HEALTHWAYS, INC
Form 10-K
March 13, 2015

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

FORM 10-K

[X] Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

For the Fiscal Year Ended December 31, 2014

or

[ ] Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

Commission file number 000-19364

HEALTHWAYS, INC.
(Exact name of registrant as specified in its charter)

Delaware	62-1117144
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

701 Cool Springs Boulevard, Franklin, TN 37067
(Address of principal executive offices) (Zip code)

(615) 614-4929
(Registrant's telephone number, including area code)

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

Title of each class	Name of each exchange on which registered
Common Stock - $.001 par value, and related Preferred Stock Purchase Rights	The NASDAQ Stock Market LLC

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 No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act.

Yes No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days.

Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, 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 No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of the 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 check mark 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.

Large accelerated filer 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 Act).

Yes No

As of June 30, 2014, the last business day of the registrant's most recently completed second fiscal quarter, the aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant was approximately $515.6 million based on the price at which the shares were last sold for such date on The NASDAQ Stock Market.

As of March 6, 2015, 35,676,272 shares of Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2015 Annual Meeting of Stockholders are incorporated by reference into Part III of this Form 10-K.

Healthways, Inc.
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PART I

Item 1. Business

Overview

Founded and incorporated in Delaware in 1981, Healthways, Inc. provides comprehensive total population health management solutions that are uniquely designed to help people improve their well-being, thereby improving their health and productivity and reducing their health-related costs. Total population health management involves a proactive approach to reducing avoidable disease incidence – a considerable improvement from the more traditional and more costly method of waiting for people to get a disease before acting.

As used throughout this report, unless the context otherwise indicates, the terms "we," "us," "our," "Healthways" or the "Company" refer collectively to Healthways, Inc. and its wholly-owned subsidiaries.

As a global leader in total population health, Healthways has established a proven value proposition: by taking a systematic approach to keeping healthy people healthy, eliminating or reducing lifestyle risks and optimizing care for persistent or chronic conditions, we help our customers reduce health-related costs and increase productivity and performance across whole populations, including workforces, health plan memberships, and communities. We are pioneers of this systematic approach, and we believe we are unique in having the capability to provide a full spectrum of proven total population health management solutions.

Healthways' comprehensive well-being improvement programs provide personalized solutions for any individual, irrespective of their health status, age or paying sponsor. Our total population health technology platform uses our proprietary analytics and predictive models to enable us to stratify the population, develop individualized well-being improvement plans and deliver action-based solutions to improve individual and organizational performance. Our technology-driven infrastructure is compatible with, and integrated into, our customers' systems. Through this data-driven process, we identify the needs of each individual in a population and determine the right level of support. This allows us to efficiently deploy successful strategies to sustain engagement, to use the best science to drive behavior change and ultimately deliver meaningful, measurable outcomes. We know that each individual in a given population often simultaneously seeks a variety of support services in his or her pursuit of improved well-being. We provide a full spectrum of services that can be delivered at scale, and in a manner that meets the needs of individuals over time.

Our value proposition, described above, has been proven and published in peer-reviewed studies. Our systematic approach and comprehensive well-being improvement solutions are designed to focus on improving a population's essential well-being elements: physical, financial, social, community and sense of purpose.

For example, to keep healthy people healthy, our wellness and prevention programs focus on education, physical fitness, nutrition, health coaching and tools that support behavior change by:

- fostering well-being improvement and disease prevention through biometric screening and proprietary well-being assessments;
- engaging people in our well-being improvement programs, such as fitness, weight management, stress management, and financial and lifestyle management; and
- providing access to our fitness center, physical and occupational therapy, chiropractic, and complementary and alternative medicine provider networks.

To eliminate or reduce lifestyle risks, our programs help to motivate people to make positive lifestyle changes and accomplish individual goals, such as increasing physical activity for seniors, overcoming nicotine addiction or generating sustainable weight loss, by:

- promoting personal change and improvement in the lifestyle behaviors that lead to poor health or chronic conditions; and
- providing personal interactions with highly trained healthcare professionals and educational materials to create and sustain healthier behaviors for those individuals at risk or in the early stages of chronic conditions.

To help people optimize care for persistent or chronic conditions we:

- incorporate the latest, evidence-based clinical guidelines into interventions to optimize patient health outcomes;
- develop care support plans and motivate members to set attainable goals for themselves;
- provide local market resources to address acute episodic interventions;
- coordinate members' care as an extension of their healthcare providers;
- provide software technology solutions and management consulting in support of well-being improvement services; and
- provide high-risk care management for members at risk for hospitalization due to complex conditions.

In North America, we operate in all 50 states and the District of Columbia. Our customers include health plans, both commercial and Medicare Advantage, large self-insured employers, including state and municipal government entities, and providers of healthcare, including integrated healthcare systems, hospitals and physician groups. We also provide services to commercial healthcare businesses and/or government entities in Brazil, Australia, and France.

Our services are delivered using a range of methods, including venue-based face-to-face interactions; print; phone; mobile and remote devices with unique applications; on-line, including social networks; and any combination of these methods to motivate and sustain healthy behaviors. Many of our programs for lifestyle support, management and education are delivered through web-based portals and mobile applications and may also offer a social networking opportunity.

We have a scalable platform that we believe will enable us to gain substantial operating leverage as we grow – our proprietary technology infrastructure and delivery capabilities are currently accessible to approximately 68 million people across four continents. Our scalable model is also flexible, and therefore the degree of our engagement and model of support can evolve with our customers' needs and preferences. In many cases, our intervention services are delivered from our domestic and international well-being improvement call centers staffed with a range of professionals including, but not limited to, nurses, dieticians, pharmacists, health coaches, exercise specialists and nutritional counselors. Our fitness center network encompasses approximately 16,000 U.S. locations. We also maintain an extensive network of over 88,000 complementary, alternative and physical medicine practitioners, which offers convenient access to the significant number of individuals who seek health services outside of the traditional healthcare system.

Customer Contracts

Our fees are generally billed on a per member per month ("PMPM") basis or upon member participation, such as the Healthways® SilverSneakers® fitness solution. For PMPM fees, we generally determine our contract fees by multiplying the contractually negotiated PMPM rate by the number of members covered by our services during the month. We typically set PMPM rates during contract negotiations with customers based on the value we expect our programs to create and a sharing of that value between the customer and the Company.

Our contracts with health plans and integrated healthcare systems generally range from three to five years with several comprehensive strategic agreements extending up to ten years in length. Contracts with self-insured employers typically have two to four-year terms. Some of our contracts allow the customer to terminate early. Some of our contracts place a portion of our fees at risk based on achieving certain performance metrics, cost savings, and/or clinical outcomes improvements ("performance-based"). Approximately 6% of revenues recorded during the

twelve months ended December 31, 2014 were performance-based and 2% of revenues were subject to final reconciliation as of December 31, 2014.

Backlog

Backlog represents the estimated average annualized revenue at target performance over the term of the contract for business awarded but not yet started. We do not consider backlog at December 31 to be a meaningful predictor of our future revenues as a significant majority of our new revenues come from a combination of expanding revenue from existing customers and new customers with contracts that are signed and started on a non-calendar year basis. Annualized revenue in backlog as of December 31, 2014 and 2013 was as follows:

(In thousands)	December 31, 2014	December 31, 2013
Annualized revenue in backlog	$ 9,100	$ 39,800

Business Strategy

Our business strategy and value proposition reflect our fundamental belief that people with higher well-being have lower overall health-related costs, improved workforce engagement and improved productivity, which yields better performance for individuals, families, health plans, governments, employers, integrated healthcare systems and communities.

We believe the entire healthcare market is shifting to payment for outcomes, not simply volume of services or time, and that total population health management is the most effective model within this pay-for-value reimbursement market. Unlike historical business models that generate revenue based on the cost of a unit of service delivered, the total population health management business model only creates recurring revenue if a positive outcome – lower medical cost and/or improved productivity – is achieved. We believe this model is better aligned with macro healthcare trends and their impact on payors, providers and consumers.

Strategic Transformation

In 2006, we recognized that an evolving healthcare landscape and difficult economic headwinds were challenging our conventional stand-alone disease management model. We therefore undertook a major strategic transformation, which is now largely complete, to become a leader in the rapidly growing total population health management industry. Over the past eight years, we designed, built, and implemented a business model that utilizes the Company's core strengths and that provides a diverse set of total population health management services to a broader set of end customer markets. The transformation involved:

- Investing in technology and innovative capabilities to form our scalable platform to deliver our comprehensive well-being improvement solution;
- Expanding the scope and extending the term of our relationships with a number of our largest customers; and
- Establishing significant new customer relationships by providing value aligned with their needs.

Ultimately, these actions led to a highly scalable business in what has become a growing industry that we have estimated to be at least a $50 billion total addressable opportunity in our current geographic markets.

Scalable Model

Our scalable model is flexible, and therefore the degree of our engagement and model of support can evolve with our customers' needs and preferences. The behavior change techniques and predictive modeling incorporated in our technology identify an individual's readiness to change and provide personalized support through appropriate interactions using a range of methods desired by an individual, including venue-based face-to-face; print; phone; mobile and remote devices with unique applications; on-line, including social networks; and any combination thereof to motivate and sustain healthy behaviors. We can take a simple approach to scaling the business by providing the support each individual needs using the most cost-effective modality.

In order to do this across millions of lives, we have built a delivery infrastructure that can accommodate the balance between cost of delivery and required intensity of intervention while still solving for the preference sensitivities of each individual so that they stay engaged. A large percentage of the population is supported through self-directed modalities of mobile, web and integrated devices. A small percentage of the population has more intensive needs and receives person-to-person services. In the end, the modalities used and intensity of service must deliver the expected result – healthier people who perform better and cost less.

While our transformation-related infrastructure and technology investments are largely complete, we continue to invest in technology and are continually refining our proprietary clinical, data management, and reporting systems to continue to meet the information management requirements of our services.

Strategic Partnerships

Strategic partnerships with leading health and well-being solutions providers are an important part of our business strategy.

Through our exclusive, 25-year relationship with Gallup which began in 2008, we have created a definitive measure and empiric database of changes in the well-being of the U.S. population based on over two million completed surveys to date, known as the Gallup-Healthways Well-Being Index®. This database supports our understanding of the causes and effects of well-being for a population. In 2012, we created a global joint venture with Gallup that has developed the next generation of Gallup-Healthways individual well-being assessment tools, known as the Gallup-Healthways Well-Being 5™, to provide employers, health providers, insurers and other interested parties with a validated capability to assess, measure and report on changes in the well-being of their employees, patients, members and customers.

Additionally, we have a series of exclusive and proprietary relationships to deliver specific solutions to our customer markets. We collaborate with Blue Zones, LLC to deliver a scaled well-being improvement solution to support our customers' initiatives to improve the well-being of entire community populations. We also have an exclusive partnership with Dr. Dean Ornish that is scaling access to the Dr. Ornish's Program for Reversing Heart Disease™ for a number of health plans, health systems and hospitals. In another exclusive arrangement, Healthways Financial Well-Being™, powered by Dave Ramsey, empowers individuals to take control of their personal finances by blending the proven approach of New York Times best-selling author and national radio show host Dave Ramsey with Healthways' intuitive technology, science-based methodology and well-being expertise.

Customer Growth Strategy

Today, we have a number of customer markets for our well-being improvement solutions, including health plans (both commercial and Medicare Advantage), self-insured employers, integrated health systems/hospitals/physician groups and international entities. Our strategy to grow the business has three components. 1) We are growing the market opportunity by adding new customers in our geographic footprint in the U.S. and abroad and adding countries in our international business. 2) We are growing the eligible lives for services within our existing customers, both as our

customers grow their eligible populations or offer our solutions more broadly within their membership. 3) We are expanding our scope of services with existing customers who initially purchased something less than our comprehensive solution.

Health Plans: A number of contracts signed and expanded since 2011 have increased both the level of integration and breadth of services provided to major regional commercial health plans, as they develop and implement a number of patient-centered medical home models. Our services extend beyond chronic care and wellness programs to include a full range of care management functions, as well as a variety of health promotion and prevention and quality improvement solutions. Examples include: Blue Zones systematic, environmental approach to community well-being, MeYou Health web and mobile device based social networking well-being improvement tools and the hospital-based Dr. Ornish's Program for Reversing Heart Disease™. We expect additional opportunities to grow in this market, based upon the competitive advantage that our total population management approach provides to health plans and their customers in addition to the external market forces orienting this market toward outcome-driven solutions.

We also provide a variety of services to most of the major Medicare Advantage health plans. We expect this market to grow as the Medicare Advantage and Medicare Supplemental health plan memberships grow with an aging population. Our SilverSneakers® senior fitness program is the largest single program within our current services to this market. We are leveraging the fitness center national network to expand our product offering in the traditional commercial health plan and large employer markets – an increasingly important part of our overall well-being improvement solution. In addition, more of the senior population is becoming interested in web-based services and mobile applications, and some of our Medicare Advantage health plan customers are therefore adding these services for personal support and social networking.

