HUMANA INC
Form 10-K
February 19, 2010
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2009

OR

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

For the transition period from _____ to _____

Commission file number 1-5975

HUMANA INC.

(Exact name of registrant as specified in its charter)

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

500 West Main Street

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

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

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

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

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

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes þ No ¨

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No þ

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes þ No ¨

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

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

Large accelerated filer þ Accelerated filer ¨ Non-accelerated filer ¨ Smaller reporting company ¨

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

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2009 was $5,356,684,733 calculated using the average price on such date of $31.85.

The number of shares outstanding of the Registrant s Common Stock as of January 31, 2010 was 170,225,097.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant s Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held April 20, 2010.

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HUMANA INC.

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For the Year Ended December 31, 2009

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Forward-Looking Statements

Some of the statements under Business, Management s Discussion and Analysis of Financial Condition and Results of Operations, and elsewhere in this report may contain forward-looking statements which reflect our current views with respect to future events and financial performance. These 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, or the Exchange Act. 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 the information discussed under the section entitled Risk Factors in this report. In making these statements, we are not undertaking to address or update them in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as we, us, our, the Company or Humana, is one of the nation s largest publicly traded health and supplemental benefits companies, based on our 2009 revenues of approximately $31.0 billion. We are a full-service benefits solutions company, offering a wide array of health and supplemental benefit products for employer groups, government benefit programs, and individuals. As of December 31, 2009, we had approximately 10.3 million members in our medical benefit plans, as well as approximately 7.2 million members in our specialty products. During 2009, 73% of our premiums and administrative services fees were derived from contracts with the federal government, including 17% related to our Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, and 12% related to our military services contracts. Under our Medicare Advantage CMS contracts in Florida, we provide health insurance coverage to approximately 377,900 members as of December 31, 2009.

Humana Inc. was organized as a Delaware corporation in 1964. Our principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202, the telephone number at that address is (502) 580-1000, and our website address is www.humana.com. We have made available free of charge through the Investor Relations section of our web site our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

This Annual Report on Form 10-K contains both historical and forward-looking information. See Item 1A. Risk Factors for a description of a number of factors that may adversely affect our results or business.

Business Segments

We manage our business with two segments: Government and Commercial. The Government segment consists of beneficiaries of government benefit programs, and includes three lines of business: Medicare, Military, and Medicaid. The Commercial segment consists of members enrolled in our medical and specialty products marketed to employer groups and individuals. When identifying our segments, we aggregated products

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with similar economic characteristics. These characteristics include the nature of customer groups as well as pricing, benefits, and underwriting requirements. These segment groupings are consistent with information used by our Chief Executive Officer.

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

Our Products

As more fully described in the products discussion that follows, we provide health insurance benefits under health maintenance organization, or HMO, Private Fee-For-Service, or PFFS, and preferred provider organization, or PPO, plans. In addition, we provide other benefits with our specialty products including dental, vision, and other supplementary benefits. The following table presents our segment membership at December 31, 2009, and premiums and administrative services only, or ASO, fees by product for the year ended December 31, 2009:

	Medical Membership	Specialty Membership	Premiums	ASO Fees	Total Premiums and ASO Fees	Percent of Total Premiums and ASO Fees
			(dollars in thousands)			
Government:						
Medicare Advantage:						
HMO	591,900		$ 7,633,764	$	$ 7,633,764	25.1%
PFFS	564,200		5,630,690		5,630,690	18.5%
PPO	352,400		3,148,847		3,148,847	10.4%
Total Medicare Advantage	1,508,500		16,413,301		16,413,301	54.0%
Medicare stand-alone PDP	1,927,900		2,327,418		2,327,418	7.6%
Total Medicare	3,436,400		18,740,719		18,740,719	61.6%
Medicaid insured	401,700		646,195		646,195	2.1%
Military services insured	1,756,000		3,426,739		3,426,739	11.3%
Military services ASO	1,278,400			108,442	108,442	0.3%
Total military services	3,034,400		3,426,739	108,442	3,535,181	11.6%
Total Government	6,872,500		22,813,653	108,442	22,922,095	75.3%
Commercial:						
Fully-insured:						
PPO	1,053,200		3,188,598		3,188,598	10.5%
HMO	786,300		2,996,560		2,996,560	9.9%
Total fully-insured	1,839,500		6,185,158		6,185,158	20.4%
ASO	1,571,300			373,376	373,376	1.2%
Specialty		7,200,100	927,940	14,317	942,257	3.1%
Total Commercial	3,410,800	7,200,100	7,113,098	387,693	7,500,791	24.7%

Total	10,283,300	7,200,100	$ 29,926,751	$ 496,135	$ 30,422,886	100.0%

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Our Products Marketed to Government Segment Members and Beneficiaries

Medicare

We have participated in the Medicare program for private health plans for over 20 years and have established a national presence, offering at least one type of Medicare plan in all 50 states. The resulting growing membership base provides us with greater ability to expand our network of PPO and HMO providers. We employ strategies including health assessments and clinical guidance programs such as lifestyle and fitness programs for seniors to guide Medicare beneficiaries in making cost-effective decisions with respect to their health care, including cost savings that occur from making positive behavior changes that result in living healthier.

Medicare is a federal program that provides persons age 65 and over and some disabled persons under the age of 65 certain hospital and medical insurance benefits. Hospitalization benefits are provided under Part A, without the payment of any premium, for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Eligible beneficiaries are required to pay an annually adjusted premium to the federal government to be eligible for physician care and other services under Part B. Beneficiaries eligible for Part A and Part B coverage under traditional Medicare are still required to pay out-of-pocket deductibles and coinsurance. Prescription drug benefits are provided under Part D. CMS, an agency of the United States Department of Health and Human Services, administers the Medicare program.

Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, to Medicare eligible persons under HMO, PPO, and PFFS plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of original Medicare, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data analysis techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, disease management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Since 2006, Medicare beneficiaries have had more health plan options, including a prescription drug benefit option. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits.

Our Medicare HMO and PPO plans, which cover Medicare-eligible individuals residing in certain counties, may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations, HMO plans provide no out-of-network benefits. PPO plans carry an out-of network benefit that is subject to higher member cost-sharing. In most cases, these beneficiaries are required to pay a monthly premium to the HMO or PPO plan in addition to the monthly Part B premium they are required to pay the Medicare program.

Our Medicare PFFS plans generally have no preferred network. Individuals in these plans pay us a monthly premium to receive typical Medicare Advantage benefits along with the freedom to choose any health care provider that accepts individuals at rates equivalent to traditional Medicare payment rates.

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS s risk-adjustment model which uses health status indicators, or risk scores, to improve the adequacy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits and Improvement Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital

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inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits). CMS transitioned to this risk-based payment model while the old payment model based on demographic data including gender, age, and disability status was phased out. The phase-in of risk adjusted payment was completed in 2007. Under the risk-adjustment methodology, all health benefit organizations must collect and submit the necessary diagnosis code information to CMS within prescribed deadlines.

Commensurate with the phase-in of the risk-adjustment methodology, payments to Medicare Advantage plans were increased by a budget neutrality factor. The budget neutrality factor was implemented to prevent overall health plan payments from being reduced during the transition from the previous payment model, based upon average original Medicare fee-for-service spending, to the risk-adjustment payment model. The budget neutrality adjustment began phasing out in 2007 and will be fully eliminated by 2011.

At December 31, 2009, we provided health insurance coverage under CMS contracts to approximately 1,508,500 Medicare Advantage members for which we received premium revenues of approximately $16.4 billion, or 54.0%, of our total premiums and ASO fees for the year ended December 31, 2009. Under our Medicare Advantage contracts with CMS in Florida, we provided health insurance coverage to approximately 377,900 members. These contracts accounted for premium revenues of approximately $5.2 billion, which represented approximately 31.8% of our Medicare Advantage premium revenues, or 17.1% of our total premiums and ASO fees for the year ended December 31, 2009.

Our HMO, PFFS, and PPO products covered under Medicare Advantage contracts with CMS are renewed generally for a one-year term each December 31 unless CMS notifies us of its decision not to renew by August 1 of the year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage business have been renewed for 2010.

Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D. Generally, Medicare-eligible individuals enroll in one of our plan choices between November 15 and December 31 for coverage that begins January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles and co-insurance. Our revenues from CMS and the beneficiary are determined from our bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described beginning on page 60. Our stand-alone PDP contracts with CMS are renewed generally for a one-year term each December 31 unless CMS notifies us of its decision not to renew by August 1 of the year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP business have been renewed for 2010.

Medicare stand-alone PDP premium revenues were approximately $2.3 billion, or 7.6% of our total premiums and ASO fees for the year ended December 31, 2009.

Medicaid Product

Medicaid is a federal program that is state-operated to facilitate the delivery of health care services primarily to low-income residents. Each electing state develops, through a state-specific regulatory agency, a Medicaid managed care initiative that must be approved by CMS. CMS requires that Medicaid managed care plans meet federal standards and cost no more than the amount that would have been spent on a comparable fee-for-service basis. States currently either use a formal proposal process in which they review many bidders before selecting one or award individual contracts to qualified bidders who apply for entry to the program. In either case, the contractual relationship with a state generally is for a one-year period. Under these contracts, we

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receive a fixed monthly payment from a government agency for which we are required to provide health insurance coverage to enrolled members. Due to the increased emphasis on state health care reform and budgetary constraints, more states are utilizing a managed care product in their Medicaid programs.

Our Medicaid business, which accounted for premium revenues of approximately $646.2 million, or 2.1%, of our total premiums and ASO fees for the year ended December 31, 2009, consists of contracts in Puerto Rico and Florida, with the vast majority in Puerto Rico.

Military Services

Under our TRICARE South Region contract with the United States Department of Defense, or DoD, we provide health insurance coverage to the dependents of active duty military personnel and to retired military personnel and their dependents. Currently, three health benefit options are available to TRICARE beneficiaries. In addition to a traditional indemnity option, participants may enroll in a HMO-like plan with a point-of-service option or take advantage of reduced copayments by using a network of preferred providers, similar to a PPO.

We have participated in the TRICARE program since 1996 under contracts with the Department of Defense. Our current TRICARE South Region contract, which we were awarded in 2003, covers approximately 3.0 million eligible beneficiaries as of December 31, 2009 in Florida, Georgia, South Carolina, Mississippi, Alabama, Tennessee, Louisiana, Arkansas, Texas and Oklahoma. The South Region is one of the three regions in the United States as defined by the Department of Defense. Of these eligible beneficiaries, 1.3 million were TRICARE ASO members representing active duty beneficiaries, seniors over the age of 65 and beneficiaries in Puerto Rico for which the Department of Defense retains all of the risk of financing the cost of their health benefit. We have subcontracted with third parties to provide selected administration and specialty services under the contract. The original 5-year South Region contract expired March 31, 2009. Through an Amendment of Solicitation/Modification of Contract to the TRICARE South Region contract, an additional one-year option period, the sixth option period, which runs from April 1, 2009 through March 31, 2010, was exercised by the government. The Amendment also provides for two additional six-month option periods: the seventh option period runs from April 1, 2010 through September 30, 2010 and the eighth option period runs from October 1, 2010 through March 31, 2011. Exercise of each of the seventh and eighth option periods is at the government s option. On December 16, 2009, we were notified by Department of Defense TRICARE Management Activity, or TMA, that it intends to exercise its options to extend the TRICARE South Region contract for Option Period VII and Option Period VIII. The exercise of these option periods would effectively extend the TRICARE South Region contract through March 31, 2011. The contract s transition provisions require the continuation of certain activities, primarily claims processing, during a wind-down period lasting approximately six months following the expiration date. Claims incurred on or prior to the expiration date would continue to be processed during the wind-down period under the terms existing prior to the expiration date.

