread, which varies depending on our credit ratings, ranges from 80 to 125 basis points for our 4-year agreement, and 85 to 137.5 basis points for our 364-day agreement. We also pay an annual facility fee regardless of utilization. This facility fee, currently 25 basis points, may fluctuate between 15 and 50 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings under either credit agreement will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate basis, at our option.

These credit agreements, and the agreement relating to the conduit commercial paper program described below, contain customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of net worth, minimum interest coverage, and maximum leverage ratios. At March 31, 2004, we were in compliance with all applicable financial covenant requirements. The terms of each of these credit agreements also include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow. We have not experienced a material adverse effect and we know of no circumstances or events which would be reasonably likely to result in a material adverse effect. We do not believe the material adverse effect clause poses a material funding risk to Humana in the future.

Commercial Paper Programs

We maintain indirect access to the commercial paper market through our conduit commercial paper financing program. Under this program, a third party issues commercial paper and loans the proceeds of those issuances to us so that the interest and principal payments on the loans match those on the underlying commercial paper. The $265 million, 364-day revolving credit agreement supports the conduit commercial paper financing program of up to $265 million.

We also maintain and may issue short-term debt securities under a commercial paper program when market conditions allow. The program is backed by our credit agreements described above. Under the terms of our credit agreements, aggregate borrowings under both the credit agreements and commercial paper program cannot exceed $530 million.

At March 31, 2004, we had no direct or indirect (conduit) commercial paper borrowings outstanding.

Other Borrowings

Other borrowings of $4.8 million at March 31, 2004 represent financing for the renovation of a building, bear interest at 2% per annum, are collateralized by the building, and are payable in various installments through 2014.

Shelf Registration

On April 1, 2003, our universal shelf registration became effective with the Securities and Exchange Commission. This allows us to register debt or equity securities, from time to time, with the amount, price and terms to be determined at the time of the sale. After the issuance of our $300 million, 6.30% senior notes in August 2003, we have up to $300 million remaining from a total of $600 million under the universal shelf registration. The universal shelf registration allows us to use the net proceeds from any future sales of our securities for our operations and for other general corporate purposes, including repayment or refinancing of borrowings, working capital, capital expenditures, investments, acquisitions, or the repurchase of our outstanding securities.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, is limited based on the entity s level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

As of March 31, 2004, we maintained aggregate statutory capital and surplus of $1,142.5 million in our state regulated health insurance subsidiaries. Each of these subsidiaries was in compliance with applicable statutory requirements which aggregated $664.0 million. Although the minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements can vary significantly at the state level. Certain states rely on risk-based capital requirements, or RBC, to define the required levels of equity.

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RBC is a model developed by the National Association of Insurance Commissioners to monitor an entity s solvency. This calculation indicates recommended minimum levels of required capital and surplus and signals regulatory measures should actual surplus fall below these recommended levels. If RBC were adopted by all states at March 31, 2004, each of our subsidiaries would be in compliance and we would have $419.2 million of aggregate capital and surplus above any of the levels that require corrective action under RBC.

One TRICARE subsidiary under the Regions 3 and 4 contract with the Department of Defense is required to maintain current assets at least equivalent to its current liabilities. We were in compliance with this requirement at March 31, 2004.

Future Liquidity Needs

Because of the items discussed in this Liquidity section, we believe that funds from future operating cash flows and funds available under our credit agreements and commercial paper program are sufficient to meet short and intermediate-term liquidity needs. We also believe these sources of funds are adequate to allow us to fund selected expansion opportunities, as well as to fund capital requirements.

Cautionary Statements

This document includes both historical and forward-looking statements. The forward-looking statements are made within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including, among other things, the information discussed below. In making these statements, we are not undertaking to address or update each factor in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

If the premiums we charge are insufficient to cover the cost of health care services delivered to our members, or if our estimates of medical claim reserves based upon our estimates of future medical claims are inadequate, our profitability could decline.

We use a significant portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments, allocations of some centralized expenses and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our medical cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future medical claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record medical claims reserves for future payments. We continually review estimates of future payments relating to medical claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves. However, increases in the use or cost of services by our members, competition, government regulations and many other factors may and often do cause actual health care costs to exceed what was estimated and reflected in premiums.

These factors may include:

increased use of medical facilities and services, including prescription drugs;

increased cost of such services;

the Company s membership mix;

membership in markets lacking adequate provider networks;

changes in the demographic characteristics of an account or market;

termination of capitation arrangements resulting in the transfer of membership to fee-for-service arrangements;

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changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;

catastrophes, including acts of terrorism or epidemics;

the introduction of new or costly treatments, including new technologies;

medical cost inflation; and

new government mandated benefits or other regulatory changes.