Self-Insured Employers: Large self-insured employers, including state and municipal government entities, continue to demand services that focus across the entire population of employees and their dependent family members. These employers typically seek to utilize a broad array of our intervention capabilities. Our comprehensive well-being improvement solution targets a much larger improvement in employer performance and profitability by reducing the impact of productivity lost for health-related reasons, in addition to improving individuals' health and reducing direct healthcare costs. With the success of our total population health management work, we expect to enhance our competitive advantage by responding to and meeting employers' needs for a healthier, higher-performing, and less costly workforce.

Integrated Health Systems / Hospitals / Physician Groups: Significant changes in healthcare payment structures, from fee for service to outcomes–based payments, have expanded our opportunities to provide services to integrated healthcare systems, hospitals, and physicians. In 2011, we acquired Navvis & Company, a well-established provider of strategic counsel and change management services that enable its healthcare system clients to become future-ready clinical enterprises within the healthcare industry's rapidly emerging value-based reimbursement system. Our strategy includes providing integrated healthcare systems, hospitals and physician enterprises with both consultative strategic planning services and an array of solutions that enable and support the delivery of Physician-Directed Population Health solutions. We expect to continue to grow the number and size of our health systems relationships through the ongoing deployment of services including consulting, our acute to post-acute Care Transitions Solution™, the Dr. Ornish's Program for Reversing Heart Disease™, and the aggregation of risk lives within health systems for our total population management services.

International Entities: Our international business continues to grow within our existing geographic footprint of Australia, France and Brazil. Additionally, we have a pipeline of opportunities and expect our international business will continue to expand. Our international strategy is to pursue opportunities in countries with a relatively developed healthcare infrastructure, including the existence of one or more payors with a large volume of at risk lives. This approach allows us to partner either directly with government payors or with the private insurers and service providers that operate in those countries.

We expect to increase our competitive advantage and strong market position by leveraging the scope of our well-being improvement services and capabilities, including our medical information content, behavior change processes and techniques, strategic relationships, health provider networks and fitness center relationships. We also expect to continue to scale the delivery of our solutions by employing a blend of our state-of-the-art well-being improvement

call centers and proprietary technologies, modalities, and techniques. While our core total population health infrastructure and technology investments are complete and our scalable platform is in place, we may add new capabilities and technologies through internal development, strategic alliances with other entities and/or selective acquisitions or investments.

Segment and Major Customer Information

We have two operating segments (domestic and international) that we have aggregated into one reportable segment, well-being improvement services. During 2014, Humana, Inc. ("Humana") comprised approximately 11.6% of our revenues. Our primary contract with Humana continues through 2016. No other customer accounted for 10% or more of our revenues in 2014.

Competition

The healthcare industry is highly competitive and subject to continual change in the manner in which services are provided. Other entities, whose financial, research, staff, and marketing resources may exceed our resources, are marketing a variety of total population health management services and other services or have announced an intention to offer such services to health plans, both commercial and Medicare Advantage; large self-insured employers, including state and municipal government entities; and providers of healthcare, including integrated healthcare systems, hospitals, and physician groups. These entities include health and wellness companies, retail drug stores, major pharmaceutical companies, health plans, healthcare web-based and/or print content companies, home healthcare organizations, providers, pharmacy benefit management companies, medical device and diagnostic companies, healthcare information technology companies, Internet-based medical content companies, revenue cycle management companies, consulting firms and other entities.

We believe we have advantages over our competitors because of the breadth and depth of our well-being improvement capabilities, including the scope of our strategic relationships; state-of-the-art proprietary information technology; predictive modeling and data integration capabilities; behavior-change techniques; the comprehensive recruitment and training of our clinical colleagues; our experienced management team; the comprehensive clinical nature and evidence-based scientific foundation of our product offerings; our established reputation for providing well-being improvement services to members wishing to maintain health, who possess health risk factors or are diagnosed with chronic diseases; and the proven financial and clinical results delivered by our programs as evidenced through a library of published peer-reviewed outcomes studies. However, we cannot assure you that we can compete effectively with other entities such as those noted above.

Industry Integration and Consolidation

Consolidation has been an important factor in all aspects of the healthcare industry, including the well-being and health management sector. While we believe the size of our membership base provides us with the economies of scale to compete even in a consolidating market, we cannot assure you that we can effectively compete with companies formed as a result of industry consolidation or that we can retain existing health plan, integrated healthcare system, or employer customers if they are acquired by other entities which already have or contract for programs similar to ours or are not interested in our programs.

Pursuant to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, "PPACA"), the U.S. Department of Health & Human Services ("HHS") established a Medicare Shared Savings Program that promotes accountability and coordination of care among providers through the creation of Accountable Care Organizations ("ACOs"). The program allows providers, including hospitals, physicians, and other designated professionals, to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. We provide support and services for multiple ACOs that serve Medicare fee-for-service beneficiaries through our partnerships with integrated health systems. Further, PPACA required HHS to establish voluntary national bundled payment programs under which participating groups of providers receive a single payment for certain medical conditions or episodes of care. While ACOs and bundled payments are Medicare programs under PPACA, commercial insurers and private managed care health plans may increasingly shift to ACO and bundled payment models as well. We expect these and other changes resulting from PPACA to further encourage integration and

increase consolidation in the healthcare industry.

Governmental Regulation

Governmental regulation impacts us in a number of ways in addition to those regulatory risks presented under Item 1A. "Risk Factors" below.

Patient Protection and Affordable Care Act

PPACA changes how healthcare services are covered, delivered, and reimbursed through, among other things, significant reductions in the growth of Medicare program payments. In addition, PPACA reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement. PPACA contains provisions that have, and will continue to have, an impact on our customers, including commercial health plans and Medicare Advantage programs.

Among other things, PPACA decreases the number of uninsured individuals and expands coverage through the expansion of public programs and private sector health insurance as well as a number of health insurance market reforms. In addition, PPACA encourages the utilization of preventive services and wellness programs, such as those we provide. However, PPACA also directly affects the customers or prospective customers that contract for our services and may increase their costs and/or reduce their revenues. For example, PPACA prohibits commercial health plans from using gender, health status, family history, or occupation to set premium rates, eliminates pre-existing condition exclusions, and bans annual benefit limits. In addition, PPACA mandates minimum medical loss ratios ("MLRs") for health plans such that the percentage of health coverage premium revenue spent on healthcare medical costs and quality improvement expenses be at least 80% for individual and small group health plans and 85% for large group coverage and Medicare Advantage plans, with policyholders receiving rebates, and the Centers for Medicare and Medicaid Services ("CMS") receiving refunds in the case of Medicare Advantage plans, if the actual loss ratios fall below these minimums.

Changes in laws governing reimbursement to health plans providing services under governmental programs such as Medicare and Medicaid may affect us. PPACA impacts Medicare Advantage programs in a variety of ways. PPACA reduces premium payments to Medicare Advantage plans such that the managed care per capita payments paid by CMS to Medicare Advantage plans are, on average, equal to those for traditional Medicare. While PPACA awards bonuses to Medicare Advantage plans that achieve service benchmarks and quality ratings, overall payments to Medicare Advantage plans are significantly reduced under PPACA. The impact of these reductions on our business is not yet clear.

It is difficult to predict with any reasonable certainty the full impact of PPACA on the Company due to the law's complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, remaining or new court challenges, and possible amendment or repeal. For example, the U.S. Supreme Court will decide a case known as King v. Burwell during the 2015 session, which challenges the extension of federal subsidies to premiums for health insurance policies purchased through American Health Benefit Exchanges ("Exchanges") operated by the federal government. If the plaintiffs prevail, the case could significantly affect implementation of PPACA, including making it more difficult for residents of states not operating Exchanges to purchase or maintain insurance coverage.

Other Laws

While many of the governmental and regulatory requirements affecting healthcare delivery generally do not directly apply to us, our customers must comply with a variety of regulations including Medicare Advantage marketing and other restrictions, the licensing and reimbursement requirements of federal, state and local agencies and the requirements of municipal building codes and health codes. Certain of our services, including health service utilization management and certain claims payment functions, require licensure by government agencies. We are

subject to a variety of legal requirements in order to obtain and maintain such licenses.

Certain of our professional healthcare employees, such as nurses, must comply with individual licensing requirements. All of our healthcare professionals who are subject to licensing requirements are licensed in the state in which they are physically present, such as the professionals located at a well-being improvement call center. Multiple state licensing requirements for healthcare professionals who provide services telephonically over state lines may require some of our healthcare professionals to be licensed in more than one state. We continually monitor legislative, regulatory and judicial developments in telemedicine in order to stay in compliance with state and federal laws; however, new agency interpretations, federal or state legislation or regulations, or judicial decisions could increase the requirement for multi-state licensing of all well-being improvement call center health professionals, which would increase our costs of services.

Federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") extensively restrict the use and disclosure of individually-identifiable health information by health plans, most healthcare providers, and certain other entities (collectively, "covered entities"). Federal security regulations issued pursuant to HIPAA require covered entities to implement and maintain administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic individually-identifiable health information. Because we handle individually-identifiable health information on behalf of covered entities, we are considered a "business associate" and are required to comply with most aspects of the HIPAA privacy and security regulations.

Violations of HIPAA and its implementing regulations may result in criminal penalties and in civil penalties of up to $50,000 per violation for a maximum civil penalty of $1.5 million in a calendar year for violations of the same requirement. In addition, we may be contractually or directly obligated to comply with any applicable state laws or regulations related to the confidentiality and security of confidential personal information. In the event of a data breach involving individually-identifiable health information, we are subject to contractual obligations and state and federal requirements that require us to notify our customers. These requirements may also require us or our customers to notify affected individuals, regulatory agencies, and the media of the data breach. In addition, non-permitted uses and disclosures of unsecured individually identifiable health information are presumed to be breaches for which notice is required, unless it can be demonstrated that there is a low probability the information has been compromised.

Federal law contains various prohibitions related to false statements and false claims, some of which apply to private payors as well as federal programs. Actions may be brought under the federal False Claims Act by the government as well as by private individuals, known as "whistleblowers," who are permitted to share in any settlement or judgment.

There are many potential bases for liability under the False Claims Act, including knowingly and improperly avoiding repayment of an overpayment received from the government and the knowing failure to report and return an overpayment within 60 days of identifying the overpayment. Liability under the False Claims Act also arises when an entity knowingly submits a false claim for reimbursement to the federal government, and the False Claims Act defines the term "knowingly" broadly. The Health Reform Law provides that submission of claims for services or items generated in violation of certain "fraud and abuse" provisions of the Social Security Act, including the anti-kickback provisions, constitutes a false or fraudulent claim under the False Claims Act. In some cases, whistleblowers, the federal government, and some courts have taken the position that entities that allegedly have violated other statutes, such as the federal self-referral prohibition commonly known as the Stark Law, have thereby submitted false claims under the False Claims Act. From time to time, participants in the healthcare industry, including our company and our customers, may be subject to actions under the False Claims Act, and it is not possible to predict the impact of such actions.

Employees

As of March 1, 2015, we had approximately 2,700 employees. Our employees are not subject to any collective bargaining agreements. We believe we have good relationships with our employees.

Available Information

Our Internet address is www.healthways.com. We make available free of charge, on or through our Internet website, our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission (the "SEC"). The public may read and copy any materials that we file with the SEC at the SEC's Public Reference Room at 100 F Street NE, Washington DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. The SEC maintains an Internet site that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC at www.sec.gov.

Item 1A. Risk Factors

In the execution of our business strategy, our operations and financial condition are subject to certain risks. A summary of certain material risks is provided below, and you should take such risks into account in evaluating any investment decision involving the Company. This section does not describe all risks applicable to us and is intended only as a summary of certain material factors that could impact our operations in the industry in which we operate. Other sections of this Annual Report on Form 10-K (this "Report") contain additional information concerning these and other risks.

We depend on payments from customers, and cost reduction pressure on our customers may adversely affect our business and results of operations.

The healthcare industry currently faces significant cost reduction pressures as a result of increased competition, constrained revenues from governmental and private sources, increasing underlying medical care costs and general economic conditions. We believe that these pressures will continue and possibly intensify.

We believe that our solutions, which are geared to foster well-being improvement by engaging people in health improvement programs, specifically assist our customers in controlling the costs of healthcare; however, the pressures to reduce costs in the short term may negatively affect our ability to sign and/or retain contracts under existing terms or to restructure these contracts on terms that would not have a material negative impact on our results of operations. These financial pressures could have a negative impact on our results of operations.

A significant percentage of our revenues is derived from health plan customers.

A significant percentage of our revenues is derived from health plan customers. The health plan industry continues to consolidate, and we cannot assure you that we will be able to retain health plan customers if they are acquired by other health plans that already participate in competing programs or are not interested in our programs. In addition, a reduction in the number of covered lives enrolled with our health plan customers or a decision by our health plan customers to take programs in-house could adversely affect our results of operations. Our health plan customers are subject to increased obligations under PPACA, including benefit mandates, limitations on exclusions and factors used for rate setting, requirements for MLRs, and increased taxes. In determining how to meet these requirements, current or prospective customers may seek reduced fees or choose to reduce or delay the purchase of our services.