The TRICARE South Region contract contains provisions that require us to negotiate a target health care cost amount annually with the federal government. Any variance from the target health care cost is shared with the federal government. Accordingly, events and circumstances not contemplated in the negotiated target health care cost amount may have a material adverse effect on us. These changes may include an increase or reduction in the number of persons enrolled or eligible to enroll due to the federal government s decision to increase or decrease U.S. military deployments.

In July 2009, we were notified by the Department of Defense that we were not awarded the third generation TRICARE program contract for the South Region which had been subject to competing bids. We filed a protest with the Government Accountability Office, or GAO, in connection with the award to another contractor citing discrepancies between the award criteria and procedures prescribed in the request for proposals issued by the DoD and those that appear to have been used by the DoD in making its contractor selection. In October 2009, we learned that the GAO had upheld our protest, determining that the TMA evaluation of our proposal had unreasonably failed to fully recognize and reasonably account for the likely cost savings associated with our

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record of obtaining network provider discounts from our established network in the South Region. On December 22, 2009, we were advised that TMA notified the GAO of its intent to implement corrective action consistent with the discussion contained within the GAO s decision with respect to our protest. At this time, we are not able to determine what actions TMA will take in response to recommendations by the GAO, nor can we determine whether or not the protest decision by the GAO will have any effect upon the ultimate disposition of the contract award.

For the year ended December 31, 2009, military services premium revenues were approximately $3.4 billion, or 11.3% of our total premiums and ASO fees, and military services ASO fees totaled $108.4 million, or 0.3% of our total premiums and ASO fees. The TRICARE South Region contract represents approximately 97% of total military services premiums and ASO fees.

International Operations

In August 2006, we established our subsidiary Humana Europe in the United Kingdom to provide commissioning support to Primary Care Trusts, or PCTs, in England. Under the contracts we are awarded, we work in partnership with local PCTs, health care providers, and patients to strengthen health-service delivery and to implement strategies at a local level to help the National Health Service enhance patient experience, improve clinical outcomes, and reduce costs. For the year ended December 31, 2009, revenues under these contracts were approximately $9.0 million, or less than 0.1% of our total premium and ASO fees.

Our Products Marketed to Commercial Segment Employers and Members

We offer medical and specialty benefits to employer groups and individuals in the commercial market. Our commercial medical products offered as HMO, PPO or ASO, more fully described in the following sections, include offerings designed to provide additional options to the consumer. For example, our Smart products give more cost control and predictability to employers and more choice and control over healthcare decision-making to employees. Online tools and resources deliver information, convenience, and easy access for members enrolled in our Smart products. Our other consumer offerings include products with a high deductible offering in conjunction with a spending account.

HMO

Our commercial HMO products provide prepaid health insurance coverage to our members through a network of independent primary care physicians, specialty physicians, and other health care providers who contract with the HMO to furnish such services. Primary care physicians generally include internists, family practitioners, and pediatricians. Generally, the member s primary care physician must approve access to certain specialty physicians and other health care providers. These other health care providers include hospitals, nursing homes, home health agencies, pharmacies, mental health and substance abuse centers, diagnostic centers, optometrists, outpatient surgery centers, dentists, urgent care centers, and durable medical equipment suppliers. Because the primary care physician generally must approve access to many of these other health care providers, the HMO product is considered the most restrictive form of a health benefit plan.

An HMO member, typically through the member s employer, pays a monthly fee, which generally covers, together with some copayments, health care services received from, or approved by, the member s primary care physician. We participate in the Federal Employee Health Benefits Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government s health insurance program for Federal employees, retirees, former employees, family members, and spouses. For the year ended December 31, 2009, commercial HMO premium revenues totaled approximately $3.0 billion, or 9.9% of our total premiums and ASO fees.

PPO

Our commercial PPO products, which are marketed primarily to employer groups and individuals, include some types of wellness and utilization management programs. However, they typically include more cost-sharing

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

As part of our PPO products, we offer HumanaOne, a major medical product marketed directly to individuals. We offer this product in select markets where we can generally underwrite risk and utilize our existing networks and distribution channels. This individual product includes provisions mandated by law to guarantee renewal of coverage for as long as the individual chooses.

For the year ended December 31, 2009, employer and individual commercial PPO premium revenues totaled approximately $3.2 billion, or 10.5% of our total premiums and ASO fees.

ASO

We also offer ASO products to employers who self-insure their employee health plans. We receive fees to provide administrative services which generally include the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded employers. These products may include all of the same benefit and product design characteristics of our fully-insured PPO or HMO products described previously. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, most ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs. For the year ended December 31, 2009, commercial ASO fees totaled $373.4 million, or 1.2% of our total premiums and ASO fees.

Specialty

We also offer various specialty products, including dental, vision, and other supplemental products as well as disease management services under Corphealth, Inc. (d/b/a LifeSynch) and mail-order pharmacy benefit administration services for our members under Humana Pharmacy, Inc. (d/b/a *Right*SourceRx[SM]). During 2007, we made investments which significantly expanded our specialty product offerings with the acquisitions of CompBenefits Corporation and KMG America Corporation. These acquisitions significantly increased our dental membership and added new product offerings, including vision and other supplemental health and life products. The supplemental health plans cover, for example, some of the costs associated with cancer and critical illness. Other supplemental health products also include a closed block of approximately 36,000 long-term care policies acquired in connection with the KMG acquisition. No new policies have been written since 2005 under this closed block. At December 31, 2009, we had approximately 7.2 million specialty members, including 3.8 million dental members and 2.5 million vision members. For the year ended December 31, 2009, specialty product premiums and ASO fees were approximately $942.3 million, or 3.1% of our total premiums and ASO fees.

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Membership

The following table summarizes our total medical membership at December 31, 2009, by market and product:

	Government				Commercial				
	Medicare Advantage	Medicare stand-alone PDP	Medicaid	Military services	PPO	HMO	ASO	Total	Percent of Total
				(in thousands)					
Florida	377.9	82.0	51.8		104.4	160.0	81.3	857.4	8.3%
Kentucky	59.3	41.1			116.3	41.7	525.8	784.2	7.6%
Texas	96.2	172.5			165.6	152.0	125.9	712.2	6.9%
Puerto Rico	14.8	0.3	349.9		39.0	15.6	36.1	455.7	4.4%
Illinois	72.1	54.0			137.1	70.0	94.8	428.0	4.2%
Ohio	51.2	64.0			12.7	89.0	170.4	387.3	3.8%
Wisconsin	50.5	40.4			63.6	52.9	170.8	378.2	3.7%
Louisiana	79.6	28.3			39.6	30.4	133.8	311.7	3.0%
Tennessee	68.7	54.3			62.8	18.7	65.5	270.0	2.6%
Missouri/Kansas	63.3	105.6			63.1	13.1	7.0	252.1	2.5%
Georgia	41.9	51.6			8.3	91.2	36.2	229.2	2.2%
Indiana	31.8	61.0			32.0	2.9	50.5	178.2	1.7%
Michigan	34.8	62.5			40.0		5.9	143.2	1.4%
North Carolina	63.5	69.6			8.0			141.1	1.4%
Arizona	31.4	25.6			30.5	25.1	12.2	124.8	1.2%
Virginia	51.5	63.5			3.3			118.3	1.2%
Colorado	19.5	22.6			40.2	23.7		106.0	1.0%
California	7.3	95.8			1.2			104.3	1.0%
Military services				1,756.0				1,756.0	17.1%
Military services ASO				1,278.4				1,278.4	12.5%
Others	293.2	833.2			85.5		55.1	1,267.0	12.3%
Totals	1,508.5	1,927.9	401.7	3,034.4	1,053.2	786.3	1,571.3	10,283.3	100.0%

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care physicians, specialist physicians, dentists and providers of ancillary health care services and facilities. These ancillary services and facilities include ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

We use a variety of techniques to provide access to effective and efficient use of health care services for our members. These techniques include the coordination of care for our members, product and benefit designs, hospital inpatient management systems and enrolling members into various disease management programs. The focal point for health care services in many of our HMO networks is the primary care physician who, under contract with us, provides services to our members, and may control utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. Some physicians may have arrangements under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met. Our hospitalist programs use specially-trained physicians to effectively manage the entire range of an HMO member s medical care during a hospital admission and to effectively coordinate the member s discharge and post-discharge care. We have available a variety of disease management programs related to specific medical conditions such as congestive heart failure, coronary artery disease, prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

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We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate or diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index or other nationally recognized inflation indexes. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

Our contracts with physicians typically are renewed automatically each year, unless either party gives written notice, generally ranging from 90 to 120 days, to the other party of its intent to terminate the arrangement. Most of the physicians in our PPO networks and some of our physicians in our HMO networks are reimbursed based upon a fixed fee schedule, which typically provides for reimbursement based upon a percentage of the standard Medicare allowable fee schedule.

Capitation

For approximately 2.4% of our medical membership at December 31, 2009, we contract with hospitals and physicians to accept financial risk for a defined set of HMO membership. In transferring this risk, we prepay these providers a monthly fixed-fee per member, known as a capitation (per capita) payment, to coordinate substantially all of the medical care for their capitated HMO membership, including some health benefit administrative functions and claims processing. For these capitated HMO arrangements, we generally agree to reimbursement rates that target a benefit ratio. The benefit ratio measures underwriting profitability and is computed by taking total benefit expenses as a percentage of premium revenues. Providers participating in hospital-based capitated HMO arrangements generally receive a monthly payment for all of the services within their system for their HMO membership. Providers participating in physician-based capitated HMO arrangements generally have subcontracted directly with hospitals and specialist physicians, and are responsible for reimbursing such hospitals and physicians for services rendered to their HMO membership.

For approximately 5.7% of our medical membership at December 31, 2009, we contract with physicians under risk-sharing arrangements whereby physicians have assumed some level of risk for all or a portion of the medical costs of their HMO membership. Although these arrangements do include physician capitation payments for services rendered, we share hospital and other benefit expenses and process substantially all of the claims under these arrangements.

Physicians under capitation arrangements typically have stop loss coverage so that a physician s financial risk for any single member is limited to a maximum amount on an annual basis. We monitor the financial performance and solvency of our capitated providers. However, we remain financially responsible for health care services to our members in the event our providers fail to provide such services.