Failure to adequately price our products or estimate sufficient medical claim reserves may result in a material adverse effect on our financial position, results of operations and cash flows.

If we do not design and price our products properly and competitively, our membership and profitability could decline.

We are in a highly competitive industry. Many of our competitors are more established in the health care industry and have a larger market share and greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the MedicareAdvantage program, in e-commerce insurance or benefit programs and in consumer-directed health plans. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. The commercial pricing environment, particularly in the smaller-sized groups, is extremely competitive, and several of our competitors, including public and not-for-profit companies, are pricing aggressively to gain market share.

Premium increases, introduction of new product designs, and our relationship with our providers in various markets, among other issues, could affect our membership levels. Other actions that could affect membership levels include the possible exit of or entrance to MedicareAdvantage or Commercial markets. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, or if it declines, or if we lose accounts with favorable medical cost experience while retaining or increasing membership in accounts with unfavorable medical cost experience, our business and results of operations could be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, our business could be materially adversely affected.

Our future performance depends in large part upon our management team s ability to execute our strategy to position the company for the future. This strategy includes the growth of our Commercial segment business, introduction of new products and benefit designs, including our Smart products, the successful implementation of our e-business initiatives, the adoption of new technologies and the integration of acquired businesses. We believe that the adoption of new technologies will contribute toward a reduction in administrative costs as we more closely align our workforce with our membership. This alignment is achieved through reductions in workforce or by employing additional people in certain strategic operating areas such as sales and underwriting. Additionally, we have consolidated our service centers and their related systems as part of our operational initiatives. There can be no assurance that we will be able to successfully implement our operational and strategic initiatives

that are intended to position the company for future growth. Failure to implement this strategy may result in a material adverse effect on our financial position, results of operations and cash flows.

If we fail to properly maintain the integrity of our data, or to strategically implement new information systems, or to protect our proprietary rights to our systems, our business could be materially adversely affected.

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional systems. We have been taking steps to reduce the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have

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operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties failure to perform adequately under the contract, due to internal or external factors. Due to continued consolidation in the industry, there are a limited number of service organizations with the size, scale and capabilities to effectively provide certain of these services, especially with regard to pharmacy benefits processing and management. However, we believe that other organizations could provide similar services on comparable terms. A change in service providers, however, could result in a decline in service quality and effectiveness or less favorable contract terms which could adversely affect our operating results.

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

There can be no assurance that our process of improving existing systems, developing new systems to support our operations, integrating new systems, protecting our proprietary information, and improving service levels will not be delayed or that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data may result in a material adverse effect on our financial positions, results of operations and cash flows.

If we fail to manage prescription drug costs successfully, our financial results could suffer.

In general, prescription drug costs have been rising over the past few years. These increases are due to the introduction of new drugs costing significantly more than existing drugs, direct to consumer advertising by the pharmaceutical industry that creates consumer demand for particular brand-name drugs, and members seeking medications to address lifestyle changes. In order to control prescription drug costs, we have implemented multi-tiered copayment benefit designs for prescription drugs, including our four-tiered copayment benefit design, Rx4 and an Rx allowance program. We cannot assure that these efforts will be successful in controlling costs. Failure to control these costs could have a material adverse effect on our financial position, results of operations and cash flows.

We are involved in various legal actions, which, if resolved unfavorably to us, could result in substantial monetary damages.

We are a party to a variety of legal actions that affect our business, including employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, and tort claims.

We, together with some of our competitors in the health benefits business are defendants in a number of purported class action lawsuits. These include an action originally filed against us and nine of our competitors that purports to be brought on behalf of health care providers. Two

companies have now settled this action. This suit alleges breaches of federal statutes, including ERISA and RICO. Depending upon the outcome of these cases, these lawsuits may cause or force changes in the practices of the managed care industry.

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management and offering of products and services. These include and could include in the future:

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefits;
- challenges to the use of some software products used in administering claims;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for our providers alleged malpractice;

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allegations of anti-competitive and unfair business activities;

provider disputes over compensation and termination of provider contracts;

disputes related to self-funded business, including actions alleging claim administration errors;

claims related to the failure to disclose some business practices; and

claims relating to customer audits and contract performance.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, RICO and other statutes may be sought. While we currently have insurance coverage for some of these potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. Additionally, the cost of business insurance coverage has increased significantly. As a result, we have increased the amount of risk that we self-insure, particularly with respect to matters incidental to our business. We believe that we are adequately insured for claims in excess of our self-insurance. However, some types of damages, like punitive damages, may not be covered by insurance, particularly in those jurisdictions in which coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

A description of material legal actions in which we are currently involved is included under Legal Proceedings in Item 1 of Part II. We cannot predict the outcome of these suits with certainty, and we are incurring expenses in the defense of these matters. In addition, recent court decisions, including some that erode protections under the Employee Retirement Income Security Act, or ERISA, and legislative activity may increase our exposure for any of these types of claims. Therefore, these legal actions could have a material adverse effect on our financial position, results of operations and cash flows.