In addition, PPACA required that each state establish or participate in an Exchange (as defined above) where individuals may compare and purchase health insurance. Health plans participating in an Exchange must offer a set of minimum benefits, known as "essential health benefits," and may elect to offer additional benefits. Chronic disease management is one of the ten essential health benefits. The parameters of the chronic disease management benefit may vary based upon each state's specific benchmark plan which sets the standard for each market. It is possible that our services will not qualify under these standards in some or all states. We cannot predict whether individuals who are currently receiving our services will switch to health plans offered through the Exchanges that do not include our services. If we are unable to provide services to health plans participating in Exchanges, if health plans in the Exchanges that engage our services are not successful, or if the Exchanges otherwise reduce the number of members receiving our services or the payments we receive, our results of operations could be negatively impacted.

We currently derive a significant percentage of our revenues from one customer.

Because of the size of its membership, Humana comprised approximately 11.6% of our revenues in 2014. No other customer accounted for 10% or more of our revenues in 2014. Our primary contract with Humana continues through 2016. The loss or restructuring of a contract with, Humana or other large customers could have a material adverse effect on our business and results of operations.

Our business strategy is dependent in part on developing new and additional products and services to complement our existing products and services, as well as establishing additional distribution channels through which we may offer our products and services.

Our strategy focuses on helping people adopt and/or maintain healthy behaviors, reducing health-related risk factors, and optimizing care for identified health conditions. While we have considerable experience in solutions for a broad range of health conditions, any new or modified programs will involve inherent risks of execution, such as our ability to implement our programs within expected timelines or cost estimates; our ability to obtain adequate financing to provide the capital that may be necessary to support our operations and to support or guarantee our performance under new contracts; and our ability to deliver outcomes on any new products or services. In addition, as part of our business strategy, we may enter into relationships to establish additional distribution channels through which we may offer our products and services. As we offer products through new or alternative distribution channels, we may face difficulties, such as potential customer overlap, which may lead to pricing conflicts, which may adversely affect our business.

Our business strategy relating to the development and introduction of new products and services exposes us to risks such as limited customer acceptance and additional expenditures that may not result in additional net revenue.

An important component of our business strategy is to focus on new products and services that enable us to provide immediate value to our customers, such as Dr. Dean Ornish's Lifestyle Management Programs. Customer acceptance of these new products and services cannot be predicted with certainty, and if we fail to execute properly on this strategy or to adapt this strategy as market conditions evolve, our ability to grow revenue and our results of operations may be adversely affected.

If we fail to successfully implement our business strategy, our financial performance and our growth could be materially and adversely affected.

Our future financial performance and success are dependent in large part upon our ability to implement our business strategy successfully. Implementation of our strategy will require effective management of our operational, financial and human resources and will place significant demands on those resources. See Item 1. "Business – Business Strategy" for more information regarding our business strategy. There are risks involved in pursuing our strategy, including the following:

- We may not be able to hire or retain the personnel necessary to manage our strategy effectively.
- We may be unsuccessful in implementing improvements to operational efficiency and such efforts may not yield the intended result.
- Execution of our strategy may cause us to incur substantial implementation costs, make substantial investments in technology and/or incur additional indebtedness, which may divert capital away from our traditional business operations.

In addition to the risks set forth above, implementation of our business strategy could be affected by a number of factors beyond our control, such as increased competition, legal developments, government regulation, general economic conditions, increased operating costs or expenses, and changes in industry trends. We may decide to alter or discontinue certain aspects of our business strategy at any time. If we are not able to implement our business strategy successfully, our long-term growth and profitability may be adversely affected. Even if we are able to implement some or all of the initiatives of our business strategy successfully, our operating results may not improve to the extent we anticipate, or at all.

Our inability to renew and/or maintain contracts with our customers could adversely affect our business and results of operations.

If our customers choose not to renew their contracts with us, our business and results of operations could be materially adversely affected. No contracts subject to renewal in 2015 individually represent 2% or more of our 2014 revenues.

Failure to successfully execute on the terms of our contracts could result in significant harm to our business.

Our ability to grow and expand our business is contingent upon our ability to achieve desired performance metrics, cost savings, and/or clinical outcomes improvements under our existing contracts and to favorably resolve contract billing and interpretation issues with our customers. Some of our contracts place a portion of our fees at risk or provide for gain share opportunity based on achieving such metrics, savings, and/or improvements. We cannot guarantee that we will achieve and reach mutual agreement with customers with respect to contractually required performance metrics, cost savings and/or clinical outcomes improvements under our contracts within the expected time frames. Unusual and unforeseen patterns of healthcare utilization by individuals with diseases or conditions for which we provide services could adversely affect our ability to achieve desired performance metrics, cost savings, and clinical outcomes. Our inability to meet or exceed the targets under our customer contracts could have a material adverse effect on our business and results of operations. Also, our ability to provide financial guidance with respect to performance-based contracts is contingent upon our ability to accurately forecast variables that affect performance and the timing of revenue recognition under the terms of our contracts ahead of data collection and reconciliation.

In addition, certain of our contracts are increasing in complexity, requiring integration of data, systems, people, programs and services, the execution of sophisticated business activities, and the delivery of a broad array of services to large numbers of people who may be geographically dispersed. The failure to successfully manage and execute the terms of these agreements could result in the loss of fees and/or contracts and could adversely affect our business and results of operations.

We depend on the timely receipt of accurate data from our customers and our accurate analysis of such data.

Identifying which members may benefit from receiving our services and measuring our performance under our contracts are highly dependent upon the timely receipt of accurate data from our customers and our accurate analysis of such data. Data acquisition, data quality control and data analysis are complex processes that carry a risk of untimely, incomplete or inaccurate data from our customers or flawed analysis of such data, which could have a material adverse effect on our ability to recognize revenues.

Our ability to achieve estimated annualized revenue in backlog is based on certain estimates.

Our ability to achieve estimated annualized revenue in backlog in the manner and within the timeframe we expect is based on certain estimates regarding the implementation of our services. We cannot assure you that the amounts in backlog will ultimately result in revenues in the manner and within the timeframe we expect.

Changes in macroeconomic conditions may adversely affect our business.

Economic difficulties and other macroeconomic conditions could reduce the demand and/or the timing of purchases for certain of our services from customers and potential customers. Loss of a significant customer or a reduction in a customer's enrolled lives could have a material adverse effect on our business and results of operations. In addition, changes in economic conditions could create liquidity and credit constraints. We cannot assure you that we would be able to secure additional financing if needed and, if such funds were available, that the terms and conditions would be acceptable to us.

The continued expansion of our services into international markets subjects us to additional business, regulatory and financial risks.

We provide health improvement programs and services in Brazil, Australia, and France, and we intend to continue expanding our international operations as part of our business strategy. We have incurred and expect to continue to incur costs in connection with pursuing business opportunities in international markets. Our success in the international markets will depend in part on our ability to anticipate the rate of market acceptance of our solutions and the individual market dynamics and regulatory requirements in potential international markets. Because the international market for our services is still developing and also involves many new solutions, there is no guarantee that we will be able to achieve the necessary cost savings and clinical outcomes improvements under our contracts with international customers within the expected time frames and reach mutual agreement with customers with respect to those outcomes. The failure to accurately forecast the costs of implementing our strategy of establishing a presence in these markets could have a material adverse effect on our business.

In addition, as a result of doing business in foreign markets, we are subject to a variety of additional risks that are different from the risks we face within the United States. Our future operating results in these countries or in other countries or regions throughout the world could be negatively affected by a variety of factors that are beyond our control. These factors include political conditions, economic conditions, legal and regulatory constraints, currency regulations, and other matters in any of the countries or regions in which we operate, now or in the future. In addition, foreign currency exchange rates and fluctuations may have an impact on our future costs or on future cash flows from our international operations, and could adversely affect our financial performance. Other factors that may impact our international operations include foreign trade, monetary and fiscal policies both of the United States and of other

countries, laws, regulations, and other activities of foreign governments, agencies, and similar organizations. Additional risks inherent in our international operations generally include, among others, the costs and difficulties of managing international operations, adverse tax consequences and greater difficulty in enforcing intellectual property rights in countries other than the United States.

We may experience difficulties associated with the implementation and/or integration of new businesses, services (including outsourced services), technologies, solutions, or products.

We may face substantial difficulties, costs, and delays in effectively implementing and/or integrating acquired businesses, services (including outsourced services), or technologies into our platform. Implementing internally-developed solutions and/or integrating newly acquired businesses, services (including outsourced services), and technologies could be costly and time-consuming and may strain our resources. Consequently, we may not be successful in implementing and/or integrating these new businesses, services, or technologies and may not achieve anticipated revenue and cost benefits.

The performance of our business and the level of our indebtedness could prevent us from meeting the obligations under our debt agreement or the cash convertible senior notes or have an adverse effect on our future financial condition, our ability to raise additional capital, or our ability to react to changes in the economy or our industry.

On June 8, 2012, we entered into the Fifth Amended and Restated Revolving Credit and Term Loan Agreement (the "Fifth Amended Credit Agreement"), which was amended on February 5, 2013, March 15, 2013, July 1, 2013, April 14, 2014, and December 29, 2014. On July 16, 2013, we completed the issuance of $150.0 million aggregate principal amount of cash convertible senior notes due 2018 (the "Cash Convertible Notes"), and on October 1, 2013, we entered into an Investment Agreement (the "Investment Agreement") with CareFirst Holdings, LLC ("CareFirst"). Pursuant to the Investment Agreement, we issued to CareFirst a convertible subordinated promissory note in an aggregate original principal amount of $20 million (the "CareFirst Convertible Note"). As of December 31, 2014, our long-term debt under these arrangements, including the current portion but excluding the debt discount, was $272.5 million.

Our ability to service our indebtedness (including the debt outstanding under the Fifth Amended Credit Agreement, the Cash Convertible Notes and the CareFirst Convertible Note) will depend on our ability to generate cash in the future. We cannot assure you that our business will generate sufficient cash flow from operations or that future borrowings will be available in an amount sufficient to enable us to service our indebtedness or to fund other liquidity needs.

The Fifth Amended Credit Agreement contains various financial covenants, restricts the payment of dividends, and limits the amount of repurchases of our common stock. A breach of any of these covenants could result in a default under the Fifth Amended Credit Agreement, in which all amounts outstanding under the Fifth Amended Credit Agreement may become immediately due and payable, and all commitments under the Fifth Amended Credit Agreement to extend further credit may be terminated. In addition, a payment default, including an acceleration following an event of default, under the Fifth Amended Credit Agreement or under our indenture for the Cash Convertible Notes, could each trigger an event of default under the other debt instrument, which could result in the principal of and the accrued and unpaid interest on such debt becoming due and payable.

Our indebtedness could adversely affect our future financial condition or our ability to react to changes in the economy or industry by, among other things:

- increasing our vulnerability to a downturn in general economic conditions, loss of revenue and/or profit margins in our business, or to increases in interest rates, particularly with respect to the portion of our outstanding debt that is subject to variable interest rates;
- potentially limiting our ability to obtain additional financing or to obtain such financing on favorable terms;
- causing us to dedicate a portion of future cash flow from operations to service or pay down our debt, which reduces the cash available for other purposes, such as operations, capital expenditures, and future business opportunities; and
-

possibly limiting our ability to adjust to changing market conditions and placing us at a competitive disadvantage compared to our competitors who may be less leveraged.

The conditional conversion feature of the Cash Convertible Notes, if triggered, may adversely affect our financial condition and operating results.

The cash conversion feature of the Cash Convertible Notes (the "Cash Conversion Derivative") requires bifurcation from the Cash Convertible Notes in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") Topic 815, Derivatives and Hedging. In the event the conditional conversion feature of the Cash Convertible Notes is triggered, holders of Cash Convertible Notes will be entitled to convert the Cash Convertible Notes at any time during specified periods at their option. If one or more holders elect to convert their Cash Convertible Notes, we would be required to pay cash to settle any such conversion, which could adversely affect our liquidity. In addition, even if holders do not elect to convert their Cash Convertible Notes, we could be required under applicable accounting rules to reclassify all or a portion of the outstanding principal of the Cash Convertible Notes as a current rather than long-term liability, which could result in a material reduction of our net working capital.

The accounting for the Cash Convertible Notes and related cash convertible notes hedge transactions may result in volatility to our consolidated statements of comprehensive income (loss).

The Cash Conversion Derivative that is part of the Cash Convertible Notes is accounted for as a derivative liability pursuant to ASC Topic 470, Debt, relating to derivative instruments and hedging activities. In general, the initial valuation of the conversion option was bifurcated from the debt component of the Cash Convertible Notes and is measured at fair value each reporting period. For each financial statement period after issuance of the Cash Convertible Notes, a hedge gain (or loss) will be reported in our consolidated statements of comprehensive income (loss) to the extent the valuation of the Cash Conversion Derivative changes from the previous period. In connection with the issuance of the Cash Convertible Notes, we entered into privately negotiated convertible note hedge transactions (the "Cash Convertible Notes Hedges"), which are cash-settled and are recorded and carried at fair value as a derivative asset and are intended to offset the gain (or loss) associated with changes to the valuation of the Cash Conversion Derivative. Although we do not expect there to be a material net impact to our consolidated statements of comprehensive income (loss) as a result of our issuing the Cash Convertible Notes and entering into the Cash Convertible Notes Hedges, we cannot assure you these transactions will be completely offset, which may result in volatility to our consolidated statements of comprehensive income (loss).