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Medical membership under these various arrangements was as follows at December 31, 2009 and 2008:

	Government Segment						Commercial Segment			
	Medicare Advantage	Medicare stand-alone PDP	Military services	Military Services ASO	Medicaid	Total Segment	Fully-Insured	ASO	Total Segment	Total Medical
Medical Membership:										
December 31, 2009										
Capitated HMO hospital system based	31,000					31,000	22,200		22,200	53,200
Capitated HMO physician group based	50,200				117,600	167,800	26,300		26,300	194,100
Risk-sharing	285,100				279,200	564,300	22,400		22,400	586,700
Other	1,142,200	1,927,900	1,756,000	1,278,400	4,900	6,109,400	1,768,600	1,571,300	3,339,900	9,449,300
Total	1,508,500	1,927,900	1,756,000	1,278,400	401,700	6,872,500	1,839,500	1,571,300	3,410,800	10,283,300
December 31, 2008										
Capitated HMO hospital system based	25,600					25,600	24,000		24,000	49,600
Capitated HMO physician group based	48,400				146,500	194,900	27,500		27,500	222,400
Risk-sharing	274,100				235,600	509,700	25,000		25,000	534,700
Other	1,087,800	3,066,600	1,736,400	1,228,300	89,000	7,208,100	1,902,300	1,642,000	3,544,300	10,752,400
Total	1,435,900	3,066,600	1,736,400	1,228,300	471,100	7,938,300	1,978,800	1,642,000	3,620,800	11,559,100
Medical Membership Distribution:										
December 31, 2009										
Capitated HMO hospital system based	2.1%					0.5%	1.2%		0.6%	0.5%
Capitated HMO physician group based	3.3%				29.3%	2.4%	1.5%		0.8%	1.9%
Risk-sharing	18.9%				69.5%	8.2%	1.2%		0.7%	5.7%
All other membership	75.7%	100.0%	100.0%	100.0%	1.2%	88.9%	96.1%	100.0%	97.9%	91.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
December 31, 2008										
Capitated HMO hospital system based	1.8%					0.3%	1.2%		0.7%	0.4%
Capitated HMO physician	3.4%				31.1%	2.5%	1.4%		0.8%	1.9%

group based										
Risk-sharing	19.1%				50.0%	6.4%	1.3%		0.7%	4.7%
All other membership	75.7%	100.0%	100.0%	100.0%	18.9%	90.8%	96.1%	100.0%	97.8%	93.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Capitation expense as a percentage of total benefit expense was as follows for the years ended December 31, 2009, 2008, and 2007:

	2009		2008 (dollars in thousands)		2007	
Benefit Expenses:						
Capitated HMO expense	$ 560,914	2.3%	$ 510,606	2.2%	$ 366,075	1.8%
Other benefit expense	24,214,088	97.7%	23,197,627	97.8%	19,904,456	98.2%
Consolidated benefit expense	$ 24,775,002	100.0%	$ 23,708,233	100.0%	$ 20,270,531	100.0%

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Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies, as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Sets, or HEDIS, which is used by employers, government purchasers and the National Committee for Quality Assurance, or NCQA, to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Physicians participating in our networks must satisfy specific criteria, including licensing, patient access, office standards, after-hours coverage, and other factors. Most participating hospitals also meet accreditation criteria established by CMS and/or the Joint Commission on Accreditation of Healthcare Organizations.

Recredentialing of participating providers occurs every two to three years, depending on applicable state laws. Recredentialing of participating physicians includes verification of their medical licenses; review of their malpractice liability claims histories; review of their board certifications, if applicable; and review of applicable quality information. Committees, composed of a peer group of physicians, review the applications of physicians being considered for credentialing and recredentialing.

We request accreditation for certain of our health plans from NCQA, the Accreditation Association for Ambulatory Health Care, and the Utilization Review Accreditation Commission, or URAC. URAC performs reviews for utilization management standards and for health plan and health network standards in quality management, credentialing, rights and responsibilities, and network management. Accreditation or external review by an approved organization is mandatory in the states of Florida and Kansas for licensure as an HMO. Certain commercial businesses, like those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA performs reviews of our compliance with standards for quality improvement, credentialing, utilization management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in all of our commercial HMO/POS markets except Puerto Rico, in all of our Medicare HMO markets with the exception of Illinois which will be surveyed in 2010, and for nearly all our PPO markets.

Sales and Marketing

We use various methods to market our Medicare, Medicaid, and commercial products, including television, radio, the Internet, telemarketing, and direct mailings.

At December 31, 2009, we employed approximately 1,700 sales representatives, as well as approximately 900 telemarketing representatives who assisted in the marketing of Medicare products by making appointments for sales representatives with prospective members. We also market our Medicare products via a strategic alliance with Wal-Mart Stores, Inc., or Wal-Mart. This alliance includes stationing Humana representatives in certain Wal-Mart stores, SAM S CLUB locations, and Neighborhood Markets across the country providing an opportunity to enroll Medicare eligible individuals in person. In addition, we market our Medicare products through licensed independent brokers and agents including strategic alliances with State Farm® and United Services Automobile Association, or USAA. Commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure approved by CMS.

Individuals become members of our commercial HMOs and PPOs through their employers or other groups which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer s or group s exclusive source of health insurance benefits by offering a variety of HMO, PPO, and

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specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. We also offer commercial health insurance and specialty products directly to individuals.

At December 31, 2009, we used licensed independent brokers and agents and approximately 1,200 licensed employees to sell our commercial products. Many of our employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics including certain other incentives for our commercial brokers. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

Underwriting

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

Underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs, including HMOs and PPOs owned by Blue Cross/Blue Shield plans. Many of our competitors have larger memberships and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in the section entitled Risk Factors in this report.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation s health care system.

Our management works proactively to ensure compliance with all governmental laws and regulations affecting our business. We are unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting our businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on our results of operations, financial position, or cash flows.

For a description of all of the material current activities in the federal and state legislative areas, see the section entitled Risk Factors in this report.

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Other

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers compensation, and officer and director errors and omissions risks. Professional and general liability risks may include, for example, medical malpractice claims and disputes with members regarding benefit coverage. We retain certain of these risks through our wholly-owned, captive insurance subsidiary. We reduce exposure to these risks by insuring levels of coverage for losses in excess of our retained limits with a number of third-party insurance companies. We remain liable in the event these insurance companies are unable to pay their portion of the losses.

Centralized Management Services

We provide centralized management services to each of our health plans and both of our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, and customer service.

Employees

As of December 31, 2009, we had approximately 28,100 employees, including 31 employees covered by collective bargaining agreements. We believe we have good relations with our employees and have not experienced any work stoppages.

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ITEM 1A. RISK FACTORS

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, or if our estimates of benefit expenses are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefit expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. These estimates, however involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in payment patterns and medical cost trends.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), 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 benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit 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 benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services, including prescription drugs;
- increased cost of such services;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- possible changes in our pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g. hurricanes and earthquakes);
- the introduction of new or costly treatments, including new technologies;
- medical cost inflation; and

government mandated benefits or other regulatory changes, including any that result from CMS Medicare Advantage and Medicare Part D risk adjustment regulatory changes.

In addition, we also estimate costs associated with long-duration insurance policies including life insurance, annuities, health, and long-term care policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. These future policy benefit reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, withdrawal and maintenance expense assumptions from published actuarial tables, as modified based upon actual experience. The basis for the liability for future policy benefits is established at the time each contract is acquired and would

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only change if our experience deteriorates to the point the level of the liability is not adequate to provide for future policy benefits. Future policy benefits payable include $571.9 million at December 31, 2009 associated with a closed block of long-term care policies acquired in connection with the November 30, 2007 KMG acquisition. Long-term care policies provide for long-duration coverage and, therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual morbidity and mortality rates from those assumed in our reserves are particularly significant to our closed block of long-term care policies. We monitor the loss experience of these long-term care policies, and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. We filed and received approval for certain state premium rate increases in 2009 and continue to expect to file for premium rate increases for additional states in 2010. However, to the extent premium rate increases or loss experience vary from our acquisition date assumptions, future adjustments to reserves could be required.

Failure to adequately price our products or estimate sufficient benefits payable or future policy benefits payable may result in a material adverse effect on our results of operations, financial position, and cash flows.

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have 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 Medicare program as well as in Smart products and other consumer health plans, such as high deductible health plans with Health Savings Accounts (HSAs). We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. 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. Factors such as business consolidations, strategic alliances, legislative reform and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or Commercial markets, or the termination of a large contract, including the possible termination of our TRICARE contract.

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, if membership declines, or if we lose accounts with favorable medical cost experience while retaining or increasing membership in accounts with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in the Medicare business.

Our future performance depends in large part upon our management team s ability to execute our strategy to position us for the future. This strategy includes opportunities created by the expansion of our Medicare programs, including our HMO and PPO, as well as our stand-alone PDP products. We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. The expansion of our provider networks and our success in attracting members to our network-based products positions us well for changes in the Medicare program that will effectively eliminate the non-network PFFS plan option in 2011, although there can be no assurances that our PFFS members will choose to move to our network-based products. We are continuing to implement various operational and strategic initiatives, including further developing our

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networks and building network-based plan offerings to address the adequate network requirement. We anticipate these initiatives, together with certain counties exemption from the network requirement, to result in more than 95% of our PFFS members having the choice of remaining in a Humana plan in 2011. Over the last few years we have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We are offering both the stand-alone Medicare prescription drug coverage and Medicare Advantage health plan with prescription drug coverage in addition to our other product offerings. We offer the Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia.

The growth of our Medicare business is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare business in relation to our other businesses may intensify the risks to us inherent in the Medicare business. There is significant concentration of our revenues in the Medicare business, with approximately 62% of our total premiums and ASO fees in 2009 generated from our Medicare business. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

Additionally, our strategy includes the growth of our Commercial segment business, with emphasis on our ASO and individual products, introduction of new products and benefit designs, including our Smart products and other consumer offerings such as HSAs, and our specialty products such as dental, vision and other supplemental products, as well as the adoption of new technologies and the integration of acquired businesses and contracts.

There can be no assurance that we will be able to successfully implement our operational and strategic initiatives, including outsourcing certain business functions, that are intended to position us for future growth or that the products we design will be accepted or adopted in the time periods assumed. Failure to implement this strategy may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we fail to properly maintain the integrity of our data, to strategically implement new information systems, or to protect our proprietary rights to our systems, our business may 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 information 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. 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. 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 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 or other legal problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

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. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results.

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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, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

Our business plans also include becoming a quality e-business organization by enhancing interactions with customers, brokers, agents, providers and other stakeholders through web-enabled technology. Our strategy includes sales and distribution of health benefit products through the Internet, and implementation of advanced self-service capabilities, for internal and external stakeholders.

There can be no assurance that our process of improving existing systems, developing new systems to support our expanding 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 results of operations, financial position, and cash flows.