As a government contractor, we are exposed to additional risks that could adversely affect our business or our willingness to participate in government health care programs.

A significant portion of our revenues relates to federal, state and local government health care coverage programs, including the TRICARE, MedicareAdvantage, and Medicaid programs. These programs involve various risks, including:

the possibility of reduced or insufficient government reimbursement in the future;

the possibility that we will not be able to extend or renew any of the contracts relating to these programs. These contracts also are generally subject to frequent change, including changes that may reduce the number of persons enrolled or eligible to enroll, reduce the revenue we receive or increase our administrative or health care costs under those programs. We continue to work on transitioning our TRICARE business in the interim period before the commencement of the new South contract which is scheduled to begin August 1, 2004 as it relates to our current Regions 3 and 4 contracts and November 1, 2004 as it relates to the current Region 6 contract. If this schedule is realized, our TRICARE membership is expected to temporarily decline to 1.5 million in July 2004, and is expected to increase to 2.8 million in November 2004. This will also result in a decline in revenues during the third and fourth quarters of 2004.

in the event government reimbursement were to decline from projected amounts, our failure to reduce the health care costs associated with these programs could have a material adverse effect on our business. Changes to these government programs in the future may also affect our ability or willingness to participate in these programs. Other than as described herein, the loss of our current or future TRICARE contracts, would have a material adverse effect on our financial position, results of operations and cash flows;

at March 31, 2004, under one of our contracts with the Centers for Medicare and Medicaid Services, or CMS, we provided health insurance coverage to approximately 229,900 members in Florida. This contract accounted for approximately 15% of our total premiums and ASO fees for the three months ended March 31, 2004. The loss of this and other CMS contracts or significant changes in the MedicareAdvantage

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program as a result of legislative action, including reductions in payments to us or increases in benefits to members without corresponding increases in payments, may have a material adverse effect on our financial condition, results of operations and cash flows;

in December 2003, The Medicare Prescription Drug, Improvement and Modernization Act, or DIMA, was signed into law. DIMA includes provisions that require the 2004 stabilization funding to be directed toward increased reimbursement for providers, increased benefits or access for members or decreased member premiums. We believe DIMA will open new opportunities for us. However, DIMA may intensify competition in the seniors health services market. We do not believe that the benefit to our 2004 financial position, results of operations or cash flows will be material;

higher comparative medical costs;

government regulatory and reporting requirements;

higher marketing and advertising costs per member as a result of marketing to individuals as opposed to groups; and

the possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act.

Our industry is currently subject to substantial government regulation, which, along with possible increased governmental regulation or legislative reform, increases our costs of doing business and could adversely affect our profitability.

The health care industry in general, and health insurance, particularly health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs, are subject to substantial federal and state government regulation, including:

regulation relating to minimum net worth;

licensing requirements;

approval of policy language and benefits;

mandated benefits and processes;

provider compensation arrangements;

member disclosure;

approval of entry, withdrawal or re-entry into a state or market;

premium rates; and

periodic examinations by state and federal agencies.

State regulations require our licensed, operating subsidiaries to maintain minimum net worth requirements and restrict some investment activities. Additionally, those regulations restrict the ability of our subsidiaries to make dividend payments, loans, loan repayments or other payments to us.

In recent years, significant federal and state legislation affecting our business has been enacted. State and federal governmental authorities are continually considering changes to laws and regulations applicable to us and are currently considering regulations relating to:

mandatory benefits and products;

rules tightening time periods in which claims must be paid;

medical malpractice reform;

defining medical necessity;

health insurance access;

provider compensation and contract language;

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- disclosure of provider fee schedules and other data impacting payments to providers;
- product flexibility and use of innovative technology;
- disclosure of provider quality information;
- health plan liability to members who fail to receive appropriate care;
- disclosure and composition of physician networks;
- formation of regional/national association health plans for small employers;
- adding further restrictions and administrative requirements on the use, retention, transmission, processing, production and disclosure of personally identifiable health information,
- physicians ability to collectively negotiate contract terms with carriers, including fees; and
- mental health parity.

All of these proposals could apply to us.