We are subject to counterparty risk with respect to the Cash Convertible Notes Hedges.

The counterparties to the Cash Convertible Notes Hedges (the "Counterparties") are financial institutions or affiliates of financial institutions, and we will be subject to the risk that these Counterparties may default or otherwise fail to perform, or may exercise certain rights to terminate their obligations, under the Cash Convertible Notes Hedges. Our exposure to the credit risk of the Counterparties will not be secured by any collateral. If one or more of the Counterparties to one or more of the Cash Convertible Notes Hedges becomes subject to insolvency proceedings, we will become an unsecured creditor in those proceedings with a claim equal to our exposure at the time under those transactions. Our exposure will depend on many factors but, generally, the increase in our exposure will be correlated to the increase in the market price of our common stock and in volatility of our common stock. In addition, upon a default or other failure to perform, or a termination of obligations, by one of the Counterparties, we may suffer adverse tax consequences and dilution with respect to our common stock. We can provide no assurances as to the financial stability or viability of any of the Counterparties.

We have a significant amount of goodwill and intangible assets, the value of which could become impaired.

We have recorded significant portions of the purchase price of certain acquisitions as goodwill and/or intangible assets. At December 31, 2014, we had approximately $338.8 million and $69.2 million of goodwill and intangible assets, respectively. We review goodwill and intangible assets not subject to amortization for impairment on an annual basis (during the fourth quarter) or more frequently whenever events or circumstances indicate that the carrying value may not be recoverable. If we determine that the carrying values of our goodwill and/or intangible

assets are impaired, we may incur a non-cash charge to earnings, which could have a material adverse effect on our results of operations for the period in which the impairment occurs.

A failure of our information systems could adversely affect our business.

Our ability to deliver our services depends on effectively using information technology. We expect to continually invest in updating and expanding our information technology capabilities. In some cases, we may have to make systems investments before we generate revenues from contracts with new customers. In addition, these system requirements expose us to technology obsolescence risks.

We rely upon our information systems for operating and monitoring all major aspects of our business. These systems and, therefore, our operations could be damaged or interrupted by natural disasters, power loss, network failure, improper operation by our employees, data privacy or security breaches, computer viruses, computer hacking, network penetration or other illegal intrusions or other unexpected events. Any disruption in the operation of our information systems, regardless of the cause, could adversely impact our operations, which may adversely affect our financial condition, results of operations and cash flows.

A cyber-security incident could result in the loss of confidential data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, or common law theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

The nature of our business involves the receipt and storage of a significant amount of health information about the participants in our programs. The secure maintenance of this confidential information is critical to our business operations. To protect our information systems from attack, damage and unauthorized use, we have implemented multiple layers of security, including technical safeguards, processes, and our people. Our defenses are monitored and routinely tested internally and by external parties. Despite these efforts, threats from malicious persons and groups, new vulnerabilities, and advanced attacks against information systems create risk of cyber security incidents. There can be no assurance that we will not be subject to cyber security incidents that bypass our security measures, result in loss of personal health information or other data subject to privacy laws or disrupt our information systems or business. As a result, cyber-security and the continued development and enhancement of our controls, processes and practices remain a priority for us. We may be required to expend significant additional resources in our efforts to modify or enhance our protective measures against evolving threats or to investigate and remediate any cyber security vulnerabilities. The occurrence of a breach in security of our systems or those of our third-party vendors and other service providers could result in interruptions, delays, the loss, access, misappropriation, disclosure or corruption of data, liability under privacy, security and consumer protection laws or litigation under these or other laws, including common law theories, and subject us to federal and state governmental inquiries, any of which could have a material, adverse effect on our financial condition and results of operations and harm our business reputation.

If we lose the services of our Chief Executive Officer or other members of our senior management team, we may not be able to execute our business strategy.

We believe that our success depends in significant part upon the continued service of our senior management team. In particular, we believe that our Chief Executive Officer, Ben R. Leedle, Jr., is critical to our strategic direction and is uniquely positioned to lead the Company through the current business environment in the healthcare industry that is largely due to the changes resulting from healthcare reform. The loss of our Chief Executive Officer, even temporarily, or any other member of our senior management team could have a material adverse effect on our business.

We face competition for staffing, which may increase our labor costs and reduce profitability.

We compete with other healthcare and services providers in recruiting qualified management, including executives with the required skills and experience to operate and grow our business, and staff personnel for the day-to-day operations of our business and well-being improvement call centers, including nurses, health coaches, and other healthcare professionals. In some markets, the scarcity of nurses, experienced health coaches, and other medical support personnel has become a significant operating issue to healthcare businesses. These challenges may require us to enhance wages and benefits to recruit and retain qualified management and other professionals. A failure to attract and retain qualified management, nurses, health coaches, and other healthcare professionals, or to control labor costs, could have a material adverse effect on our profitability.

Our industry is a rapidly evolving and highly competitive segment of the healthcare industry.

The rapidly growing industry in which we operate is an evolving segment of the overall healthcare industry with many entities marketing or announcing an intention to offer a variety of total population health improvement services and other services to health plans, integrated healthcare systems, self-insured employers, and government entities. The financial, research, staff, and marketing resources of these entities may exceed our resources,

We believe we have advantages over our competitors because of the breadth and depth of our well-being improvement capabilities, including our scope of strategic relationships, state-of-the-art proprietary information technology, predictive modeling capabilities, behavior-change techniques, the comprehensive recruitment and training of our clinical colleagues, our experienced management team, the comprehensive clinical nature of our product offerings, our established reputation for providing well-being improvement services to members with health risk factors or chronic diseases, and the proven financial and clinical outcomes of our programs. However, we cannot assure you that we can compete effectively with other companies.

We are party to litigation that could force us to pay significant damages and/or harm our reputation.

We are subject to certain legal proceedings, which potentially involve large claims and significant defense costs (see Item 3. "Legal Proceedings"). These legal proceedings and any other claims that we may face, whether with or without merit, could result in costly litigation, and divert the time, attention, and resources of our management. Although we currently maintain various types of liability insurance, there can be no assurance that the coverage limits of such insurance policies will be adequate or that all such claims will be covered by insurance. Although we believe that we have conducted our operations in full compliance with applicable statutory and contractual requirements and that we have meritorious defenses to outstanding claims, it is possible that resolution of these legal matters could have a material adverse effect on our results of operations. In addition, legal expenses associated with the defense of these matters may be material to our results of operations in a particular financial reporting period.

Compliance with federal and state legislative and regulatory initiatives could adversely affect our results of operations or may require us to spend substantial amounts acquiring and implementing new information systems or modifying existing systems.

Our customers are subject to considerable state and federal government regulation. Many of these regulations are vaguely written and subject to differing interpretations that may, in certain cases, result in unintended consequences that could impact our ability to effectively deliver services.

We believe that federal requirements governing the confidentiality of individually-identifiable health information permit us to obtain individually-identifiable health information for well-being improvement purposes from a covered entity; however, state laws or regulations could impose additional and more restrictive privacy and security restrictions. We are required to comply with most requirements of the HIPAA privacy and security laws and regulations and may be subject to criminal or civil penalties for violations of these regulations. In addition,

impermissible uses and disclosures of unsecured individually identifiable health information are presumed to be breaches for which notice must be made by us or our customers to affected individuals and, in some cases, the media, unless it can be demonstrated that there is a low probability that the information has been compromised.

Although we continually monitor the extent to which federal and state legislation and regulations govern our operations, new federal or state legislation or regulations that restrict our ability to obtain and handle individually-identifiable health information or that otherwise restrict our operations could have a material adverse effect on our results of operations.

Government regulators may interpret current regulations or adopt new legislation governing our operations in a manner that subjects us to penalties or negatively impacts our ability to provide services.

Broadly written Medicare fraud and abuse laws and regulations may be subject to varying interpretations, which may expose us to potential civil and criminal litigation regarding the structure of current and past contracts entered into with our customers.

Expanding the well-being and health management industry to Medicare beneficiaries enrolled in Medicare Advantage plans could lead to increased direct regulation of well-being and health management services. Further, providing services to Medicare Advantage beneficiaries may result in our being subject directly to various federal laws and regulations, including the federal False Claims Act, billing and reimbursement requirements and other provisions related to fraud and abuse.

In addition, certain of our services, including health utilization management and certain claims payment functions, require licensure by government agencies. We are subject to a variety of legal requirements in order to obtain and maintain such licenses, but little guidance is available to determine the scope of some of these requirements. Failure to obtain and maintain any required licenses or failure to comply with other laws and regulations applicable to our business could have a material negative impact on our operations.

Certain of our professional healthcare employees, such as nurses, must comply with individual licensing requirements.

All of our healthcare professionals who are subject to licensing requirements, such as the professionals located at a well-being improvement call center, are licensed in the state in which they are physically present. Multiple state licensing requirements for healthcare professionals who provide services telephonically over state lines may require us to license some of our healthcare professionals in more than one state. We continually monitor legislative, regulatory, and judicial developments in telemedicine; however, new agency interpretations, federal or state legislation or regulations, or judicial decisions could increase the requirement for multi-state licensing of all well-being improvement call center health professionals, which could increase our costs of services and could have a material adverse effect on our results of operations.

Healthcare reform legislation may result in a reduction to our revenues from government health programs and private insurance companies.

Among other things, PPACA decreases the number of uninsured individuals and expands coverage through the expansion of public programs, increased access to private sector health insurance and a number of health insurance market reforms. PPACA also encourages utilization of preventive services and wellness programs, such as those provided by the Company. However, PPACA also directly affects our customers or prospective customers and may increase their costs and/or reduce their revenues. For example, PPACA prohibits commercial health plans from using gender, health status, family history, or occupation to set premium rates, eliminates pre-existing condition exclusions, and bans annual benefit limits. In addition, PPACA mandates minimum MLRs for health plans such that the percentage of health coverage premium revenue spent on healthcare medical costs and quality improvement expenses must be at least 80% for individual and small group health plans and 85% for large group coverage and Medicare Advantage plans, with policyholders receiving rebates, and CMS receiving refunds in the case of Medicare Advantage plans, if the actual loss ratios fall below these minimums. PPACA provides for reductions in funding to Medicare Advantage programs, which may cause some Medicare Advantage plans to raise beneficiary premiums or limit benefits.

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While we believe that our programs and services specifically assist our customers in controlling their costs and improving their competitiveness, it is possible that the reforms imposed by PPACA will adversely affect the profitability of our customers and cause our customers or prospective customers to reduce or delay the purchase of our services or to demand reduced fees. Further, demand for our programs could be reduced if Medicare Advantage plans respond to PPACA funding reductions or other changes by eliminating our programs or by limiting or changing benefits in a manner that causes some Medicare Advantage beneficiaries to terminate their Medicare Advantage coverage.

Because of PPACA's complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, remaining or new court challenges, and possible amendment or repeal, we are unable to predict all of the ways in which PPACA could impact the Company. We could also be impacted by future healthcare reform legislative initiatives and/or government regulation.

We are exploring and evaluating strategic alternatives for the Company, and there can be no assurance that we will be successful in consummating a viable strategic alternative, that any such strategic alternative will yield additional value for stockholders, or that the process will not have an adverse impact on our business.

In January 2015, we announced that we retained J.P. Morgan Securities LLC as financial advisor to assist in exploring and evaluating a broad range of strategic alternatives. No decision has been made to enter into any transaction at this time, and there can be no assurances that this evaluation will result in any specific transaction. The process of exploring strategic alternatives may be time-consuming and disruptive to our business operations, and if we are unable to effectively manage the process, our business, financial condition, and results of operations could be adversely affected. In addition, identifying and evaluating potential strategic alternatives may result in the incurrence of expenses and could expose us to increased risk of claims or other litigation arising from the pursuit of one or more transactions.

Any strategic decision will involve risks and uncertainties, and we cannot assure you that any potential transaction or other strategic alternative, if identified, evaluated and consummated, will provide greater value to our stockholders than that reflected in the current stock price. Any potential transaction would be dependent upon a number of factors that may be beyond our control, including, among other factors, market conditions, industry trends and the interest of third parties in our business.

We do not intend to comment regarding the evaluation of strategic alternatives until such time as our board of directors has determined the outcome of the process or otherwise has deemed that disclosure is appropriate. As a consequence, perceived uncertainties related to the future of the Company may result in the loss of potential business opportunities and may make it more difficult for us to attract and retain qualified personnel and business partners.

Item 1B. Unresolved Staff Comments

Not applicable.

Item 2. Properties

We lease approximately 264,000 square feet of office space in Franklin, Tennessee, which contains our corporate headquarters and one of our well-being improvement call centers, pursuant to an agreement that expires in February 2023. We also lease approximately 92,000 square feet of office space in Chandler, Arizona which contains additional corporate employees and one of our well-being improvement call centers.

