HEALTHWAYS, INC
Form 10-K
March 14, 2014

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, 2013

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 x

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 x

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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 x 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 x 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.
x

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 x 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 x

As of June 30, 2013, 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 $534.7 million based on the price at which the shares were last sold for such date on The NASDAQ Stock Market.

As of March 7, 2014, 35,208,572 shares of Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2014 Annual Meeting of Stockholders are incorporated by reference into Part III of this Form 10-K.

Healthways, Inc.
Form 10-K
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PART I

Item 1. Business

Overview

Founded and incorporated in Delaware in 1981, Healthways, Inc. ("Healthways") provides specialized, comprehensive solutions to help people improve their well-being, thereby improving their health and productivity and reducing their health-related costs.

We believe well-being consists of five essential elements:

· Purpose: Liking what you do each day and being motivated to achieve your goals

· Social: Having supportive relationships and love in your life

· Financial: Managing your economic life to reduce stress and increase security

· Community: Liking where you live, feeling safe and having pride in your community

· Physical: Having good health and enough energy to get things done daily

Our solutions provide highly specific and personalized interventions for each individual in a population, irrespective of health status, age or payor. Through a simple, but powerful, data-driven process we identify the needs of each individual and determine the right level of support. This allows us to deploy successful strategies to sustain engagement, to use the best science to drive behavior change and ultimately deliver meaningful, measurable outcomes. Our services are delivered using a range of methods desired by an individual including venue-based face-to-face interactions; print; phone; mobile and remote devices with unique applications; on-line including social networks; and any combination thereof to motivate and sustain healthy behaviors.

In North America, 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, in all 50 states and the District of Columbia. We also provide services to commercial healthcare businesses and/or government entities in Brazil, Australia, and France. All of our interventions were developed with over 30 years of experience based in science and ongoing innovation. Our technology-driven infrastructure is compatible with, and integrated into, our customer and other vendor systems. We operate domestic and international well-being improvement call centers staffed with a wide range of licensed health professionals. Our fitness center network encompasses approximately 15,000 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.

Our guiding philosophy and approach to market are predicated on the fundamental belief that healthier people cost less and are more productive. As described more fully below, our programs are designed to improve individual and organizational well-being by helping people adopt or maintain healthy behaviors, reduce health-related risk factors, and optimize their care for identified health conditions.

First, our programs are designed to help people adopt or maintain healthy behaviors by:

· fostering wellness and disease prevention through total population screening, well-being assessments and supportive interventions; and

- engaging people in our well-being improvement programs and networks, such as fitness, weight management, stress management, financial and lifestyle management skills, chiropractic, and complementary and alternative medicine.

Our prevention programs focus on education, physical fitness, nutrition, health coaching, and tools that support behavior change. These programs improve the well-being status of member populations and reduce the short- and long-term health-related costs for participants, including associated costs from the loss of employee productivity. 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 enhancement opportunity. Our web-based tools include the Well-Being Connect® portal, and our educational capabilities include the Dave Ramsey Core™ Financial Wellness program. We also utilize mobile applications such as wellbeingGO®, and our MeYou Health subsidiary unique mobile applications include Well-Being Tracker™, Daily Challenge®, and Walkadoo™.

Second, our programs are designed to help people reduce health-related risk factors by:

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

We engage our customers' covered populations through specific interactions that are sensitive to each individual's health risks and needs. In many situations, we utilize predictive modeling capabilities to allow us to identify and stratify those participants who are most at risk for an adverse health event. Our programs are designed to motivate people to make positive lifestyle changes and accomplish individual goals, such as increasing physical activity for seniors through the Healthways SilverSneakers® fitness solution, overcoming nicotine addiction through the QuitNet® on-line smoking cessation community, or generating sustainable weight-loss through our Innergy® solution.

Finally, our programs are designed to help people optimize care for identified health conditions by:

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

Our approach is to use proprietary, analytic models to identify individuals who are likely to incur future high costs, including those who have specific gaps in care, and through evidence-based interventions drive adherence to proven standards of care, medication regimens and physicians' plans of care to reduce disease progression and related medical spending. Specific examples of interventions include our Care Transitions hospital readmissions avoidance program and the Dr. Dean Ornish Program for Reversing Heart Disease™.

We recognize that each individual in a given population plays a variety of roles in his or her pursuit of improved well-being, often simultaneously. By providing the full spectrum of services to meet each individual's needs, we believe our interventions can be delivered at scale and in a manner that reflects those unique needs over time. We believe that real and sustainable behavior change generates measurable, long-term cost savings and improved individual and business performance for our customers.

Customer Contracts

Our fees are generally billed on a per member per month ("PMPM") basis or upon member participation. 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. In addition, some of our services, such as the Healthways SilverSneakers fitness solution, include fees that are based upon member participation.

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 4% of revenues recorded during the year ended December 31, 2013 were performance-based of which 3% were subject to final reconciliation as of December 31, 2013.