There can be no assurance that we will be able to continue to obtain or maintain required governmental approvals or licenses or that legislative or regulatory changes will not have a material adverse effect on our business. Delays in obtaining or failure to obtain or maintain required approvals could adversely affect our revenue or the number of our members, increase costs or adversely affect our ability to bring new products to market as forecasted.

The National Association of Insurance Commissioners, or NAIC, has adopted risk-based capital requirements, also known as RBC, which is subject to state-by-state adoption and to the extent implemented, sets minimum capitalization requirements for insurance and HMO companies. The NAIC recommendations for life insurance companies were adopted in all states and the prescribed calculation for HMOs has been adopted in most states in which we operate. The HMO rules may increase the minimum capital required for some of our subsidiaries.

The NAIC is also evaluating the adoption of Sarbanes-Oxley type audit committee standards and requirements for additional attestations by management and external auditors. We expect the proposal to be amended during the review process. However, as currently drafted, the proposal would cause us to expend substantial resources.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers and seeking protections for confidentiality and security of patient data. Under the new HIPAA standard transactions and code sets rules, we have made significant systems enhancements and invest in new technological solutions. The compliance and enforcement date for standard

transactions and code sets rules was October 16, 2003. We have continued to be in compliance with this regulation. However, as many providers indicated that they could not yet comply, CMS stated that covered entities making a good faith effort to comply with HIPAA transactions and code-set standards would be allowed to implement contingency plans to maintain their operations and cash flows. On October 15, 2003, we announced implementation of a contingency plan to accept non-compliant electronic transactions from our providers. We have continued to accept and process transactions sent in pre-HIPAA electronic formats from providers who are showing a good-faith effort and currently expect to do so until all providers and clearinghouses are capable of transmitting fully compliant standards transactions as defined in the HIPAA implementation guidelines or until CMS begins enforcement of the HIPAA Electronic Data Interchange regulations. Management believes that the implementation of our contingency plans has minimized any disruptions in our business operations during this transition. However, if entities with which we do business do not ultimately comply with the HIPAA transactions and code set standards, it could result in disruptions of certain of our business operations.

Additionally, under the new HIPAA privacy rules, which became effective on April 14, 2003, we must now comply with a variety of requirements concerning the use and disclosure of individuals protected health information, establish rigorous internal procedures to protect health information and enter into business associate contracts with those companies to whom protected health information is disclosed. Regulations issued in February 2003 set standards for the security of electronic health information requiring compliance by April 21, 2005. Violations of these rules will subject us to significant penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. The final rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent. HIPAA could also expose us to additional liability for violations by our business associates.

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Another area receiving increased focus is the time in which various laws require the payment of health care claims. Many states already have legislation in place covering payment of claims within a specific number of days. However, due to provider groups advocating for laws or regulations establishing even stricter standards, procedures and penalties, we expect additional regulatory scrutiny and supplemental legislation with respect to claims payment practices. The provider-sponsored bills are characterized by stiff penalties for late payment, including high interest rates payable to providers and costly fines levied by state insurance departments and attorneys general. This legislation and possible future regulation and oversight could expose our Company to additional liability and penalties.

We are also subject to various governmental audits and investigations. These can include audits and investigations by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, the Defense Contract Audit Agency, and state Departments of Insurance and Departments of Health. These activities could result in the loss of licensure or the right to participate in various programs, or the imposition of fines, penalties and other sanctions. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services.

If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business could be adversely affected.

We contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. These providers may share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner.

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may, in some cases, compete directly with us. If these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be adversely affected.

In some situations, we have contracts with individual or groups of primary care physicians for an actuarially determined, fixed, per-member-per-month fee under which physicians are paid an amount to provide all required medical services to our members (i.e. capitation). The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us, even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have an adverse effect on the provision of services to our members and our operations.

Our ability to obtain funds from our subsidiaries is restricted.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., the parent company. These subsidiaries generally are regulated by states Departments of Insurance. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends from these subsidiaries that exceed specified amounts, or, in some states, any amount. In addition, we normally notify the state Departments of Insurance prior to making payments that do not require approval. We are also required by law to maintain specific prescribed minimum amounts of capital in these subsidiaries. One TRICARE subsidiary under the Regions 3 and 4 contract with the Department of Defense is required to maintain current assets at least equivalent to its current liabilities.

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Increased litigation and negative publicity could increase our cost of doing business.

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation and governmental review of industry practices. These factors may adversely affect our ability to market our products or services, may require us to change our products or services, may increase the regulatory burdens under which we operate and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our financial position, results of operations and cash flows.