In addition, we lease office space for our six other well-being improvement call center locations for an aggregate of approximately 140,000 square feet of space with lease terms expiring on various dates from 2015 to 2021. Our operations support and training offices contain approximately 70,000 square feet in aggregate and have lease terms

expiring from 2015 to 2022.

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Item 3. Legal Proceedings

Contract Disputes

On September 10, 2012, Plastipak Packaging, Inc. ("Plastipak") filed suit in the Circuit Court for Wayne County, Michigan seeking damages relating to an alleged breach of a services agreement with us. On February 4, 2015, the Court announced an award of $7.2 million in favor of Plastipak, which amount is included in our consolidated balance sheet and results of operations as of and for the year ended December 31, 2014.

Junk Fax Prevention Act Lawsuits

On September 16, 2014, Healthways and its wholly owned subsidiary, Healthways WholeHealth Networks, Inc. ("HWHN"), were named in a putative class action lawsuit filed in the Superior Court of California, County of Los Angeles, seeking damages and other relief relating to alleged violations of the Telephone Consumer Protection Act ("TCPA"), as amended by the Junk Fax Prevention Act ("JFPA"), in connection with faxes allegedly transmitted to members of HWHN's network of complementary and alternative care practitioners. The JFPA prohibits sending an "unsolicited advertisement" to a fax machine and requires the sender to provide a notice to allow a recipient to "opt out" of future fax transmissions (including, pursuant to rules promulgated by the Federal Communications Commission ("FCC"), those sent with the prior express invitation or permission of the recipient). The complaint seeks damages in excess of $5 million. The case has been removed to the United States District Court for the Central District of California, Eastern Division ("California Matter").

On December 22, 2014, HWHN was also named in a putative class action lawsuit filed in the United States District Court for the Northern District of Illinois, Eastern Division ("Illinois Matter"), seeking damages and other relief relating to alleged violations of the TCPA, the Illinois Consumer Fraud and Deceptive Business Practices Act, and Illinois common law in connection with faxes allegedly sent to members of HWHN's network of complementary and alternative care practitioners. The complaint seeks damages in an unstated amount.

We deny the claims and intend to vigorously defend these actions.

In connection with these actions, on March 2, 2015, Healthways and HWHN filed with the FCC a Petition for Retroactive Waiver ("Waiver Petition") of the FCC's regulation that requires advertising faxes sent with the prior express invitation or permission of the recipient to include an "opt-out" notice. The FCC has previously granted retroactive waivers of that regulation to several petitioners who were facing lawsuits alleging that the petitioners failed to include the "opt-out" language in fax advertisements sent with the prior express invitation or permission of the recipients. We cannot predict whether the FCC will grant our Waiver Petition or, if granted, the impact on the California Matter or the Illinois Matter.

Performance Award Lawsuit

On September 4, 2012, Milton Pfeiffer ("Plaintiff"), claiming to be a stockholder of the Company, filed a putative derivative action against the Company and the Board of Directors (the "Board") in Delaware Chancery Court (the "Court") alleging that the Compensation Committee of the Board and the Board breached their fiduciary duties and violated the Company's 2007 Stock Incentive Plan (the "Plan") by granting Ben R. Leedle, Jr., Chief Executive Officer and President of the Company, discretionary performance awards under the Plan in the form of options to purchase an aggregate of 500,000 shares of the Company's common stock, which consisted of a performance award in November 2011 granting Mr. Leedle the right to purchase 365,000 shares and a performance award in February 2012 granting Mr. Leedle the right to purchase 135,000 shares (the "Performance Awards"). Plaintiff alleges that the Performance Awards exceeded what is authorized by the Plan and that the Company's 2012 proxy statement, in which the Performance Awards are disclosed, is false and misleading. Plaintiff also alleges that Mr. Leedle breached his fiduciary duties and was unjustly enriched by receiving the Performance Awards. Plaintiff is seeking, among other

things, the rescission or disgorgement of all alleged "excess" awards granted to Mr. Leedle under the Performance Awards, to recover any incidental damages to the Company, and an award of attorneys' fees and expenses. On November 2, 2012, the Company and the Board filed a Motion to Dismiss because Plaintiff failed to make a demand upon the Board as required by Delaware law. On November 8, 2013, the Court denied the Company's Motion to Dismiss. On February 21, 2014, the Company filed its answer and intends to vigorously defend the allegations.

Summary

We are also subject to other contractual disputes, claims and legal proceedings that arise from time to time in the ordinary course of our business. While we are unable to estimate a range of potential losses, we do not believe that any of the legal proceedings pending against us as of the date of this report, some of which are expected to be covered by insurance policies, will have a material adverse effect on our financial condition but may have an adverse effect on our financial results for a particular period. As these matters are subject to inherent uncertainties, our view of these matters may change in the future.

Item 4. Mine Safety Disclosures

Not applicable.

Executive Officers of the Registrant

The following table sets forth certain information regarding our executive officers as of March 13, 2015. Executive officers of the Company serve at the pleasure of the Board.

Officer	Age	Position
Ben R. Leedle, Jr.	54	Chief Executive Officer and director of the Company since September 2003. President of the Company from May 2002 through October 2008 and April 2011 to present. Executive Vice President and Chief Operating Officer of the Health Plan Group from 2000 until May 2002. Senior Vice President of the Company from 1996 until 2000.
Michael Farris	55	Chief Commercial Officer of the Company since October 2012. Navvis & Company Chief Executive Officer from 2004 to September 2012.
Alfred Lumsdaine	49	Chief Financial Officer of the Company since January 2011. Chief Accounting Officer of the Company from February 2002 until January 2011.
Matthew Michela	51	Chief Operating Officer of the Company since September 2014. Market Executive Officer of the Company from January 2013 until September 2014. Senior Vice President of iHealth Technologies from July 2012 to January 2013 which was acquired by iHealth Technologies, Inc in July 2012. Founder, President, and Chief Operating Officer of Care Management International from April 2006 to July 2012.
Glenn Hargreaves	48	Chief Accounting Officer of the Company since July 2012 and Controller since January 2011. Director of Tax of the Company from April 2005 until January 2011.
Mary Flipse	48	General Counsel of the Company since July 2012. Director, Corporate Counsel of the Company from February 2012 to July 2012. Operations Counsel of the Company from August 2011 until February 2012. Assistant General Counsel of King Pharmaceuticals from May 2005 to July 2011.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

Our common stock is traded on The NASDAQ Stock Market ("NASDAQ") under the symbol "HWAY".

The following table sets forth the high and low sales prices per share of our common stock as reported by NASDAQ for the relevant periods.

	High	Low
Year ended December 31, 2014		
First quarter	$17.36	$11.50
Second quarter	18.73	16.05
Third quarter	18.68	15.61
Fourth quarter	20.20	13.99
Year ended December 31, 2013		
First quarter	$13.24	$9.82
Second quarter	17.62	10.97
Third quarter	22.20	15.36
Fourth quarter	18.72	9.59

Unregistered Sales of Equity Securities

As described further below in "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources", CareFirst has an opportunity to earn warrants based on achievement of certain quarterly thresholds for revenue. On December 17, 2014, we issued to CareFirst warrants to purchase 65,163 shares of our common stock at an exercise price of $16.36 per share. The issuance of these warrants was exempt from registration under Section 4(a)(2) of the Securities Act of 1933, as amended, because it was a transaction not involving a public offering.

Holders

At March 4, 2015, there were approximately 10,100 holders of our common stock, including 215 stockholders of record.

Dividends

We have never declared or paid a cash dividend on our common stock. We intend to retain any earnings to finance the growth and development of our business and do not expect to declare or pay any cash dividends in the foreseeable future. Our Board will review our dividend policy from time to time and may declare dividends at its discretion; however, our Fifth Amended Credit Agreement places restrictions on the payment of dividends. For further discussion of the Fifth Amended Credit Agreement, see Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operation - Liquidity and Capital Resources."

Securities Authorized for Issuance Under Equity Compensation Plans

See Part III, Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters," for information regarding securities authorized for issuance under our equity compensation plans, which is incorporated by reference herein.

Item 6. Selected Financial Data

The following table represents selected financial data. The table should be read in conjunction with Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Item 8, "Financial Statements and Supplementary Data" of this Report.

(In thousands, except per share data)	Year Ended December 31, 2014	Year Ended December 31, 2013	Year Ended December 31, 2012	Year Ended December 31, 2011	Year Ended December 31, 2010
Operating Results:					
Revenues	$742,183	$663,285	$677,170	$688,765	$720,333
Cost of services (exclusive of depreciation and amortization included below)	598,280	547,387	533,880	510,724	493,713
Selling, general and administrative expenses	65,377	61,205	60,888	64,843	72,830
Depreciation and amortization	53,378	52,791	51,734	49,988	52,756
Legal settlement charges	17,715	—	—	—	—
Impairment loss	—	—	—	183,288	—
Restructuring and related charges	—	—	1,773	9,036	10,258
Operating income (loss)	$7,433	$1,902	$28,895	$(129,114)	$90,776
Gain on sale of investment	—	—	—	—	(1,163)
Interest expense	17,581	16,079	14,149	13,193	14,164
Income (loss) before income taxes	$(10,148)	$(14,177)	$14,746	$(142,307)	$77,775
Income tax expense (benefit)	(4,587)	(5,636)	6,722	15,386	30,445
Net income (loss)	$(5,561)	$(8,541)	$8,024	$(157,693)	$47,330
Basic income (loss) per share:	$(0.16)	$(0.25)	$0.24	$(4.68)	$1.39
Diluted income (loss) per share: [1]	$(0.16)	$(0.25)	$0.24	$(4.68)	$1.36
Weighted average common shares and equivalents:					
Basic	35,302	34,489	33,597	33,677	34,129
Diluted [1]	35,302	34,489	33,836	33,677	34,902
Balance Sheet Data:					
Cash and cash equivalents	$1,765	$2,584	$1,759	$864	$1,064
Working capital (deficit)	(7,629)	(5,194)	13,551	8,774	547
Total assets	811,908	749,011	748,268	708,905	861,689
Long-term debt	231,112	237,582	278,534	266,117	243,425
Other long-term liabilities	72,993	51,003	26,602	31,351	39,140
Stockholders' equity	304,590	302,690	278,821	265,716	430,841

Other Operating Data:					
Annualized revenue in backlog	$9,100	$39,800	$39,000	$29,400	$37,100

(1) The assumed exercise of stock-based compensation awards for the years ended December 31, 2014, December 31, 2013 and December 31, 2011 was not considered because the impact would be anti-dilutive.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

Founded and incorporated in Delaware in 1981, Healthways, Inc. provides comprehensive total population health management solutions that are uniquely designed to help people improve their well-being, thereby improving their health and productivity and reducing their health-related costs. Total population health management involves a proactive approach to reducing avoidable disease incidence – a considerable improvement from the more traditional and more costly method of waiting for people to get a disease before acting.

As a global leader in total population health, Healthways has established a proven value proposition: by taking a systematic approach to keeping healthy people healthy, eliminating or reducing lifestyle risks and optimizing care for persistent or chronic conditions, we help our customers reduce health-related costs and increase productivity and performance across whole populations, including workforces, health plan memberships, and communities. We are pioneers of this systematic approach, and we believe we are unique in having the capability to provide a full spectrum of proven total population health management solutions.

Healthways' comprehensive well-being improvement programs provide personalized solutions for any individual, irrespective of their health status, age or paying sponsor. Our total population health technology platform uses our proprietary analytics and predictive models to enable us to stratify the population, develop individualized well-being improvement plans and deliver action-based solutions to improve individual and organizational performance. Our technology-driven infrastructure is compatible with, and integrated into, our customers' systems. Through this data-driven process, we identify the needs of each individual in a population and determine the right level of support. This allows us to efficiently deploy successful strategies to sustain engagement, to use the best science to drive behavior change and ultimately deliver meaningful, measurable outcomes. We know that each individual in a given population often simultaneously seeks a variety of support services in his or her pursuit of improved well-being. We provide a full spectrum of services that can be delivered at scale, and in a manner that meets the needs of individuals over time.

Our value proposition, described above, has been proven and published in peer-reviewed studies. Our systematic approach and comprehensive well-being improvement solutions are designed to focus on improving a population's essential well-being elements: physical, financial, social, community and sense of purpose.

For example, to keep healthy people healthy, our wellness and prevention programs focus on education, physical fitness, nutrition, health coaching and tools that support behavior change by:

- fostering well-being improvement and disease prevention through biometric screening and proprietary well-being assessments;
- engaging people in our well-being improvement programs, such as fitness, weight management, stress management, and financial and lifestyle management; and
- providing access to our fitness center, physical and occupational therapy, chiropractic, and complementary and alternative medicine provider networks.

To eliminate or reduce lifestyle risks, our programs help to motivate people to make positive lifestyle changes and accomplish individual goals, such as increasing physical activity for seniors, overcoming nicotine addiction or generating sustainable weight loss, by:

- promoting personal change and improvement in the lifestyle behaviors that lead to poor health or chronic conditions; and
- providing personal interactions with highly trained healthcare professionals and educational materials to create and sustain healthier behaviors for those individuals at risk or in the early stages of chronic conditions.