Technology

Our solutions require sophisticated analytical, data management, Internet, and computer-telephony capabilities based on state-of-the-art technology. These solutions help us deliver our services to large populations within our customer base. Our predictive modeling capabilities, including insights gained from well-being assessments such as the Gallup-Healthways Well-Being 5™ diagnostic tool, allow us to identify and stratify those participants who are most at risk for an adverse health event. We incorporate behavior-change science with consumer-friendly interactions to facilitate consumer preferences for engagement and convenience supporting improvement across all five elements of well-being: physical, financial, social, purpose and community. We use sophisticated data analytical and reporting solutions to validate the impact of our programs on clinical and financial outcomes. Our application offerings support integrating the primary care physician into the team of well-being experts working on behalf of participants. We continue to invest heavily in technology, as evidenced by our long-term applications and technology services outsourcing agreement with HP Enterprise Services, LLC, and are continually expanding and improving our proprietary clinical, data management, and reporting systems to continue to meet the information management requirements of our services. 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; on-line; and any combination thereof to motivate and sustain healthy behaviors.

Backlog

Backlog represents the estimated average annualized revenue at target performance over the term of the contract for business awarded but not yet started. Annualized revenue in backlog as of December 31, 2013 and 2012 was as follows:

(In thousands)	December 31, 2013	December 31, 2012
Annualized revenue in backlog	$39,800	$39,000

Business Strategy

The World Health Organization defines health as "…not only the absence of infirmity and disease, but also a state of physical, mental, and social well-being."

Our business strategy reflects our passion to enhance well-being and, as a result, reduce overall health-related costs and improve workforce engagement, yielding better performance for individuals, families, health plans, governments, employers, integrated healthcare systems, and communities. Our solutions are designed to improve well-being by helping people to:

- adopt or maintain healthy behaviors;
- reduce health-related risk factors; and
- optimize care for identified health conditions.

We believe it is critical to impact an entire population's well-being and underlying health status in a long-term, cost-effective way. Believing that what gets measured gets acted upon, in 2008, we entered into an exclusive, 25-year relationship with Gallup to create a definitive measure and empiric database of changes in the well-being of the U.S. population, known as the Gallup-Healthways Well-Being Index® ("WBI"), as well as processes to establish benchmarking for purposes of comparing the well-being of any subset of the national population. The responses to

the over 1.9 million completed WBI surveys to date have provided Gallup and us with an unmatched database to support our mutual goal of understanding the causes and effects of well-being for a population. In October 2012, we created a global joint venture with Gallup that has developed the next generation of Gallup-Healthways individual well-being assessment tools, 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.

To enhance well-being within their respective populations, our current and prospective customers require solutions that focus on the underlying drivers of healthcare demand, address worsening health status, reverse or slow unsustainable cost trends, foster healthy behaviors, mitigate health risk factors, and manage chronic conditions. Our strategy is to deliver programs that engage individuals and help them enhance their well-being and underlying health status regardless of their starting point. Published, peer-reviewed studies prove we can achieve well-being improvements in a population that generate significant cost savings and increases in productivity by providing effective programs that support the individual throughout his or her well-being journey.

Our strategy includes, as a priority, the ongoing expansion of our value proposition through our total population management capabilities. We continue to enhance our well-being improvement solutions to extend our reach and effectiveness and to meet increasing demand for integrated solutions. The flexibility of our programs allows customers to provide a range of services they deem appropriate for their organizations. Customers may select from certain single program options up to a total-population approach, in which all members of a customer's population are eligible to receive our services. Our strategy also includes the ongoing enhancement and deployment of our proprietary technology platform known as Embrace®. This platform, which is essential to our total population management solution, enables us to integrate data from the healthcare organizations and other entities interacting with an individual. Embrace provides for the delivery of our integrated solutions and ongoing communications between the individual and his or her medical and health experts, 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 thereof to motivate and sustain healthy behaviors.

A number of contracts signed since 2011 have expanded both the level of integration and breadth of services provided to major regional commercial health plans, in some cases 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, prevention and quality improvement solutions. Examples include our collaboration with Blue Zones, LLC in delivering a scaled well-being improvement solution to support health plan initiatives in a number of states; our wholly-owned subsidiary MeYou Health, LLC in bringing to market well-being improvement tools in the social media space through internet and personal device delivery methods; and our exclusive partnership with Dr. Ornish that is creating access to the Dr. Dean Ornish Program for Reversing Heart Disease for a growing number of health plans.

We continue to provide a variety of services to most of the major Medicare Advantage health plans and expect this market to grow as Medicare Advantage offerings gain an increasing share of the growing Medicare-eligible population. Our Silver Sneakers program is the largest single program within our current services but some of our health plan customers are adding additional services including web-based and mobile applications for personal support and social networking as more of the senior population becomes interested in these modalities of interaction.