We are involved in various legal actions, which, if resolved unfavorably to us, could result in substantial monetary damages. Increased litigation and negative publicity could increase our cost of doing business.

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, securities laws claims, and tort claims.

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 benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers alleged malpractice;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation and termination of provider contracts;
- disputes related to ASO business, including actions alleging claim administration errors;

claims related to the failure to disclose some business practices;

claims relating to customer audits and contract performance; and

claims relating to dispensing of drugs associated with our in-house mail-order pharmacy.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act 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 our insurance may not be

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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. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

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 results of operations, financial position, and cash flows.

See Legal Proceedings in Note 16 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

Our business activities are subject to substantial government regulation. New laws or regulations, or changes in existing laws or regulations or their manner of application, could increase our cost of doing business and may adversely affect our business, profitability and financial condition. In addition, as a government contractor, we are exposed to additional risks that may adversely affect our business or our willingness to participate in government health care programs.

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, Military, and Medicaid programs. Our Government segment accounted for approximately 75% of our total premiums and ASO fees for the year ended December 31, 2009. These programs involve various risks, as described further below.

At December 31, 2009, under our contracts with CMS we provided health insurance coverage to approximately 377,900 Medicare Advantage members in Florida. These contracts accounted for approximately 17% of our total premiums and ASO fees for the year ended December 31, 2009. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory 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 results of operations, financial position, and cash flows.

At December 31, 2009, our military services business, which accounted for approximately 12% of our total premiums and ASO fees for the year ended December 31, 2009, primarily consisted of the TRICARE South Region contract which covers approximately 3.0 million beneficiaries. The original 5-year South Region contract expired March 31, 2009. Through an Amendment of Solicitation/Modification of Contract to the TRICARE South Region contract, an additional one-year option period, the sixth option period, which runs from April 1, 2009 through March 31, 2010, was exercised by the government. The Amendment also provides for two additional six-month option periods: the seventh option period runs from April 1, 2010 through September 30, 2010 and the eighth option period runs from October 1, 2010 through March 31, 2011. Exercise of each of the seventh and eighth option periods is at the government s option. On December 16, 2009, we were notified by TMA that it intends to exercise its options to extend the TRICARE South Region contract for Option Period VII and Option Period VIII. The exercise of these option periods would effectively extend the TRICARE South Region contract through March 31, 2011. As required under the current contract, the target underwritten health care cost and underwriting fee amounts for each option period are negotiated. Any variance from the target health care cost is shared with the federal government. Accordingly, events and circumstances not contemplated in the negotiated target health care cost amount may have a material adverse effect on us. These changes may include an increase or reduction in the number of persons enrolled or eligible to

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enroll due to the federal government s decision to increase or decrease U.S. military deployments. In the event government reimbursements were to decline from projected amounts, our failure to reduce the health care costs associated with these programs may have a material adverse effect on our results of operations, financial position, and cash flows.

In July 2009, we were notified by the DoD that we were not awarded the third generation TRICARE program contract for the South Region which had been subject to competing bids. We filed a protest with the GAO in connection with the award to another contractor citing discrepancies between the award criteria and procedures prescribed in the request for proposals issued by the DoD and those that appear to have been used by the DoD in making its contractor selection. In October 2009, we learned that the GAO had upheld our protest, determining that the TMA evaluation of our proposal had unreasonably failed to fully recognize and reasonably account for the likely cost savings associated with our record of obtaining network provider discounts from our established network in the South Region. On December 22, 2009, we were advised that TMA notified the GAO of its intent to implement corrective action consistent with the discussion contained within the GAO s decision with respect to our protest. At this time, we are not able to determine what actions TMA will take in response to recommendations by the GAO, nor can we determine whether or not the protest decision by the GAO will have any effect upon the ultimate disposition of the contract award. For 2009, premiums and ASO fees associated with the TRICARE South Region contract were $3.4 billion, or 11.2% of our total premiums and ASO fees. We are continuing to evaluate issues associated with our military services businesses such as potential impairment of certain assets primarily consisting of goodwill, which had a carrying value of $49.8 million at December 31, 2009, potential exit costs, possible asset sales, and a strategic assessment of ancillary businesses. Goodwill was not impaired at December 31, 2009.

At December 31, 2009, under our contracts with the Puerto Rico Health Insurance Administration, or PRHIA, we provided health insurance coverage to approximately 349,900 Medicaid members in Puerto Rico. These contracts accounted for approximately 2% of our total premiums and ASO fees for the year ended December 31, 2009.

Our Medicaid contracts with the PRHIA for the East and Southeast regions were extended through December 31, 2009 with no change in terms. The PRHIA has confirmed its intention to extend the current contracts until June 30, 2010, with no changes in terms and is in the process of executing such extensions. The loss of these contracts or significant changes in the Puerto Rico Medicaid program 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 results of operations, financial position, and cash flows.

There is a 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.

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage plans according to health severity. A risk-adjustment model pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk adjusted premium payment to Medicare Advantage plans.

CMS is continuing to perform audits of selected Medicare Advantage plans of various companies to validate the provider coding practices and resulting economics under the actuarial risk-adjustment model used to calculate the individual member capitation paid to Medicare Advantage plans. Several Humana contracts have been selected by CMS for audit and we expect that CMS will continue conducting audits for the 2007 contract year and beyond. We are unable to estimate the financial impact of any audits that may be conducted related to 2007 revenue and beyond and whether any findings

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would cause a change to our method of estimating future premium revenue in bid submissions made to CMS for future contract years, or compromise premium rate assumptions made in our bids for prior contract years. At this time, we do not know whether CMS will require payment adjustments to be made using an audit methodology without comparison to original Medicare coding, and using its method of extrapolating findings to the entire contract. However, if CMS requires payment adjustments to be made using an audit methodology without comparison to original Medicare coding, and using a method of extrapolating findings to the entire contract, and if we are unable to obtain any relief preventing the payment adjustments from being implemented, we believe that such adjustments would have a material adverse effect on our results of operations, financial position, and cash flows.

The President of the United States and members of the U.S. Congress have proposed significant reforms to the U.S. health care system. In November 2009, the U.S. House of Representatives passed the Affordable Health Care for America Act and in December 2009 the U.S. Senate passed The Patient Protection and Affordable Care Act, which we refer to collectively as the Acts . While there are significant differences between the two Acts, they include, for example, limiting Medicare Advantage payment rates, mandatory issuance of insurance coverage, requirements that would limit the ability of health plans and insurers to vary premiums based on assessments of underlying risk, stipulating annual rebates to enrollees if the amount of premium revenues expended on medical costs falls below prescribed ratios for group and individual health insurance coverage, and imposing new non-deductible taxes on health insurers increasing in the aggregate from $2 billion to $10 billion annually over ten years. In addition, certain members of Congress have proposed a single-payer health care system, a government health insurance option to compete with private plans, and other expanded public health care measures. Various health insurance reform proposals are also emerging at the state level.

Because of the unsettled nature of these initiatives and the numerous steps required to implement them, we cannot predict what health insurance initiatives, if any, will be implemented at the federal or state level, or the effect any future legislation or regulation will have on our business. However, legislative changes, if enacted, may have a material adverse affect on our results of operations, including lowering our Medicare payment rates and increasing our expenses associated with the non-deductible excise tax, financial position, including goodwill recoverability, and cash flows.

Our CMS contracts which cover members prescription drugs under Medicare Part D contain provisions for risk sharing and payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a risk corridor). We estimate and recognize an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Beginning in 2008, the risk corridor thresholds increased which means we bear more risk. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $144.6 million at December 31, 2009.

Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS s portion of claims costs which exceed the member s out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS s prospective subsidies against actual prescription drug costs we paid is made after the end of the year.

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Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS s claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS s claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment as a low-income or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS s share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

In addition, the health care industry in general and health insurance, particularly HMOs and PPOs, are subject to substantial federal and state government regulation:

Medicare Improvements for Patients and Providers Act of 2008

The enactment of the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA, in July 2008 could affect our Medicare operations. Principally, beginning in 2011 sponsors of Medicare Advantage PFFS plans will be required to contract with providers to establish adequate networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. Additionally, MIPPA prohibits several different kinds of marketing activities by Medicare plan sponsors and their brokers, and will phase out indirect medical education, or IME, costs beginning in 2010. We are continuing to implement various operational and strategic initiatives that are intended to answer the challenges presented by MIPPA. In addition, most of our PFFS enrollees reside in geographies where we have developed a provider network and offer a networked plan. We will continue to develop our networks and build network-based plan offerings to address the adequate network requirement. We anticipate these initiatives, together with certain counties exemption from the network requirement, to result in more than 95% of our PFFS members having the choice of remaining in a Humana plan in 2011. Nonetheless, there can be no assurance that we will be able to successfully implement those initiatives. Failure to implement this strategy may result in a material adverse effect on our results of operations, financial position, and cash flows.

Health Insurance Portability and Accountability Act (HIPAA)

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. 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. The 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.

These regulations set standards for the security of electronic health information. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans).

On February 17, 2009, the American Recovery and Reinvestment Act of 2009, or ARRA, was enacted into law. In addition to including a temporary subsidy for health care continuation coverage issued pursuant to the Consolidated Omnibus Budget Reconciliation Act, or COBRA, the ARRA also expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other things, ARRA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to the U.S. Department of Health

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and Human Services in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. ARRA also requires business associates to comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA s provisions and requires the U.S. Department of Health and Human Services to issue regulations implementing its privacy and security enhancements. We will continue to assess the impact of these regulations on us as they are issued.

State Regulation

Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance-related services regulate our operations including: licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re-entry into a state or market, rate formulas, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance-related products we offer are sold under licenses issued by the applicable insurance regulators.

Our licensed subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports.

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and 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.

Although 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. Based on the statutory financial statements as of December 31, 2009, we maintained aggregate statutory capital and surplus of $3.6 billion in our state regulated subsidiaries, $1.2 billion above the aggregate $2.4 billion in applicable statutory requirements which would trigger any regulatory action by the respective states.

Other Investigations

We are also subject to various governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations are also conducted 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, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

Any failure to manage administrative costs could hamper profitability.

The level of our administrative expenses impacts our profitability. While we proactively attempt to effectively manage such expenses, increases or decreases in staff-related expenses, additional investment in new

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products (including our opportunities in the Medicare programs), greater emphasis on small group and individual health insurance products, acquisitions, and implementation of regulatory requirements may occur from time to time.

There can be no assurance that we will be able to successfully contain our administrative expenses in line with our membership and this may result in a material adverse effect on our results of operations, financial position, and cash flows.

Any failure by us to manage acquisitions and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue this strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, or if multiple transactions are pursued simultaneously. In 2008, we acquired UnitedHealth Group s Las Vegas, Nevada individual SecureHorizons Medicare Advantage HMO business, OSF Health Plans, Inc., Metcare Health Plans, Inc., and PHP Companies, Inc. (d/b/a Cariten Healthcare), and in late 2007, we acquired KMG America Corporation and CompBenefits Corporation. The failure to successfully integrate these entities and businesses or failure to produce results consistent with the financial model used in the analysis of the acquisition may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. We may also be at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position, and cash flows.