To help people optimize care for persistent or chronic conditions we:

- incorporate the latest, evidence-based clinical guidelines into interventions to optimize patient health outcomes;
- develop care support plans and motivate members to set attainable goals for themselves;
- provide local market resources to address acute episodic interventions;
- coordinate members' care as an extension of their healthcare providers;
- provide software technology solutions and management consulting in support of well-being improvement services; and
- provide high-risk care management for members at risk for hospitalization due to complex conditions.

In North America, we operate in all 50 states and the District of Columbia. Our customers include health plans, both commercial and Medicare Advantage, large self-insured employers, including state and municipal government entities, and providers of healthcare, including integrated healthcare systems, hospitals and physician groups. We also provide services to commercial healthcare businesses and/or government entities in Brazil, Australia, and France.

Our services are delivered using a range of methods, including venue-based face-to-face interactions; print; phone; mobile and remote devices with unique applications; on-line, including social networks; and any combination of these methods to motivate and sustain healthy behaviors. Many of our programs for lifestyle support, management and education are delivered through web-based portals and mobile applications and may also offer a social networking opportunity.

We have a scalable platform that we believe will enable us to gain substantial operating leverage as we grow – our proprietary technology infrastructure and delivery capabilities are currently accessible to approximately 68 million people across four continents. Our scalable model is also flexible, and therefore the degree of our engagement and model of support can evolve with our customers' needs and preferences. In many cases, our intervention services are delivered from our domestic and international well-being improvement call centers staffed with a range of professionals including, but not limited to, nurses, dieticians, pharmacists, health coaches, exercise specialists and nutritional counselors. Our fitness center network encompasses approximately 16,000 U.S. locations. We also maintain an extensive network of over 88,000 complementary, alternative and physical medicine practitioners, which offers convenient access to the significant number of individuals who seek health services outside of the traditional healthcare system.

Forward-Looking Statements

This Report contains forward-looking statements, which are based upon current knowledge, assumptions, beliefs, estimates and expectations, involve a number of risks and uncertainties, and are subject to the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995. Forward-looking statements include all statements that are not historical statements of fact and those regarding the intent, belief, or expectations of the Company, including, without limitation, all statements regarding the Company's future earnings and results of operations, and can be identified by the use of words like "may," "believe," "will," "can," "expect," "project," "estimate," "anticipate," "plan," or "continue" and similar expressions. Readers are cautioned that any such forward-looking statements are not guarantees of future performance and involve significant risks and uncertainties, and that actual results may vary from those in the forward-looking statements as a result of various factors, including, but not limited to:

- the effectiveness of management's strategies and decisions;
- our ability to sign and implement new contracts for our solutions;
- our ability to accurately forecast the costs required to successfully implement new contracts;
- our ability to renew and/or maintain contracts with our customers under existing terms or restructure these contracts on terms that would not have a material negative impact on our results of operations;
- our ability to effectively compete against other entities, whose financial, research, staff, and marketing resources may exceed our resources;
- our ability to accurately forecast our revenues, margins, earnings and net income, as well as any potential charges that we may incur as a result of changes in our business;
- our ability to accurately forecast performance and the timing of revenue recognition under the terms of our customer contracts ahead of data collection and reconciliation;
- the impact of PPACA on our operations and/or the demand for our services;
- our ability to anticipate change and respond to emerging trends in the domestic and international markets for healthcare and the impact of the same on demand for our services;
- the risks associated with deriving a significant concentration of our revenues from a limited number of customers;
- the risks associated with foreign currency exchange rate fluctuations and our ability to hedge against such fluctuations;
- our ability to achieve and reach mutual agreement with customers with respect to the contractually required performance metrics, cost savings and clinical outcomes improvements, or to achieve such metrics, savings and improvements within the timeframes contemplated by us;

- our ability to achieve estimated annualized revenue in backlog in the manner and within the timeframe we expect, which is based on certain estimates regarding the implementation of our services;

- our ability and/or the ability of our customers to enroll participants and to accurately forecast their level of enrollment and participation in our programs in a manner and within the timeframe anticipated by us;

- the ability of our customers to provide timely and accurate data that is essential to the operation and measurement of our performance under the terms of our contracts;

- our ability to favorably resolve contract billing and interpretation issues with our customers;

- our ability to service our debt, make principal and interest payments as those payments become due, and remain in compliance with our debt covenants;

- the risks associated with changes in macroeconomic conditions, which may reduce the demand and/or the timing of purchases for our services from customers or potential customers, reduce the number of covered lives of our existing customers, or restrict our ability to obtain additional financing;

- counterparty risk associated with the Cash Convertible Notes Hedges, interest rate swap agreements, and foreign currency exchange contracts;

- the risks associated with valuation of the Cash Convertible Notes Hedges and the Cash Conversion Derivative, which may result in volatility to our consolidated statements of comprehensive income (loss) if these transactions do not completely offset one another;

- our ability to integrate new or acquired businesses, services (including outsourced services), or technologies into our business and to accurately forecast the related costs;

- our ability to anticipate and respond to strategic changes, opportunities, and emerging trends in our industry and/or business and to accurately forecast the related impact on our revenues and earnings;

- the impact of any impairment of our goodwill or other intangible assets;

- our ability to develop new products and deliver and report outcomes on those products;

- our ability to implement our integrated data and technology solutions platform within the required timeframe and expected cost estimates and to develop and enhance this platform and/or other technologies to meet evolving customer and market needs;

- our ability to obtain adequate financing to provide the capital that may be necessary to support our operations and to support or guarantee our performance under new contracts;

- unusual and unforeseen patterns of healthcare utilization by individuals with diseases or conditions for which we provide services;

- the ability of our customers to maintain the number of covered lives enrolled in the plans during the terms of our agreements;

- the risks associated with data privacy or security breaches, computer hacking, network penetration and other illegal intrusions of our information systems or those of third-party vendors or other service providers, which may result in unauthorized access by third parties to customer, employee or our information or patient health information and lead to enforcement actions, fines and other litigation against us;

- the impact of any new or proposed legislation, regulations and interpretations relating to Medicare or Medicare Advantage;

- the impact of future state, federal, and international legislation and regulations applicable to our business, including PPACA, on our ability to deliver our services and on the financial health of our customers and their willingness to purchase our services;

- current geopolitical turmoil, the continuing threat of domestic or international terrorism, and the potential emergence of a health pandemic or infectious disease outbreak;

- the impact of legal proceedings involving us and/or our subsidiaries;

- our exploration and evaluation of a broad range of possible strategic alternatives, including whether any appropriate alternatives will be identified and, if identified, whether any such alternative will result in a consummated transaction; and

- other risks detailed in this Report, including those set forth in Item 1A. "Risk Factors."

We undertake no obligation to update or revise any such forward-looking statements.

Critical Accounting Policies

We describe our accounting policies in Note 1 to the consolidated financial statements. We prepare the consolidated financial statements in conformity with generally accepted accounting principles in the United States ("U.S. GAAP"), which requires us to make estimates and judgments that affect the reported amounts of assets and liabilities and related disclosures at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

We believe the following accounting policies are the most critical in understanding the estimates and judgments that are involved in preparing our financial statements and the uncertainties that could impact our results of operations, financial condition and cash flows.

Revenue Recognition

We recognize revenue as services are performed when persuasive evidence of an arrangement exists, collectability is reasonably assured, and amounts are fixed or determinable.

Our fees are generally billed on a PMPM basis or upon member participation, such as the Healthways® SilverSneakers® fitness solution. For PMPM fees, we generally determine our contract fees by multiplying the contractually negotiated PMPM rate by the number of members covered by our services during the month. We typically set PMPM rates during contract negotiations with customers based on the value we expect our programs to create and a sharing of that value between the customer and the Company. Some of our contracts place a portion of

our fees at risk based on achieving certain performance metrics, cost savings, and/or clinical outcomes improvements ("performance-based"). Approximately 6% of revenues recorded during the year ended December 31, 2014 were performance-based of which 2% were subject to final reconciliation as of December 31, 2014.

We generally bill our customers each month for the entire amount of the fees contractually due for the prior month's enrollment, which typically includes the amount, if any, that is performance-based and may be subject to refund should we not meet performance targets. Fees for participation are typically billed in the month after the services are provided. Deferred revenues arise from contracts that permit upfront billing and collection of fees covering the entire contractual service period, generally 12 months. A limited number of our contracts provide for certain performance-based fees that cannot be billed until after they are reconciled with the customer.

We recognize revenue as follows: (1) we recognize the fixed portion of PMPM fees and fees for service as revenue during the period we perform our services; and (2) we recognize performance-based revenue based on the most recent assessment of our performance, which represents the amount that the customer would legally be obligated to pay if the contract were terminated as of the latest balance sheet date.

We generally assess our level of performance for our contracts based on medical claims and other data that the customer is contractually required to supply, interim assessments of achievement against performance targets, or metrics available from our operating platforms. A minimum of four to nine months' data is typically required for us to measure performance. In assessing our performance, we may include estimates such as medical claims incurred but not reported. In addition, we may also provide reserves for contractual allowances (such as data reconciliation differences) as appropriate.

If data is insufficient or incomplete to measure performance, or interim performance measures indicate that we are not meeting performance targets, we do not recognize performance-based fees subject to refund as revenues but instead record them in a current liability account entitled "contract billings in excess of earned revenue." Only in the event we do not meet performance levels by the end of the measurement period, typically one year, are we contractually obligated to refund some or all of the performance-based fees. We would only reverse revenues that we had already recognized if performance to date in the measurement period, previously above targeted levels, subsequently dropped below targeted levels.

During the settlement process under a contract, which generally occurs six to eight months after the end of a contract year, we settle any performance-based fees and reconcile healthcare claims and clinical data. As of December 31, 2014, cumulative performance-based revenues that have not yet been settled with our customers but that have been recognized in the current and prior years totaled approximately $26.0 million, all of which were based on actual data. Data reconciliation differences, for which we provide contractual allowances until we reach agreement with respect to identified issues, can arise between the customer and us due to customer data deficiencies, omissions, and/or data discrepancies.

Performance-related adjustments (including any amounts recorded as revenue that were ultimately refunded), changes in estimates, or data reconciliation differences may cause us to recognize or reverse revenue in a current fiscal year that pertains to services provided during a prior fiscal year. During 2014, 2013 and 2012, we recognized a net increase in revenue of $7.9 million, $8.2 million, and $9.2 million that related to services provided prior to each respective year.

We are currently evaluating the impact that the adoption of Accounting Standards Update ("ASU") No. 2014-09, "Revenue from Contracts with Customers" ("ASU 2014-9") (as discussed below) will have on our revenue recognition policies and procedures, financial position, result of operations, cash flows, financial disclosures and control framework.

Impairment of Intangible Assets and Goodwill

We review goodwill for impairment at the reporting unit level (operating segment or one level below an operating segment) on an annual basis or more frequently whenever events or circumstances indicate that the carrying value may not be recoverable. We may elect to perform a qualitative assessment to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying value. If we conclude during the qualitative assessment that this is the case or if we elect not to perform a qualitative assessment, we perform a quantitative review as described below.

During a quantitative review of goodwill, we estimate the fair value of each reporting unit using a combination of a discounted cash flow model and a market-based approach, and we reconcile the aggregate fair value of our reporting units to our consolidated market capitalization. Estimating fair value requires significant judgments, including management's estimate of future cash flows, which is dependent on internal forecasts, estimation of the long-term growth rate for our business, the useful life over which cash flows will occur, and determination of our weighted average cost of capital, as well as relevant comparable company earnings multiples for the market-based approach. Changes in these estimates and assumptions could materially affect the estimate of fair value and potential goodwill impairment for each reporting unit.

If we determine that the carrying value of goodwill is impaired based upon an impairment review, we calculate any impairment using a fair-value-based goodwill impairment test as required by U.S. GAAP. The fair value of a reporting unit is the price that would be received upon a sale of the unit as a whole in an orderly transaction between market participants at the measurement date.

Except for a trade name that has an indefinite life and is not subject to amortization, we amortize identifiable intangible assets, such as acquired technologies and customer contracts, over their estimated useful lives using the straight-line method. We assess the potential impairment of intangible assets subject to amortization whenever events or changes in circumstances indicate that the carrying values may not be recoverable. If we determine that the carrying value of other identifiable intangible assets may not be recoverable, we calculate any impairment using an estimate of the asset's fair value based on the estimated price that would be received to sell the asset in an orderly transaction between market participants.

We review intangible assets not subject to amortization, which consist of a trade name, on an annual basis or more frequently whenever events or circumstances indicate that the assets might be impaired. We estimate the fair value of the trade name using a present value technique, which requires management's estimate of future revenues attributable to this trade name, estimation of the long-term growth rate for these revenues, and determination of our weighted average cost of capital. Changes in these estimates and assumptions could materially affect the estimate of fair value for the trade name.

Future events could cause us to conclude that impairment indicators exist and that goodwill and/or other intangible assets are impaired. Any resulting impairment loss could have a material adverse impact on our financial condition and results of operations.