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Item 3. Quantitative and Qualitative Disclosure about Market Risk

No material changes have occurred in our exposures to market risk since the date of our Annual Report on Form 10-K for the fiscal year ended December 31, 2003.

Item 4. Controls and Procedures

We carried out an evaluation, under the supervision and with the participation of our Chief Executive Officer, or CEO and Chief Financial Officer, or CFO, of the effectiveness of the design and operation of our disclosure controls and procedures including our internal controls over financial reporting for the quarter ended March 31, 2004.

The Company s management, including the CEO and CFO, does not expect that our disclosure controls and procedures including our internal controls over financial reporting will prevent all error and all fraud. However, they have been designed to give reasonable assurance about the effectiveness of the design and operation of our disclosure controls and procedures including our internal controls over financial reporting. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Control system limitations include the realities that judgments in decision-making can be faulty, and that breakdowns can occur because of simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the control. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events. Over time, controls may become inadequate because of changes in conditions, or the degree of compliance with the policies or procedures may deteriorate. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

Based on this evaluation, our CEO and CFO concluded that our disclosure controls and procedures including our internal controls over financial reporting are effective in timely alerting them to material information required to be included in our periodic SEC reports. There have been no significant changes in our internal controls over financial reporting or in other factors that are reasonably likely to affect those controls over financial reporting during the Company s quarter ended March 31, 2004.

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Part II. Other Information

Item 1: Legal Proceedings

For a description of the litigation and legal proceedings pending against us, see Legal Proceedings in Footnote 10 to the condensed financial statements beginning on page 12 of this Form 10-Q.

Item 2: Changes in Securities, Use of Proceeds and Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the quarter ended March 31, 2004 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (2)(3)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs
January 2004	150,000	$ 20.7130	150,000	$ 96,893,049
February 2004	129,000	$ 21.2539	129,000	$ 94,151,299
March 2004	407,000	$ 19.9013	407,000	$ 86,051,470
Total	686,000	$ 20.3331	686,000	$ 86,051,470

(1) We repurchased an aggregate of 686,000 shares of our common stock pursuant to the repurchase program that we publicly announced in July 2003 (the Program).
(2) Our board of directors approved the repurchase by us of shares of our common stock having a value of up to $100 million in the aggregate pursuant to the Program. The expiration date of this program is January 2005.
(3) Excludes 34,970 shares repurchased in connection with employee equity-based compensation plans.

Item 3: Defaults Upon Senior Securities

None.

Item 4: Submission of Matters to a Vote of Security Holders

(a) The regular annual meeting of the stockholders of Humana Inc. was held in Louisville, Kentucky on April 22, 2004, for the purpose of voting on the proposal described below.

(b) Proxies for the meeting were solicited pursuant to Section 14(a) of the Securities Exchange Act of 1934 and there was no solicitation in opposition to management s nominees for directors. All of management s nominees for directors were elected as set forth in clause (c) below.

(c) One proposal was submitted to a vote of security holders as follows:

(1) The stockholders approved the election of the following persons as directors of the Company:

Name	For	Withheld
David A. Jones	143,847,127	6,896,001
David A. Jones, Jr.	144,919,397	5,823,731
Frank A. D Amelio	145,758,879	4,984,249
Michael E. Gellert	144,587,237	6,155,891
John R. Hall	145,702,721	5,040,407
Kurt J. Hilzinger	147,748,980	2,994,148
Michael B. McCallister	145,188,686	5,554,442
W. Ann Reynolds, Ph.D.	145,545,130	5,197,998

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Part II. Other Information, continued

Item 5: Other Information

None.

Item 6: Exhibits and Reports on Form 8-K

(a) Exhibit Index:

12	Computation of ratio of earnings to fixed charges.
31.1	CEO certification pursuant to Section 302 of Sarbanes Oxley Act of 2002.
31.2	CFO certification pursuant to Section 302 of Sarbanes Oxley Act of 2002.
32	CEO and CFO certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

(b) Reports on Form 8-K

(1) On February 2, 2004, we furnished a report regarding our fourth quarter of 2003 earnings release.

(2) On April 1, 2004, we filed a report regarding the completion of the acquisition of Ochsner Health Plan.

(3) On April 26, 2004, we furnished a report regarding our first quarter of 2004 earnings release.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

HUMANA INC.

(Registrant)

Date: May 7, 2004 By: /s/ JAMES H. BLOEM

James H. Bloem

Senior Vice President And Chief Financial Officer

(Principal Accounting Officer)

Date: May 7, 2004 By: /s/ ARTHUR P. HIPWELL

Arthur P. Hipwell

Senior Vice President and General Counsel