If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business may 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 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 specialty groups, 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 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 may 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. This type of contract is referred to as a capitation contract. 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

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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 may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows.

Our pharmacy business is highly competitive and subjects us to regulations in addition to those we face with our core health benefits businesses.

Our pharmacy business, opened in 2006, competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, and Internet companies as well as other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state s board of pharmacy. In addition, some states have proposed laws to regulate online pharmacies, and we may be subject to this legislation if it is passed. Federal agencies further regulate our pharmacy operations. Pharmacies must register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, and the application of state laws related to the operation of internet and mail-services pharmacies. The failure to adhere to these laws and regulations may expose our pharmacy subsidiary to civil and criminal penalties.

Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance.

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as AWP, average selling price, which is referred to as ASP, and wholesale acquisition cost. Recent events have raised uncertainties as to whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. The DOJ is currently conducting, and the U.S. House of Representatives Commerce Committee has conducted, an investigation into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our mail-order pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

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If we do not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, our gross margins may decline.

We have contractual relationships with pharmaceutical manufacturers or wholesalers that provide us with purchase discounts and volume rebates on certain prescription drugs dispensed through our mail-order and specialty pharmacies. These discounts and volume rebates are generally passed on to clients in the form of steeper price discounts. Changes in existing federal or state laws or regulations or in their interpretation by courts and agencies or the adoption of new laws or regulations relating to patent term extensions, and purchase discount and volume rebate arrangements with pharmaceutical manufacturers, may reduce the discounts or volume rebates we receive and materially adversely impact our results of operations, financial position, and cash flows.

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., our parent company. These subsidiaries generally are regulated by states Departments of Insurance. We are also required by law to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium generated. A significant increase in premium volume will require additional capitalization from our parent company. 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. In the event that we are unable to provide sufficient capital to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected.

Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers. Our 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded) and contain a change of control provision that may require us to purchase the notes under certain circumstances. In addition, our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency s opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under recent regulatory and public scrutiny over the ratings assigned to various fixed-income products. As a result, rating agencies may (i) become more conservative in their methodology and criteria, (ii) increase the frequency or scope of their credit reviews, (iii) request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

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We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would increase, our sales and earnings could decrease and our results of operations, financial position, and cash flows may be materially adversely affected.

Changes in economic conditions may adversely affect our results of operations, financial position, and cash flows.

The U.S. economy continues to experience a period of recession and increased unemployment. We have closely monitored the impact that this volatile economy is having on our Commercial segment operations. Workforce reductions have caused corresponding membership losses in our fully-insured group business. Continued weakness in the U.S. economy, and any resulting increases in unemployment, may materially adversely affect our Commercial medical membership, results of operations, financial position, and cash flows.

Additionally, the continued weakness of the U.S. economy may adversely affect the budget of individual states and of the federal government. That could result in attempts to reduce payments in our federal and state government health care coverage programs, including the Medicare, military services, and Medicaid programs, and could result in an increase in taxes and assessments on our activities. Although we could attempt to mitigate or cover our exposure from such increased costs through, among other things, increases in premiums, there can be no assurance that we will be able to mitigate or cover all of such costs which may have a material adverse effect on our results of operations, financial position, and cash flows.

In addition, general inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to us.

The securities and credit markets may experience volatility and disruption, which may adversely affect our business.

Volatility or disruption in the securities and credit markets could impact our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairments are considered using variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that further declines in fair value may occur and additional material realized losses from sales or other-than- temporary impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, future expansion opportunities, and capital expenditures in the foreseeable future, and to refinance or repay debt. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

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Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the possibility that customers or lenders could develop a negative perception of our long or short-term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all.

Given the current economic climate, our stock and the stocks of other companies in the insurance industry may be increasingly subject to stock price and trading volume volatility.

Over the past two years, the stock markets have experienced significant price and trading volume volatility. Company-specific issues and market developments generally in the insurance industry and in the regulatory environment may have caused this volatility. Our stock price has fluctuated and may continue to materially fluctuate in response to a number of events and factors, including:

the potential for health care reform;

general economic conditions;

quarterly variations in operating results;

natural disasters, terrorist attacks and epidemics;

changes in financial estimates and recommendations by securities analysts;

operating and stock price performance of other companies that investors may deem comparable;

press releases or negative publicity relating to our competitors or us or relating to trends in our markets;

regulatory changes and adverse outcomes from litigation and government or regulatory investigations;

sales of stock by insiders;

changes in our credit ratings;

limitations on premium levels or the ability to raise premiums on existing policies;

increases in minimum capital, reserves, and other financial strength requirements; and

limitations on our ability to repurchase our common stock.

These factors could materially reduce our stock price. In addition, broad market and industry fluctuations may adversely affect the trading price of our common stock, regardless of our actual operating performance.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

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ITEM 2. PROPERTIES

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to this property, our other principal operating facilities are located in Louisville, Kentucky; Green Bay, Wisconsin; Tampa Bay, Florida; Cincinnati, Ohio; and San Juan, Puerto Rico, all of which are used for customer service, enrollment, and claims processing. Our Louisville and Green Bay facilities also house other corporate functions.

We own or lease these principal operating facilities in addition to other administrative market offices and medical centers. We no longer operate most of these medical centers but, rather lease or sublease them to their provider operators. The following table lists the location of properties we owned or leased, including our principal operating facilities, at December 31, 2009:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	11	58		64	133
Texas			2	34	36
Tennessee				24	24
Kentucky			9	9	18
Georgia				14	14
Ohio				13	13
South Carolina			8	5	13
Puerto Rico				12	12
Louisiana				10	10
Illinois	1			8	9
Wisconsin			1	8	9
Others				107	107
Total	12	58	20	308	398

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, including employment litigation, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. See Legal Proceedings in Note 16 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

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

Not applicable.

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PART II

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

a) *Market Information*

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2009 and 2008:

	High	Low
Year Ended December 31, 2009		
First quarter	$ 45.80	$ 18.77
Second quarter	$ 32.62	$ 25.46
Third quarter	$ 40.67	$ 28.28
Fourth quarter	$ 45.75	$ 35.91
Year Ended December 31, 2008		
First quarter	$ 86.98	$ 40.88
Second quarter	$ 51.11	$ 39.77
Third quarter	$ 50.03	$ 37.27
Fourth quarter	$ 41.26	$ 24.56

Unregistered Sales of Equity Securities and Use of Proceeds

We maintain the Humana Retirement and Savings Plan and the Humana Puerto Rico 1165(e) Retirement Plan (which we refer to collectively as the Plans), each a qualified, combined retirement plan and 401(k) plan, for the benefit of our employees, through which participants can elect, among other investment choices, to purchase our common stock at market prices. Although none of the shares purchased by the Plans are purchased from us, but are purchased by a third party administrator on the open market, it is the position of the SEC that, because we sponsor the Plans, all of the securities offered pursuant to the Plans must be registered under the Securities Act of 1933. Based upon this interpretation, we recently determined that the number of shares of our common stock purchased by participants under the Humana Retirement and Savings Plan may have exceeded the number of shares registered under the registration statement covering the Plan, and shares purchased under the Humana Puerto Rico 1165(e) Retirement Plan may not have been registered. Since these purchases were made by a third party administrator on the open market, and not from us, we did not receive any proceeds from the sale of the shares pursuant to the Plans. We have filed registration statements on Form S-8 to register future sales of our common stock to participants in the Plans. We are in the process of determining any action we intend to take in light of this situation. These shares have always been treated as outstanding for financial reporting purposes, and we do not expect that the overall effect of this issuance of unregistered shares, including the exercise of any applicable rescission rights by participants in the Plans, will have a material impact on our results of operations, financial position, and cash flows. We may also be subject to monetary fines or other regulatory sanctions as provided under applicable securities laws.

b) *Holders of our Capital Stock*

As of January 31, 2010, there were approximately 4,700 holders of record of our common stock and approximately 78,800 beneficial holders of our common stock.

c) *Dividends*

Since February 1993, we have not declared or paid any cash dividends on our common stock. We do not presently intend to pay dividends, and we currently plan to retain our earnings for future operations and growth of our businesses.

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d) *Equity Compensation Plan*

The information required by this part of Item 5 is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2010 appearing under the caption Equity Compensation Plan Information of such Proxy Statement.

e) *Stock Performance*

The following graph compares the performance of our common stock to the Standard & Poor s Composite 500 Index (S&P 500) and the Morgan Stanley Health Care Payer Index (Peer Group) for the five years ended December 31, 2009. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2004.

	12/31/04	12/31/05	12/31/06	12/31/07	12/31/08	12/31/09
HUM	$ 100	$ 183	$ 186	$ 254	$ 126	$ 148
S&P 500	$ 100	$ 103	$ 117	$ 121	$ 75	$ 92
Peer Group	$ 100	$ 137	$ 146	$ 170	$ 77	$ 118

f) *Issuer Purchases of Equity Securities*

On February 22, 2008, the Board of Directors authorized the repurchase of up to $150 million of our common shares exclusive of shares repurchased in connection with employee stock plans. During the year ended December 31, 2008, we repurchased 2.1 million shares in open market transactions for $92.8 million at an average price of $44.19. On July 28, 2008 (announced August 4, 2008), the Board of Directors increased the authorized amount to $250 million, excluding the $92.8 million used prior to that time in connection with the initial February 2008 authorization. No shares were repurchased in 2008 or 2009 under the July 2008 authorization. The July authorization was set to expire on December 31, 2009. On December 10, 2009 (announced December 11, 2009), the Board of Directors renewed its $250 million authorization through December 31, 2011. Under this authorized share repurchase program, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions, subject to certain restrictions on volume, pricing and timing. We have not yet repurchased any shares under the December 2009 authorization.

In connection with employee stock plans, we acquired 0.6 million common shares for $22.8 million and 0.2 million common shares for $13.3 million during the years ended December 31, 2009 and 2008, respectively.