Income Taxes

The objectives of accounting for income taxes are to recognize the amount of taxes payable or refundable for the current year and deferred tax liabilities and assets for the future tax consequences of events that have been recognized in an entity's financial statements or tax returns. Accounting for income taxes requires significant judgment in evaluating tax positions and in determining income tax provisions, including determination of deferred tax assets, deferred tax liabilities, and any valuation allowances that might be required against deferred tax assets.

We recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the financial statements from such a position should be measured based on the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. U.S. GAAP also provides guidance on derecognition of income tax assets and liabilities, classification of current and deferred income tax assets and liabilities, accounting for interest and penalties associated with tax positions, and income tax disclosures. Judgment is required in assessing the future tax consequences of events that have been recognized in our financial statements or tax returns. Variations in the actual outcome of these future tax consequences could materially impact our consolidated financial position, results of operations, and cash flows.

Share-Based Compensation

We measure and recognize compensation expense for all share-based payment awards over the required vesting period based on estimated fair values at the date of grant. Determining the fair value of stock options at the grant date requires judgment in developing assumptions, which involve a number of variables. These variables include, but are not limited to, the expected stock price volatility over the term of the awards and expected stock option exercise behavior. In addition, we also use judgment in estimating the number of share-based awards that are expected to be forfeited. These assumptions and judgments are further described in Note 12 to the consolidated financial statements.

Results of Operations

The following table sets forth the components of the statements of operations for the fiscal years ended December 31, 2014, 2013 and 2012 expressed as a percentage of revenues.

	Year Ended December 31, 2014		2013		2012	
Revenues	100.0	%	100.0	%	100.0	%
Cost of services (exclusive of depreciation and amortization included below)	80.6	%	82.5	%	78.8	%
Selling, general and administrative expenses	8.8	%	9.2	%	9.0	%
Depreciation and amortization	7.2	%	8.0	%	7.6	%
Legal settlement charges	2.4	%	—	%	—	%
Restructuring and related charges	—	%	—	%	0.3	%
Operating income	1.0	%	0.3	%	4.3	%
Interest expense	2.4	%	2.4	%	2.1	%
Income (loss) before income taxes	(1.4	)%	(2.1	)%	2.2	%
Income tax expense (benefit)	(0.6	)%	(0.8	)%	1.0	%
Net income (loss) [(1)]	(0.7	)%	(1.3	)%	1.2	%

(1) Figures may not add due to rounding.

Revenues

Revenues for fiscal 2014 increased $78.9 million, or 11.9%, over fiscal 2013, primarily due to:

- the commencement of contracts with new customers and growth with existing customers; and
- an increase in participation in our fitness solutions, as well as in the number of members eligible to participate in such solutions.

These increases were somewhat offset by terminations of contracts with certain customers.

Revenues for fiscal 2013 decreased $13.9 million, or 2.1%, over fiscal 2012, primarily due to contract terminations, including our contract with CIGNA in February 2013 as well as one other health plan contract (the "two terminated contracts"). These decreases were somewhat offset by the following:

- the commencement of contracts with new customers; and
- increased participation and/or increased membership in customers' existing programs.

Cost of Services

Cost of services (excluding depreciation and amortization) as a percentage of revenues for fiscal 2014 decreased to 80.6% compared to 82.5% for fiscal 2013, primarily due to the following:

- economies of scale resulting from certain types of costs that remain relatively fixed or do not increase at the same rate as revenues; and
- a decrease in support costs primarily related to our technology platform.

These decreases were somewhat offset by:

- an increase in royalty expense related to certain strategic relationships and agreements; and
- an increase in the level of short-term and long-term incentive compensation expense based on the Company's actual and projected financial performance against established targets.

Cost of services (excluding depreciation and amortization) as a percentage of revenues for fiscal 2013 increased to 82.5% compared to 78.8% for fiscal 2012, primarily due to the following:

- the impact of the two terminated contracts, which carried a lower than average cost of services as a percentage of revenues, as well as the impact of certain costs that could not be reduced in the same proportion and/or timeframe as the overall decrease in revenues; and
- an increase in support costs primarily related to both our technology platform and program enrollment partially offset by recoupment of fees related to certain supplier service level agreements.

These increases in cost of services for fiscal 2013 were slightly offset by the following decreases:

- continued economies of scale gained in our fitness solutions; and
- a reduction in healthcare benefit costs related to a decrease in claims for fiscal 2013 compared to fiscal 2012.

Selling, General and Administrative Expenses

Selling, general and administrative expenses as a percentage of revenues for fiscal 2014 decreased to 8.8% compared to 9.2% for fiscal 2013 primarily due to our ability to more effectively leverage our selling, general and administrative expenses as a result of growth in our operations, partially offset by expenses incurred in 2014 in connection with proxy contest defense costs.

Selling, general and administrative expenses as a percentage of revenues remained relatively consistent at 9.2% for fiscal 2013 and 9.0% for fiscal 2012.

Depreciation and Amortization

Depreciation and amortization expense increased 1.0% for fiscal 2014 compared to fiscal 2013, primarily due to increased depreciation expense related to our technology platform, partially offset by decreased amortization expense due to certain intangible assets becoming fully amortized during 2013 and 2014.

Depreciation and amortization expense increased 2.0% for fiscal 2013 compared to fiscal 2012, primarily due to increased depreciation expense related to our technology platform.

Legal Settlement Charges

During fiscal 2014, we incurred charges of approximately $9.4 million in connection with the Company's settlement of a legal matter included in our results of operations in the first quarter of 2014 as well as $8.3 million related to two additional legal settlements, which were reflected in our results of operations in the fourth quarter of 2014.

Restructuring and Related Charges

During fiscal 2012, we incurred net charges of $1.8 million related to a restructuring of the Company in the fourth quarter of 2012, which primarily consisted of termination benefits related to capacity realignment.

Interest Expense

Interest expense increased $1.5 million for fiscal 2014 compared to fiscal 2013, primarily due to a full year of amortization of the debt discount related to the Cash Convertible Notes, which began in July 2013. This increase was partially offset by a decrease in interest expense due to the expiration of certain interest rate swap agreements that had a higher fixed interest rate than our current interest rate swap agreements.

Interest expense for fiscal 2013 increased $1.9 million compared to fiscal 2012, primarily due to amortization of the debt discount related to the Cash Convertible Notes, which began in July 2013. This increase was somewhat offset by a decrease in interest expense related to the write-off in 2012 of previously deferred loan costs as a result of entering into the Fifth Amended Credit Agreement.

Income Tax Expense

Our effective tax benefit rate for 2014 was 45.2% and included a net benefit of $0.7 million relating to tax credits available to offset future state income taxes, which had a favorable impact on the effective tax benefit rate in light of the relatively small base of pretax loss for 2014.
Our effective tax benefit rate for 2013 was 39.8%, which included a favorable $1.1 million reduction to an unrecognized tax position due to the expiration of the applicable statutes of limitations for the 2009 tax year.

Liquidity and Capital Resources

Operating activities during fiscal 2014 provided cash of $52.1 million compared to $71.5 million during fiscal 2013. The decrease in operating cash flow resulted primarily from the following:

- an increase in days sales outstanding in accounts receivable from 49 days at December 31, 2013 to 58 days at December 31, 2014; and
- the timing of several significant vendor payments.

Investing activities during fiscal 2014 used $51.2 million in cash, which primarily consisted of capital expenditures associated with our technology platform.

Financing activities during fiscal 2014 used $0.2 million in cash primarily due to net payments under the Fifth Amended Credit Agreement partially offset by the change in our cash overdraft position.

Credit Facility

On June 8, 2012, we entered into the Fifth Amended Credit Agreement. The Fifth Amended Credit Agreement provides us with a $200.0 million revolving credit facility that expires on June 8, 2017 and includes a swingline sub facility of $20.0 million and a $75.0 million sub facility for letters of credit. The Fifth Amended Credit Agreement also provides a $200.0 million term loan facility that matures on June 8, 2017, $97.5 million of which remained outstanding at December 31, 2014, and an uncommitted incremental accordion facility of $100.0 million.

Borrowings under the Fifth Amended Credit Agreement generally bear interest at variable rates based on a margin or spread in excess of either (1) the one-month, two-month, three-month or six-month rate (or with the approval of affected lenders, nine-month or twelve-month rate) for Eurodollar deposits ("LIBOR") or (2) the greatest of (a) the SunTrust Bank prime lending rate, (b) the federal funds rate plus 0.50%, and (c) one-month LIBOR plus 1.00% (the "Base Rate"), as selected by the Company. The LIBOR margin varies between 1.75% and 3.00%, and the Base Rate margin varies between 0.75% and 2.00%, depending on our leverage ratio. The Fifth Amended Credit Agreement also provides for an annual fee ranging between 0.30% and 0.50% of the unused commitments under the revolving credit facility. Extensions of credit under the Fifth Amended Credit Agreement are secured by guarantees from all of the Company's active domestic subsidiaries and by security interests in substantially all of the Company's and such subsidiaries' assets.

On July 1, 2013, we entered into an amendment to the Fifth Amended Credit Agreement, which provided for, among other things, the amendment of certain negative covenants to permit the issuance of and payments related to the Cash Convertible Notes described above as well as increases in the maximum required levels of total funded debt to EBITDA beginning with the quarter ended June 30, 2013. On April 14, 2014 and December 29, 2014, we entered into additional amendments to the Fifth Amended Credit Agreement, which, among other things, (1) amended the calculation of consolidated EBITDA to exclude the BCBSMN legal settlement (discussed in Note 10) and, for any period that includes a fiscal quarter ending on or before December 31, 2015, up to $5 million in the aggregate of accounting charges attributable to the settlement or other satisfaction of litigation liabilities and the incurrence of

related expenses, (2) reduced the amount of the accordion facility from $200 million to $100 million, (3) provided that the net cash proceeds of an asset sale or recovery event be deposited with the administrative agent pending reinvestment or application to the payment of loans, and (4) limited the aggregate consideration payable in respect of acquisitions consummated after December 29, 2014 to $150 million. As of December 31, 2014, availability under the revolving credit facility totaled $95.9 million as calculated under the most restrictive covenant.

We are required to repay outstanding revolving loans under the revolving credit facility in full on June 8, 2017. We are required to repay term loans in quarterly principal installments aggregating (1) 1.250% of the original aggregate principal amount of the term loans during each of the eight quarters beginning with the quarter ended September 30, 2012, (2) 1.875% of the original aggregate principal amount of the term loans during each of the next four quarters beginning with the quarter ending September 30, 2014, and (3) 2.500% of the original aggregate principal amount of the term loans during each of the remaining quarters prior to maturity on June 8, 2017, at which time the entire unpaid principal balance of the term loans is due and payable.

The Fifth Amended Credit Agreement contains financial covenants that require us to maintain specified ratios or levels at December 31, 2014 of (1) a maximum total funded debt to EBITDA of 4.25 and (2) a minimum fixed charge coverage of 1.50, each as defined in the Fifth Amended Credit Agreement. We were in compliance with all of the financial covenant requirements of the Fifth Amended Credit Agreement as of December 31, 2014.

The Fifth Amended Credit Agreement contains various other affirmative and negative covenants that are typical for financings of this type. Among other things, the Fifth Amended Credit Agreement limits repurchases of our common stock and the amount of dividends that we can pay to holders of our common stock. A breach of any of these covenants could result in a default under the Fifth Amended Credit Agreement, in which event all amounts outstanding under the Fifth Amended Credit Agreement may become immediately due and payable and all commitments under the Fifth Amended Credit Agreement to extend further credit may be terminated. In addition, a payment default, including as a result of an acceleration following an event of default, under the Fifth Amended Credit Agreement or under our indenture for the Cash Convertible Notes, could each trigger an event of default under the other debt instrument, which could result in the principal of and the accrued and unpaid interest on such debt becoming due and payable.

In order to reduce our exposure to interest rate fluctuations on our floating rate debt obligations, we maintain interest rate swap agreements that effectively modify our exposure to interest rate risk by converting a portion of our floating rate debt to fixed obligations, thus reducing the impact of interest rate changes on future interest expense. Under these agreements, we receive a variable rate of interest based on LIBOR, and we pay a fixed rate of interest with interest rates ranging from 0.690% to 1.480% plus a spread (see Note 7 to the consolidated financial statements). We maintain interest rate swap agreements with current notional amounts of $125.0 million and termination dates ranging from November 2015 to December 2016. Of this amount, $75.0 million was effective at December 31, 2014, and $50.0 million will become effective in December 2015, as older interest rate swap agreements expire. We have designated these interest rate swap agreements as qualifying cash flow hedges. We currently meet the hedge accounting criteria under U.S. GAAP in accounting for these interest rate swap agreements.