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ITEM 6. SELECTED FINANCIAL DATA

	2009	2008 (a)	2007 (b)	2006 (c)	2005 (d)
	(in thousands, except per common share results, membership and ratios)				
Summary of Operations:					
Revenues:					
Premiums	$ 29,926,751	$ 28,064,844	$ 24,434,347	$ 20,729,182	$ 14,001,591
Administrative services fees	496,135	451,879	391,515	341,211	259,437
Investment income	296,317	220,215	314,239	291,880	142,976
Other revenue	241,211	209,434	149,888	54,264	14,123
Total revenues	30,960,414	28,946,372	25,289,989	21,416,537	14,418,127
Operating expenses:					
Benefits	24,775,002	23,708,233	20,270,531	17,421,204	11,651,470
Selling, general and administrative	4,227,535	3,944,652	3,476,468	3,021,509	2,195,604
Depreciation and amortization	250,274	220,350	184,812	148,598	128,858
Total operating expenses	29,252,811	27,873,235	23,931,811	20,591,311	13,975,932
Income from operations	1,707,603	1,073,137	1,358,178	825,226	442,195
Interest expense	105,843	80,289	68,878	63,141	39,315
Income before income taxes	1,601,760	992,848	1,289,300	762,085	402,880
Provision for income taxes	562,085	345,694	455,616	274,662	106,150
Net income	$ 1,039,675	$ 647,154	$ 833,684	$ 487,423	$ 296,730
Basic earnings per common share	$ 6.21	$ 3.87	$ 5.00	$ 2.97	$ 1.83
Diluted earnings per common share	$ 6.15	$ 3.83	$ 4.91	$ 2.90	$ 1.79
Financial Position:					
Cash and investments	$ 9,110,738	$ 7,185,865	$ 6,690,820	$ 5,347,454	$ 3,477,955
Total assets	14,153,494	13,041,760	12,879,074	10,098,486	6,846,851
Benefits payable	3,222,574	3,205,579	2,696,833	2,410,407	1,849,142
Debt	1,678,166	1,937,032	1,687,823	1,269,100	815,044
Stockholders equity	5,776,003	4,457,190	4,028,937	3,053,886	2,508,874
Key Financial Indicators:					
Benefit ratio	82.8%	84.5%	83.0%	84.0%	83.2%
SG&A expense ratio	13.8%	13.7%	13.9%	14.3%	15.4%
Medical Membership by Segment:					
Government:					
Medicare Advantage	1,508,500	1,435,900	1,143,000	1,002,600	557,800
Medicare stand-alone PDP	1,927,900	3,066,600	3,442,000	3,536,600	
Total Medicare	3,436,400	4,502,500	4,585,000	4,539,200	557,800
Military services insured	1,756,000	1,736,400	1,719,100	1,716,400	1,750,900
Military services ASO	1,278,400	1,228,300	1,146,800	1,163,600	1,138,200
Total military services	3,034,400	2,964,700	2,865,900	2,880,000	2,889,100
Medicaid insured	401,700	385,400	384,400	390,700	457,900
Medicaid ASO		85,700	180,600	178,400	
Total Medicaid	401,700	471,100	565,000	569,100	457,900

Total Government	6,872,500	7,938,300	8,015,900	7,988,300	3,904,800
Commercial:					
Fully-insured	1,839,500	1,978,800	1,808,600	1,754,200	1,999,800
ASO	1,571,300	1,642,000	1,643,000	1,529,600	1,171,000
Total Commercial	3,410,800	3,620,800	3,451,600	3,283,800	3,170,800
Total medical membership	10,283,300	11,559,100	11,467,500	11,272,100	7,075,600
Specialty Membership:					
Dental	3,832,900	3,633,400	3,639,800	1,452,000	1,456,500
Vision	2,459,600	2,233,000	2,272,800		
Other supplemental benefits	907,600	846,800	731,200	450,800	445,600
Total specialty membership	7,200,100	6,713,200	6,643,800	1,902,800	1,902,100

(a) Includes the acquired operations of United Health Group s Las Vegas, Nevada individual SecureHorizons Medicare Advantage HMO business from April 30, 2008, the acquired operations of OSF Health Plans, Inc. from May 22, 2008, the acquired operations of Metcare Health Plans, Inc. from August 29, 2008, and the acquired operations of PHP Companies, Inc. (d/b/a Cariten Healthcare) from October 31, 2008.

(b) Includes the acquired operations of DefenseWeb Technologies, Inc. from March 1, 2007, the acquired operations of CompBenefits Corporation from October 1, 2007, and the acquired operations of KMG America Corporation from November 30, 2007. Also includes the benefit of $68.9 million ($43.0 million after tax, or $0.25 per diluted share) related to our 2006 Medicare Part D reconciliation with CMS and the settlement of some TRICARE contractual provisions related to prior years.

(c) Includes the acquired operations of CHA Service Company from May 1, 2006.

(d) Includes the acquired operations of CarePlus Health Plans of Florida from February 16, 2005, and the acquired operations of Corphealth, Inc. from December 20, 2005. Also includes expenses of $71.9 million ($44.8 million after tax, or $0.27 per diluted common share) for a class action litigation settlement, as well as expenses of $27.0 million ($16.9 million after tax, or $0.10 per diluted common share) related to Hurricane Katrina. These expenses were partially offset by the realization of a tax gain contingency of $22.8 million, or $0.14 per diluted share.

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ITEM 7. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Overview

Headquartered in Louisville, Kentucky, Humana is one of the nation s largest publicly traded health and supplemental benefits companies, based on our 2009 revenues of approximately $31.0 billion. We are a full-service benefits solutions company, offering a wide array of health and supplemental benefit products for employer groups, government benefit programs, and individuals. As of December 31, 2009, we had approximately 10.3 million members in our medical benefit plans, as well as approximately 7.2 million members in our specialty products.

We manage our business with two segments: Government and Commercial. The Government segment consists of beneficiaries of government benefit programs, and includes three lines of business: Medicare, Military, and Medicaid. The Commercial segment consists of members enrolled in our medical and specialty products marketed to employer groups and individuals. When identifying our segments, we aggregated products with similar economic characteristics. These characteristics include the nature of customer groups as well as pricing, benefits, and underwriting requirements. These segment groupings are consistent with information used by our Chief Executive Officer.

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

Our results are impacted by many factors, but most notably are influenced by our ability to establish and maintain a competitive and efficient cost structure and to accurately and consistently establish competitive premium, ASO fee, and plan benefit levels that are commensurate with our benefit and administrative costs. Benefit costs are subject to a high rate of inflation due to many forces, including new higher priced technologies and medical procedures, new prescription drugs and therapies, an aging population, lifestyle challenges including diet and smoking, the tort liability system, and government regulation.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefit expenses as a percentage of premium revenues, represents a statistic used to measure underwriting profitability. The selling, general, and administrative expense ratio, or SG&A expense ratio, which is computed by taking total selling, general and administrative expenses as a percentage of premium revenues, administrative services fees and other revenues, represents a statistic used to measure administrative spending efficiency.

Proposed Health Insurance Initiatives

The President of the United States and members of the U.S. Congress have proposed significant reforms to the U.S. health care system. In November 2009, the U.S. House of Representatives passed the Affordable Health Care for America Act and in December 2009 the U.S. Senate passed The Patient Protection and Affordable Care Act, which we refer to collectively as the Acts . While there are significant differences between the two Acts, they include, for example, limiting Medicare Advantage payment rates, mandatory issuance of insurance coverage, requirements that would limit the ability of health plans and insurers to vary premiums based on assessments of underlying risk, stipulating annual rebates to enrollees if the amount of premium revenues expended on medical costs falls below prescribed ratios for group and individual health insurance coverage, and imposing new non-deductible taxes on health insurers increasing in the aggregate from $2 billion to $10 billion annually over ten years. In addition, certain members of Congress have proposed a single-payer health care system, a government health insurance option to compete with private plans, and other expanded public health care measures. Various health insurance reform proposals are also emerging at the state level. Because of the

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unsettled nature of these initiatives and the numerous steps required to implement them, we cannot predict what health insurance initiatives, if any, will be implemented at the federal or state level, or the effect any future legislation or regulation will have on our business. However, legislative changes, if enacted, may have a material adverse affect on our results of operations, including lowering our Medicare payment rates and increasing our expenses associated with the non-deductible excise tax, financial position, including goodwill recoverability, and cash flows.

Government Segment

Our strategy and commitment to the Medicare programs has led to significant growth. Medicare Advantage membership increased to 1,508,500 members at December 31, 2009, up 72,600 members, or 5.1% from 1,435,900 members at December 31, 2008, primarily due to sales of preferred provider organization, or PPO products. Average Medicare Advantage membership increased 11.5% in 2009 compared to 2008, including the impact from the 2008 acquisitions of Cariten, Metcare, OSF, and SecureHorizons, discussed below. Likewise, Medicare Advantage premium revenues have increased 19.1% to $16.4 billion for 2009 from $13.8 billion for 2008. Recently the mix of sales has shifted increasingly to our network-based PPO offerings, which is particularly important given the enactment of the Medicare Improvements for Patients and Providers Act of 2008, or the Act, discussed more fully below. Medicare Advantage members enrolled in network-based products was approximately 63% at December 31, 2009 compared to 51% at December 31, 2008, with our PPO membership increasing 94.6% from December 31, 2008 to December 31, 2009. Medicare Advantage members enrolled in network-based products increased to approximately 71% in January 2010. We expect Medicare Advantage membership to increase by 240,000 to 260,000 members, or approximately 16% to 17%, in 2010.

Due to the enactment of the Act in July 2008, beginning in 2011, sponsors of Medicare Advantage Private Fee-For-Service, or PFFS, plans will be required to contract with providers to establish adequate networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. We have 564,200 PFFS members, or approximately 37% of our total Medicare Advantage membership at December 31, 2009, down from 49% at December 31, 2008. Approximately 87% of our PFFS members at December 31, 2009 resided in geographies where we have developed a provider network and offer a networked plan. We are continuing to implement various operational and strategic initiatives, including further developing our networks and building network-based plan offerings to address the adequate network requirement. We anticipate these initiatives, together with certain counties exemption from the network requirement, to result in more than 95% of our PFFS members having the choice of remaining in a Humana plan in 2011.

Final 2010 Medicare Advantage rates were announced by CMS on April 6, 2009, with an effective rate decrease for the industry of 4% to 5%. Based on information available at the time we filed our 2010 bids in June 2009, we believe we have effectively designed Medicare Advantage products that address the lower rates while continuing to remain competitive compared to both the combination of original Medicare with a supplement policy as well as other Medicare Advantage competitors within our industry. In addition, we will continue to pursue our cost-reduction and outcome-enhancing strategies, including care coordination and disease management, to mitigate the adverse effects of this rate reduction on our Medicare Advantage members. Nonetheless, there can be no assurance that we will be able to successfully execute operational and strategic initiatives with respect to changes in the Medicare Advantage program. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.

We also offer Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. These plans provide varying degrees of coverage. In order to offer these plans in a given year, in June of the preceding year we must submit bids to CMS for approval. During 2008, we experienced prescription drug claim expenses for our Medicare stand-alone PDPs that were higher than we had originally assumed in the bid that we submitted to CMS in June 2007. These higher claim levels for our Medicare stand-alone PDPs reflected a combination of several variances between our actuarial bid assumptions versus our experience. These variances resulted from, among other things, differences between the actuarial utilization assumptions (which are our attempts to predict members future utilization of drugs) in the bids for one of our plans versus our actual claims

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experience in 2008, as well as an increase in the percentage of higher cost members. These issues were addressed for 2009 based on enhancements made to our bid development and review processes. Our Medicare stand-alone PDP membership declined to 1,927,900 members at December 31, 2009, down 1,138,700 members, or 37.1%, from December 31, 2008, resulting primarily from our competitive positioning as we realigned stand-alone PDP premium and benefit designs to correspond with our historical prescription drug claims experience. These actions also resulted in a substantial decline in our stand-alone PDP benefit ratio for 2009 compared to 2008. We expect Medicare stand-alone PDP membership to decrease by 50,000 to 100,000 members, or approximately 3% to 5%, in 2010 as we continue to price and design benefits to correspond with our historical experience.