1.50% Cash Convertible Senior Notes Due 2018

On July 16, 2013, we completed the issuance of $150.0 million aggregate principal amount of the Cash Convertible Notes, which bear interest at a rate of 1.50% per year, payable semiannually in arrears on January 1 and July 1 of each year, beginning on January 1, 2014. The Cash Convertible Notes will mature on July 1, 2018, unless earlier repurchased or converted into cash in accordance with their terms prior to such date. At the option of the holders, the Cash Convertible Notes are convertible into cash based on the conversion rate set forth below only upon occurrence of certain triggering events as defined in the Indenture dated as of July 8, 2013 by and between the Company and U.S. Bank National Association, none of which had occurred as of December 31, 2014. Accordingly, we have classified the Cash Convertible Notes as long-term debt at December 31, 2014 and December 31, 2013. The Cash Convertible Notes are not convertible into our common stock or any other securities under any circumstances. The initial cash conversion rate is approximately 51.38 shares of our common stock per $1,000 principal amount of Cash Convertible Notes (equivalent to an initial conversion price of approximately $19.46 per share of common stock). The Cash Convertible Notes are our senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the Cash Convertible Notes.

In connection with the issuance of the Cash Convertible Notes, we entered into Cash Convertible Notes Hedges, which are cash-settled and are intended to reduce our exposure to potential cash payments that we would be required to make if holders elect to convert the Cash Convertible Notes at a time when our stock price exceeds the conversion price. The Cash Convertible Notes Hedges, which are recorded and carried at fair value as a derivative asset, are intended to offset the gain (or loss) associated with changes to the valuation of the Cash Conversion Derivative. We also entered into separate privately negotiated warrant transactions (the "Warrants") initially relating, in the aggregate, to a notional number of shares of our common stock underlying the Cash Convertible Notes Hedges. The warrant transactions could have a dilutive effect to the extent that the market price per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the Warrants. The initial strike price of the Warrants is approximately $25.95 per share, which effectively increases the conversion price of the Cash Convertible Notes to a 60% premium to our stock price on July 1, 2013.

The net proceeds from the sale of the Cash Convertible Notes were approximately $145.3 million, after deducting the initial purchasers' discounts and commissions and the placement expenses. We used $21.6 million of the net proceeds from the sale of the Cash Convertible Notes to pay the cost of the Cash Convertible Notes Hedges (after such cost was partially offset by the proceeds to the Company from the sale of the Warrants), and we used the remainder of the net proceeds from the sale of the Cash Convertible Notes to reduce the outstanding indebtedness under the Fifth Amended Credit Agreement.

Aside from the initial premium paid, we will not be required to make any cash payments under the Cash Convertible Notes Hedges and will be entitled to receive an amount of cash from the option counterparties generally equal to the amount by which the market price per share of common stock exceeds the strike price of the Cash Convertible Note Hedges upon exercise of the conversion option. The strike price under the Cash Convertible Notes Hedges is initially equal to the conversion price of the Cash Convertible Notes. Additionally, if the market price per share of our common stock exceeds the strike price of the Warrants on any warrant exercise date we will be obligated to issue to the option counterparties a number of shares based on the amount by which the then-current market price per share of our common stock exceeds the then-effective strike price of each Warrant. We will not receive any additional proceeds if the Warrants are exercised.

CareFirst Convertible Note

On October 1, 2013, we entered into an Investment Agreement with CareFirst, which is in addition to certain existing commercial agreements between us and CareFirst relating to, among other things, disease management and care coordination services (the "Commercial Agreements"). Pursuant to the Investment Agreement, we issued the CareFirst Convertible Note in the aggregate original principal amount of $20 million to CareFirst for a purchase price of $20 million. The CareFirst Convertible Note bears interest at a rate of 4.75% per year, payable quarterly in arrears on March 31, June 30, September 30 and December 31 of each calendar year, beginning on December 31, 2013. The CareFirst Convertible Note may be prepaid only under limited circumstances and upon the terms and conditions specified therein. If the CareFirst Convertible Note has not been fully converted or redeemed in accordance with its terms, it will mature on October 1, 2019. The CareFirst Convertible Note is subordinate in right of payment to the prior payment in full of (a) all indebtedness of the Company under the Fifth Amended Credit Agreement, and (b) any other senior debt of the Company, which currently includes only the Cash Convertible Notes.

The CareFirst Convertible Note is convertible into shares of our common stock at the conversion rate determined by dividing (a) the sum of the portion of the principal to be converted and accrued and unpaid interest with respect to such principal by (b) the conversion price equal to $22.41 per share of our common stock. The conversion price is subject to adjustment for stock splits, stock dividends, recapitalizations, reorganizations, reclassifications and similar events.

CareFirst has an opportunity to earn CareFirst Warrants based on achievement of certain quarterly thresholds (the "Revenue Thresholds") for revenue derived from both the Commercial Agreements and from new business to us from

third parties as a result of an introduction or referral to us by CareFirst (collectively, the "Quarterly Revenue"). If the Quarterly Revenue is greater than or equal to the applicable Revenue Threshold for any quarter ending on or prior to September 30, 2017, then we will issue to CareFirst a certain number of warrants exercisable for the number of CareFirst Warrant Shares determined in accordance with the terms of the Investment Agreement unless (i) CareFirst elects to receive a cash payment in accordance with the terms of the Investment Agreement or (ii) there is a change of control. The aggregate number of CareFirst Warrant Shares in any single 12-month period beginning on October 1, 2013 cannot exceed 400,000, and the aggregate number of CareFirst Warrant Shares issuable pursuant to the Investment Agreement cannot exceed 1,600,000. As of December 31, 2014, we issued CareFirst Warrants totaling 190,683 at a weighted average exercise price of $16.92, all of which were issued in 2014. These CareFirst Warrants may have a dilutive effect on net income per share, and the "treasury stock" method is used in calculating the dilutive effect on earnings per share.

We believe that cash flows from operating activities, our available cash, and our anticipated available credit under the Fifth Amended Credit Agreement will continue to enable us to meet our contractual obligations and fund our current operations for the foreseeable future. We cannot assure you that we would always be able to secure additional financing if needed and, if such funds were available, whether the terms or conditions would be acceptable to us.

If contract development accelerates or acquisition opportunities arise, we may need to issue additional debt or equity securities to provide the funding for these increased growth opportunities. We may also issue debt or equity securities in connection with future acquisitions or strategic alliances. We cannot assure you that we would be able to issue additional debt or equity securities on terms that would be acceptable to us.

Any material commitments for capital expenditures are included in the "Contractual Obligations" table below.

Contractual Obligations

The following schedule summarizes our contractual cash obligations as of December 31, 2014:

	Payments due by year ended December 31,				
(in thousands)	2015	2016-2017	2018-2019	2020 and After	Total
Deferred compensation plan payments [1]	$1,918	$2,184	$1,818	$5,042	$10,962
Long-term debt and related interest [2]	25,239	95,357	172,880	—	293,476
Operating lease obligations	13,724	26,450	25,835	23,902	89,911
Capital lease obligations [3]	1,709	2,700	365	—	4,774
Purchase obligations	3,419	1,511	16	—	4,946
Outsourcing obligations [4]	20,724	39,280	41,757	31,555	133,316
Other contractual cash obligations [5]	26,245	28,130	11,422	21,425	87,222
Total Contractual Cash Obligations	$92,978	$195,612	$254,093	$81,924	$624,607

[1] Consists of payments under a non-qualified deferred compensation plan and long-term incentive cash awards.

[2] Consists of scheduled principal payments, repayment of outstanding revolving loans, and estimated interest payments on outstanding borrowings under the Fifth Amended Credit Agreement. Also includes payments in respect of the Cash Convertible Notes and CareFirst Convertible Note and payments of cash interest thereon. Total estimated interest payments are $7.7 million for 2015, $10.4 million for 2016 and 2017 combined, and $2.9 million for 2018 and 2019 combined.

[3] Consists of scheduled principal payments and estimated interest payments on capital lease obligations. Estimated interest payments are immaterial.

[4] Outsourcing obligations consist of a ten-year applications and technology services outsourcing agreement with HP Enterprise Services, LLC entered into in May 2011 that contains minimum fee requirements. Total payments over the remaining term, including an estimate for future contractual cost of living adjustments, must equal or exceed a minimum level of approximately $133.3 million; however, based on current required service and equipment level assumptions, we estimate that the remaining payments will be approximately $276.3 million. The agreement allows us to terminate all or a portion of the services provided we pay certain termination fees, which could be material to the Company.

[5] Other contractual cash obligations include a 25-year strategic relationship agreement with Gallup that we entered into in January 2008 and a 5-year global joint venture agreement with Gallup that we entered into in October 2012. We have minimum remaining contractual cash obligations of $34.5 million related to these agreements, $7.5 million

of which will occur during 2015, $6.0 million which will occur in each of 2016 and 2017 and the remaining $15.0 million of which will occur ratably over the following 15 years. The majority of the remaining other contractual cash obligations consists of royalty and license fees related to certain programs or product offerings.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements as of December 31, 2014.

Recently Issued Accounting Standards

In July 2013, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2013-11, "Income Taxes (Topic 740)—Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists," which requires an entity to present in the financial statements an unrecognized tax benefit, or a portion of an unrecognized tax benefit, as a reduction to a deferred tax asset resulting from a net operating loss carryforward, a similar tax loss, or a tax credit carryforward. However, when the above situation is not available at the reporting date or the tax law of the applicable jurisdiction does not require the entity to use the deferred tax asset for such purpose, the unrecognized tax benefit should be presented in the financial statements as a liability and should not be combined with deferred tax assets. ASU No. 2013-11 is effective prospectively for reporting periods beginning after December 15, 2013. We adopted this standard for the interim period beginning January 1, 2014. The adoption of this standard did not have a material impact on our consolidated results of operations, financial position, cash flows, or notes to the consolidated financial statements.

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-9 which creates FASB Accounting Standards Codification ("ASC") Topic 606, "Revenue from Contracts with Customers" ("ASC 606") and supersedes ASC Topic 605, "Revenue Recognition." The provisions of ASC Topic 606 provide for a single comprehensive principles-based standard for the recognition of revenue across all industries and expanded disclosure about the nature, amount, timing and uncertainty of revenue, as well as certain additional quantitative and qualitative disclosures. The standard is effective for annual periods beginning after December 15, 2016, including interim periods within those years. We are currently evaluating the impact of adopting ASC Topic 606.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Interest Rate Risk

We are subject to market risk related to interest rate changes, primarily as a result of the Fifth Amended Credit Agreement. Borrowings under the Fifth Amended Credit Agreement generally bear interest at variable rates based on a margin or spread in excess of either (1) one-month, two-month, three-month or six-month (or with the approval of affected lenders, nine-month or twelve-month) LIBOR or (2) the greatest of (a) the SunTrust Bank prime lending rate, (b) the federal funds rate plus 0.50%, and (c) the Base Rate (as previously defined), as selected by the Company. The LIBOR margin varies between 1.75% and 3.00%, and the Base Rate margin varies between 0.75% and 2.00%, depending on our leverage ratio.

In order to reduce our interest rate exposure under the Fifth Amended Credit Agreement, we have entered into interest rate swap agreements effectively converting a portion of our floating rate debt to fixed obligations with interest rates ranging from 0.690% to 1.480% plus a spread.

We estimate that a one-point interest rate change would have resulted in a change in interest expense of approximately $0.5 million for the year ended December 31, 2014.

Foreign Currency Exchange Rate Risk

As a result of our investment in international initiatives, we are also exposed to foreign currency exchange rate risks. Because a significant portion of these risks is economically hedged with currency options and forwards contracts and because our international initiatives are not yet material to our consolidated results of operations, a 10% change in foreign currency exchange rates would not have had a material impact on our consolidated results of operations,

financial position, or cash flows for the year ended December 31, 2014. We do not execute transactions or hold derivative financial instruments for trading purposes.

Item 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Healthways, Inc.

In our opinion, the accompanying consolidated balance sheet as of December 31, 2014 and the related consolidated statements of operations, comprehensive income (loss), changes in stockholders' equity and cash flows for the year then ended present fairly, in all material respects, the financial position of Healthways, Inc. and its subsidiaries at December 31, 2014, and the results of their operations and their cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Annual Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements and on the Company's internal control over financial reporting based on our integrated audit. We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audit of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PRICEWATERHOUSECOOPERS LLP
Nashville, Tennessee
March 13, 2015
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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of Healthways, Inc.

We have audited the accompanying consolidated balance sheet of Healthways, Inc. as of December 31, 2013, and the related consolidated statements of operations, comprehensive income (loss), changes in stockholders' equity and cash flows for each of the two years in the period ended December 31, 2013. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Healthways, Inc. at December 31, 2013, and the consolidated results of its operations and its cash flows for each of the two years in the period ended December 31, 2013, in conformity with U.S. generally accepted accounting principles.

/s/ Ernst & Young LLP
Nashville, Tennessee
March 14, 2014
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HEALTHWAYS, INC.
CONSOLIDATED BALANCE SHEETS
(In thousands)

ASSETS

	December 31, 2014	December 31, 2013
Current assets:		
Cash and cash equivalents	$1,765	$2,584
Accounts receivable, net	126,559	89,484
Prepaid expenses	10,680	9,228
Other current assets	7,662	6,857
Income taxes receivable	2,917	1,402
Deferred tax asset	13,118	9,667
Total current assets	162,701	119,222
Property and equipment:		
Leasehold improvements	39,285	37,463
Computer equipment and related software	316,808	290,392
Furniture and office equipment	23,257	22,881
Capital projects in process		