Our quarterly Government segment earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D benefit design results in coverage that varies as a member s cumulative out-of-pocket costs pass through successive stages of a member s plan period which begins annually on January 1 for renewals. These plan designs generally result in us sharing a greater portion of the responsibility for total prescription drug costs in the early stages and less in the latter stages. As a result, the Government segment s benefit ratio generally improves as the year progresses. In addition, the number of low-income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affect the quarterly benefit ratio pattern.

Our military services business primarily consists of the TRICARE South Region contract which covers benefits for healthcare services provided to beneficiaries through March 31, 2010. On December 16, 2009, we were notified by Department of Defense TRICARE Management Activity, or TMA, that it intends to exercise its options to extend the TRICARE South Region contract for Option Period VII and Option Period VIII. The exercise of these option periods would effectively extend the TRICARE South Region contract through March 31, 2011. In July 2009, we were notified by the Department of Defense that we were not awarded the third generation TRICARE program contract for the South Region which had been subject to competing bids. We filed a protest with the Government Accountability Office, or GAO, in connection with the award to another contractor citing discrepancies between the award criteria and procedures prescribed in the request for proposals issued by the DoD and those that appear to have been used by the DoD in making its contractor selection. In October 2009, we learned that the GAO had upheld our protest, determining that the TMA evaluation of our proposal had unreasonably failed to fully recognize and reasonably account for the likely cost savings associated with our record of obtaining network provider discounts from our established network in the South Region. On December 22, 2009, we were advised that TMA notified the GAO of its intent to implement corrective action consistent with the discussion contained within the GAO s decision with respect to our protest. At this time, we are not able to determine what actions TMA will take in response to recommendations by the GAO, nor can we determine whether or not the protest decision by the GAO will have any effect upon the ultimate disposition of the contract award. For 2009, premiums and ASO fees associated with the TRICARE South Region contract were $3.4 billion, or 11.2% of our total premiums and ASO fees. We are continuing to evaluate issues associated with our military services businesses such as potential impairment of certain assets primarily consisting of goodwill, which had a carrying value of $49.8 million at December 31, 2009, potential exit costs, possible asset sales, and a strategic assessment of ancillary businesses. Goodwill was not impaired at December 31, 2009.

Commercial Segment

Commercial segment pretax earnings, impacted by the economic recession and the highly competitive environment partially offset by higher investment income, decreased by $103.5 million, or 49.8%, for 2009 compared to 2008. Commercial segment medical membership at December 31, 2009 of 3,410,800 decreased 210,000 members, or 5.8% from December 31, 2008. The decline in membership primarily was a result of the impact of the economic recession, including the loss of two larger ASO accounts. The economic recession has led to increased in-group member attrition as employers reduce their workforce levels primarily through reductions of less experienced workers. As a result, we experienced higher utilization of benefits, mainly in our fully-insured group accounts, primarily due to the shift in the mix of members to an older workforce having more health care needs, as well as members utilizing more benefits ahead of actual or perceived layoffs, members

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seeking to maximize their benefits once their deductibles are met, and increased COBRA participation. The membership declines were partially offset by enrollment gains in our individual product, a strategic area of commercial growth. Individual membership at December 31, 2009 increased 13.0% from December 31, 2008. This increase in individual membership, together with administrative costs associated with increased business for our mail-order pharmacy, led to a higher Commercial segment SG&A expense ratio. We expect Commercial segment medical membership to decline by 160,000 to 180,000 members in 2010.

Financial Position

At December 31, 2009, cash, cash equivalents and our investment securities totaled $9.1 billion, or 64.4% of total assets, with 17.7% of the $9.1 billion invested in cash and cash equivalents. Investment securities consist of debt securities of investment-grade quality with an average credit rating by S&P of AA+ at December 31, 2009 and an average duration of approximately 4.5 years. Including cash and cash equivalents, the average duration of our investment portfolio was approximately 3.8 years. We had $5.5 million of mortgage-backed securities associated with Alt-A or subprime loans at December 31, 2009 and no collateralized debt obligations.

Our net unrealized position improved $301.3 million from a net unrealized loss position of $229.9 million at December 31, 2008 to a net unrealized gain position of $71.4 million at December 31, 2009. Gross unrealized losses were $78.4 million at December 31, 2009 compared to $313.0 million at December 31, 2008. Gross unrealized gains were $149.8 million at December 31, 2009 compared to $83.2 million at December 31, 2008. All issuers of securities we own trading at an unrealized loss remain current on all contractual payments. We believe these unrealized losses primarily were caused by an increase in market interest rates and tighter liquidity conditions in the current markets than when the securities were purchased. As of December 31, 2009, we do not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income and it is not likely that we will be required to sell these securities before recovery of their amortized costs basis, and as a result, we believe that the securities with an unrealized loss are not other-than-temporarily impaired as of December 31, 2009.

During 2008, we recognized other-than-temporary impairments of $103.1 million of which $68.7 million resulted from investments in Lehman Brothers Holdings Inc., or Lehman, or its subsidiaries. Lehman and certain of its subsidiaries filed for bankruptcy protection in 2008. The other impairments primarily relate to declines in values of securities, primarily associated with the financial services industry. Of the $103.1 million, $48.5 million was allocated to the Government segment and $54.6 million was allocated to the Commercial segment. There were no material other-than-temporary impairments in 2009.

We continuously review our investment portfolios. There is a continuing risk that further declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

In addition, in the fall of 2008 we terminated all fixed to variable interest-rate swap agreements outstanding associated with our senior notes based on recent changes in the credit market environment. In exchange for terminating these interest-rate swap agreements, we received cash of $93.0 million representing the fair value of the swap assets. This transaction also fixed the interest rate on our senior notes to a weighted-average rate of 6.08%. We may re-enter into swap agreements in the future depending on market conditions and other factors.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, future expansion opportunities, and capital expenditures in the foreseeable future, as well as to refinance or repay debt. Our long-term debt, consisting primarily of senior notes, of $1,678.2 million represented 22.5% of total capitalization at December 31, 2009, declining from 30.3% at December 31, 2008. The earliest maturity of our senior notes is in June 2016. We have available a 5-year, $1.0 billion unsecured revolving credit agreement which expires in July 2011. As of December 31, 2009, there were no borrowings outstanding under this credit agreement.

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Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and 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. In 2009, our subsidiaries paid dividends of $774.1 million to the parent compared to $296.0 million in 2008. In addition, the parent made capital contributions to our subsidiaries of $132.3 million in 2009 compared to $242.8 million in 2008.

Based on the statutory financial statements as of December 31, 2009, we maintained aggregate statutory capital and surplus of $3.6 billion in our state regulated subsidiaries, $1.2 billion above the aggregate $2.4 billion in applicable statutory requirements which would trigger any regulatory action by the respective states.

Other Highlights

- Earnings increased 60.6% to $6.15 per diluted common share in 2009 from $3.83 per diluted common share in 2008, primarily reflecting substantially lower stand-alone PDP claims expenses.

- Cash flows from operations increased $439.3 million to $1,421.6 million for the year ended December 31, 2009 compared to $982.3 million for the year ended December 31, 2008. The increase primarily resulted from increased earnings associated with lower stand-alone PDP prescription drug claims.

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, including the primary factors that accounted for those changes.

Recent Acquisitions

On October 31, 2008 we acquired PHP Companies, Inc. (d/b/a Cariten Healthcare), or Cariten, for cash consideration of approximately $256.1 million. The Cariten acquisition increased our presence in eastern Tennessee, adding approximately 49,700 commercial fully-insured members, 21,600 commercial ASO members, and 46,900 Medicare HMO members. This acquisition also added approximately 85,700 Medicaid ASO members under a contract which expired on December 31, 2008 and was not renewed.

On August 29, 2008, we acquired Metcare Health Plans, Inc., or Metcare, for cash consideration of approximately $14.9 million. The acquisition expanded our Medicare HMO membership in central Florida, adding approximately 7,300 members.

On May 22, 2008, we acquired OSF Health Plans, Inc., or OSF, a managed care company serving both Medicare and commercial members in central Illinois, for cash consideration of approximately $87.3 million. This acquisition expanded our presence in Illinois, broadening our ability to serve multi-location employers with a wider range of products, including our specialty offerings. The acquisition added approximately 33,400 commercial fully-insured members, 29,700 commercial ASO members, and 14,000 Medicare HMO and PPO members.

On April 30, 2008, we acquired UnitedHealth Group s Las Vegas, Nevada individual SecureHorizons Medicare Advantage HMO business, or SecureHorizons, for cash consideration of approximately $185.3 million, plus subsidiary capital and surplus requirements of $40 million. The acquisition expanded our presence in the Las Vegas market, adding approximately 26,700 Medicare HMO members.

On November 30, 2007, we acquired KMG America Corporation, or KMG, for cash consideration of $155.2 million plus the assumption of $36.1 million of long-term debt. KMG provides long-duration insurance benefits

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including supplemental health and life products. This acquisition added approximately 95,900 members, primarily commercial ASO. On October 1, 2007, we acquired CompBenefits Corporation, or CompBenefits, for cash consideration of $369.6 million. CompBenefits provides dental and vision insurance benefits and added approximately 4.4 million specialty members. These acquisitions expanded our commercial product offerings allowing for significant cross-selling opportunities with our medical insurance products.

On March 1, 2007, we acquired DefenseWeb Technologies, Inc., or DefenseWeb, a company responsible for delivering customized software solutions for the Department of Defense, for cash consideration of $27.5 million.

Certain of these transactions are more fully described in Note 3 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data.

Comparison of Results of Operations for 2009 and 2008

Certain financial data for our two segments was as follows for the years ended December 31, 2009 and 2008:

	2009	2008	Change	
		(dollars in thousands)	Dollars	Percentage
Premium revenues:				
Medicare Advantage	$ 16,413,301	$ 13,777,999	$ 2,635,302	19.1%
Medicare stand-alone PDP	2,327,418	3,380,400	(1,052,982)	(31.1)%
Total Medicare	18,740,719	17,158,399	1,582,320	9.2%
Military services	3,426,739	3,218,270	208,469	6.5%
Medicaid	646,195	591,535	54,660	9.2%
Total Government	22,813,653	20,968,204	1,845,449	8.8%
Fully-insured	6,185,158	6,169,403	15,755	0.3%
Specialty	927,940	927,237	703	0.1%
Total Commercial	7,113,098	7,096,640	16,458	0.2%
Total	$ 29,926,751	$ 28,064,844	$ 1,861,907	6.6%
Administrative services fees:				
Government	$ 108,442	$ 85,868	$ 22,574	26.3%
Commercial	387,693	366,011	21,682	5.9%
Total	$ 496,135	$ 451,879	$ 44,256	9.8%
Income before income taxes:				
Government	$ 1,497,606	$ 785,240	$ 712,366	90.7%
Commercial	104,154	207,608	(103,454)	(49.8)%
Total	$ 1,601,760	$ 992,848	$ 608,912	61.3%
Benefit ratios(a):				
Government	83.5%	85.9%		(2.4)%
Commercial	80.6%	80.3%		0.3%
Total	82.8%	84.5%		(1.7)%

SG&A expense ratios(b):			
Government	10.3%	10.6%	(0.3)%
Commercial	24.1%	22.4%	1.7%
Total	13.8%	13.7%	0.1%

(a) Represents total benefit expenses as a percentage of premium revenues. Also known as the benefit ratio.
(b) Represents total selling, general, and administrative expenses (SG&A) as a percentage of premium revenues, administrative services fees, and other revenues. Also known as the SG&A expense ratio.

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Ending membership was as follows at December 31, 2009 and 2008:

	2009	2008	Change Members	Change Percentage
Medical Membership:				
Government segment:				
Medicare Advantage	1,508,500	1,435,900	72,600	5.1%
Medicare stand-alone PDP	1,927,900	3,066,600	(1,138,700)	(37.1)%
Total Medicare	3,436,400	4,502,500	(1,066,100)	(23.7)%
Military services	1,756,000	1,736,400	19,600	1.1%
Military services ASO	1,278,400	1,228,300	50,100	4.1%
Total military services	3,034,400	2,964,700	69,700	2.4%
Medicaid	401,700	385,400	16,300	4.2%
Medicaid ASO		85,700	(85,700)	(100.0)%
Total Medicaid	401,700	471,100	(69,400)	(14.7)%
Total Government	6,872,500	7,938,300	(1,065,800)	(13.4)%
Commercial segment:				
Fully-insured	1,839,500	1,978,800	(139,300)	(7.0)%
ASO	1,571,300	1,642,000	(70,700)	(4.3)%
Total Commercial	3,410,800	3,620,800	(210,000)	(5.8)%
Total medical membership	10,283,300	11,559,100	(1,275,800)	(11.0)%
Specialty Membership:				
Commercial segment(a)	7,200,100	6,713,200	486,900	7.3%

(a) The Commercial segment provides a full range of insured specialty products including dental, vision, and other supplemental products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

These tables of financial data should be reviewed in connection with the discussion that follows.

Summary

Net income was $1,039.7 million, or $6.15 per diluted common share, in 2009 compared to $647.2 million, or $3.83 per diluted common share, in 2008. The year-over-year increase primarily reflects higher operating earnings in our Government segment as a result of significantly lower prescription drug claims expenses associated with our Medicare stand-alone PDP products.

Premium Revenues and Medical Membership

Premium revenues increased $1.8 billion, or 6.6%, to $29.9 billion for 2009, compared to $28.1 billion for 2008 primarily due to higher premium revenues in the Government segment. Premium revenues reflect changes in membership and increases in average per member premiums. Items impacting average per member premiums include changes in premium 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.

Government segment premium revenues increased $1.8 billion, or 8.8%, to $22.8 billion for 2009 compared to $21.0 billion for 2008 primarily attributable to higher average Medicare Advantage membership and an increase in per member premiums partially offset by a decrease in our Medicare stand-alone PDP membership.

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Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Average Medicare Advantage membership increased 11.5% in 2009 compared to 2008, including the impact from the 2008 acquisitions of Cariten, Metcare, OSF, and SecureHorizons, discussed previously. Sales of our PPO products drove the majority of the 72,600 increase in Medicare Advantage members since December 31, 2008. Medicare Advantage per member premiums increased 6.8% during 2009 compared to 2008 reflecting the effect of introducing member premiums for most of our Medicare Advantage products. Medicare stand-alone PDP premium revenues decreased $1.1 billion, or 31.1%, during 2009 compared to 2008 primarily due to a 1,138,700, or 37.1%, decrease in PDP membership since December 31, 2008, principally resulting from our competitive positioning as we realigned stand-alone PDP premium and benefit designs to correspond with our historical prescription drug claims experience.

Commercial segment premium revenues increased $16.5 million, or 0.2%, to $7.1 billion for 2009 primarily due to the acquisitions of OSF and Cariten in the second and fourth quarters of 2008, respectively, and an increase in per member premiums, substantially offset by a decline in fully-insured membership. Per member premiums for fully-insured group accounts increased 5.0% during 2009 compared to 2008. Fully-insured membership decreased 7.0%, or 139,300 members, to 1,839,500 at December 31, 2009 compared to 1,978,800 at December 31, 2008 primarily due to the impact of the economic recession which has led to increased in-group member attrition as employers reduce their workforce levels.

Administrative Services Fees

Our administrative services fees were $496.1 million for 2009, an increase of $44.2 million, or 9.8%, from $451.9 million for 2008, primarily due to an increase in per member fees, partially offset by a decline in Commercial ASO membership, primarily isolated to the loss of two larger ASO accounts.

Investment Income

Investment income totaled $296.3 million for 2009, an increase of $76.1 million from $220.2 million for 2008 primarily reflecting net realized losses in 2008 of $79.4 million compared to net realized gains of $19.5 million in 2009. Net realized losses in 2008 primarily resulted from other-than-temporary impairments in our investment and securities lending portfolios of $103.1 million. Excluding the change associated with net realized gains/losses, investment income decreased primarily due to lower interest rates, partially offset by higher average invested balances as a result of the reinvestment of operating cash flow.

Other Revenue

Other revenue totaled $241.2 million for 2009, an increase of $31.8 million from $209.4 million for 2008. The increase primarily was attributable to increased revenue from growth related to *Right*SourceRx[SM], our mail-order pharmacy.

Benefit Expenses

Consolidated benefit expense was $24.8 billion for 2009, an increase of $1.1 billion, or 4.5%, from $23.7 billion for 2008. The increase primarily was driven by an increase in Government segment benefit expense, as described below.

The consolidated benefit ratio for 2009 was 82.8%, a 170 basis point decrease from 84.5% for 2008. The decrease primarily was attributable to a decrease in the Government segment benefit ratio as described below.

The Government segment s benefit expenses increased $1.0 billion, or 5.7%, during 2009 compared to 2008 primarily due to an increase in the average number of Medicare Advantage members and the impact from the acquisitions of Cariten, Metcare, OSF, and SecureHorizons. The Government segment s benefit ratio for 2009

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was 83.5%, a 240 basis point decrease from 2008 of 85.9%, primarily driven by a 320 basis point decline in the Medicare benefit ratio. The decline in the Medicare benefit ratio primarily resulted from a substantial decline in Medicare stand-alone PDP benefit expenses as a result of our competitive positioning as we realigned stand-alone PDP premium and benefit designs to correspond with our historical prescription drug claims experience.

The Commercial segment s benefit expenses increased $36.3 million, or 0.6%, during 2009 compared to 2008 primarily due to the OSF and Cariten acquisitions in the second and fourth quarters of 2008, respectively. The benefit ratio for the Commercial segment of 80.6% for 2009 increased 30 basis points from the 2008 benefit ratio of 80.3%, primarily reflecting higher utilization associated with the general economy and the highly competitive environment, as well as the impact of the H1N1 virus, partially offset by an increase in per member premiums. We experienced higher utilization of benefits in our fully-insured group accounts as in-group attrition, primarily as a result of reductions of less experienced workers, has led to a shift in the mix of members to an older workforce having more health care needs, as well as members utilizing more benefits ahead of actual or perceived layoffs, members seeking to maximize their benefits once their deductibles are met, and increased COBRA participation.

SG&A Expense

Consolidated SG&A expenses increased $282.9 million, or 7.2%, during 2009 compared to 2008. The increase primarily resulted from an increase in the average number of our employees due to the Medicare growth and higher average individual product membership. The average number of our employees increased 1,600 to 28,500 for 2009 from 26,900 for 2008, or 5.9%.

The consolidated SG&A expense ratio for 2009 was 13.8%, increasing 10 basis points from 13.7% for 2008 primarily due to an increase in the Commercial segment SG&A expense ratio as discussed below. The consolidated SG&A expense ratio is expected to decrease to a range of 13.0% to 13.5% for 2010 from efforts to realign our cost structure.

Our Government and Commercial segments incur both direct and shared indirect overhead SG&A expenses. We allocate the indirect overhead expenses shared by the two segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

SG&A expenses in the Government segment increased $137.0 million, or 6.2%, during 2009 compared to 2008. The Government segment SG&A expense ratio decreased 30 basis points from 10.6% for 2008 to 10.3% for 2009. The decrease primarily resulted from efficiency gains associated with servicing higher average Medicare Advantage membership. For example, during 2009 we transitioned the recently acquired OSF and Metcare members into our primary Medicare service platform and eliminated the cost of having duplicate platforms.

Commercial segment SG&A expenses increased $145.9 million, or 8.5%, during 2009 compared to 2008. The Commercial segment SG&A expense ratio increased 170 basis points from 22.4% for 2008 to 24.1% for 2009. The increase primarily was due to administrative costs associated with increased business for our mail-order pharmacy and higher average individual product membership. Average individual product membership increased 17.6% during 2009 compared to 2008. Individual accounts bear a higher SG&A expense ratio due to higher distribution costs as compared to larger accounts.

Depreciation and Amortization

Depreciation and amortization for 2009 totaled $250.3 million compared to $220.4 million for 2008, an increase of $29.9 million, or 13.6%, primarily reflecting depreciation expense associated with capital expenditures since December 31, 2008.

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Interest Expense

Interest expense was $105.8 million for 2009, compared to $80.3 million for 2008, an increase of $25.5 million, primarily due to higher interest rates and higher average outstanding debt. In the second quarter of 2008, we issued $500 million of 7.20% senior notes due June 15, 2018 and $250 million of 8.15% senior notes due June 15, 2038, the proceeds of which were used for the repayment of the outstanding balance under our credit agreement. The weighted average effective interest rate for all of our long-term debt was 5.97% for 2009 and 4.73% for 2008.

Income Taxes

Our effective tax rate for 2009 of 35.1% compared to the effective tax rate of 34.8% for 2008. The increase was due to a lower proportion of tax exempt investment income to pretax income substantially offset by the reduction of the $16.8 million liability for unrecognized tax benefits in the first quarter of 2009 as a result of audit settlements. See Note 10 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate. We expect the 2010 effective tax rate to be approximately 36.0%.

Comparison of Results of Operations for 2008 and 2007

Certain financial data for our two segments was as follows for the years ended December 31, 2008 and 2007:

			Change	
	2008	**2007**	**Dollars**	**Percentage**
		(dollars in thousands)		
Premium revenues:				
Medicare Advantage	$ 13,777,999	$ 11,173,417	$ 2,604,582	