Self-insured employers, including state and municipal government entities acting as employers, continue to demand services that focus across the entire population of employees and their dependent family members. Our well-being improvement solution, in addition to improving individuals' health and reducing direct healthcare costs, targets a much larger improvement in employer performance and profitability by reducing the impact of productivity lost for health-related reasons. With the success of our work aimed at total population management, we expect to gain an even greater competitive advantage in responding to employers' needs for a healthier, higher-performing, and less costly workforce.

Significant ongoing changes in government regulation of healthcare continue to afford us expanding opportunities to provide services to integrated healthcare systems, hospitals, and physicians, in addition to health plans and employers. In 2011, we acquired Navvis & Company, a well-established provider of strategic counsel and change management services enabling its healthcare system clients to become future-ready clinical enterprises within healthcare'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 a range of capabilities that

enable and support the delivery of Physician-Directed Population Health solutions. Beginning in 2012, we signed and began the implementation of the initial set of contracts with integrated healthcare systems to provide these services. Although we initially anticipated a rapid aggregation of risk lives within health systems as creating a fast-developing market for our total population management services, we have since observed a slowing in the pace of adoption of value-based models as well as operational and data integration challenges between payors and our health system customers, which have led to a delay in the timing of achieving the originally expected volume of risk lives associated collectively with our health system customers. We expect to continue to grow the number and size of our health systems relationships through the ongoing deployment of services including, for example, consulting, hospital readmission avoidance and the Dr. Dean Ornish Program for Reversing Heart Disease.

We expect to continue to expand our international business beyond our current contracts in Australia, Brazil, and France. Our strategy is to help countries with single-payor models that to a large extent have a relatively fixed infrastructure that can be leveraged through our effective care coordination models. This approach allows us to partner either directly with government entities or with the private side of healthcare insurers and service providers that operate in those countries. Though most international business development has a relatively long sales cycle, the pipeline of opportunities continues to grow.

We plan to increase our competitive advantage in delivering our services by leveraging the scope of our well-being improvement capabilities, including our medical information content, behavior change processes and techniques, strategic relationships, health provider networks, and fitness center relationships. We also plan to continue to scale the delivery of our solutions employing a blend of our scalable, state-of-the-art well-being improvement call centers and proprietary technologies, modalities, and techniques. We may add new capabilities and technologies through internal development, strategic alliances with other entities, and/or selective acquisitions or investments. A recent example is our exclusive agreement with The Lampo Group, Inc. — headed by Dave Ramsey, a leading voice on money and business — for Healthways to deliver the CORE™ Financial Wellness program as part of our well-being improvement solution.

We will continue to enhance, expand and integrate additional capabilities with health plans, integrated healthcare systems, employers, domestic government entities, and communities, as well as the public and private sectors of healthcare in international markets.

Segment and Major Customer Information

We have aggregated our operating segments into one reportable segment, well-being improvement services. During 2013, Humana, Inc. ("Humana") comprised approximately 10.5% of our revenues. Our primary contract with Humana continues through 2016. No other customer accounted for 10% or more of our revenues in 2013.

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 population health improvement 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.

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, "PPACA") required the U.S. Department of Health & Human Services ("HHS") to establish 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 will impact 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 will award bonuses to Medicare Advantage plans that achieve service benchmarks and quality ratings, overall payments to Medicare Advantage plans are expected to be 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.

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. On January 17, 2013, HHS released a final rule that, among other things, changed the requirements for agreements between covered entities and business associates as well as agreements between business associates and their subcontractors. Covered entities and business associates were required to comply with the final rule beginning September 23, 2013, except that existing agreements may qualify for an extended compliance date of September 22, 2014.

We may be subject to civil and criminal penalties for violations of HIPAA and its implementing regulations. The American Recovery and Reinvestment Act of 2009 ("ARRA") significantly increased the civil penalties for violations, with 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, the 2013 regulations create a presumption that non-permitted uses and disclosures of unsecured individually identifiable health information constitute 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, 2014, we had approximately 2,500 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 in which we operate currently faces significant cost reduction pressures as a result of increased competition, constrained revenues from governmental and private revenue 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 high 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 undergo a period of consolidation, 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 new benefit mandates, limitations on exclusions and factors used for rate setting, requirements for MLRs, and increased taxes. In determining how to meet these requirements, health plan customers or prospective customers may seek reduced fees or choose to reduce or delay the purchase of our services.

In addition, PPACA established American Health Benefit Exchanges ("Exchanges") and required that each state establish or participate in an Exchange as of January 1, 2014 where individuals may compare and purchase health insurance. Health plans participating in an Exchange must offer a set of minimum benefits and may elect to offer additional benefits. Chronic disease management is classified as a minimum essential health benefit. 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. 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 10.5% of our revenues in 2013. Our primary contract with Humana continues through 2016. No other customer accounted for 10% or more of our revenues in 2013. The loss of, or the 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 to complement our existing services, as well as establishing additional distribution channels through which we may offer our products and services.

Our strategy focuses on helping people adopt 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 that may lead to pricing conflicts, which may adversely affect our business.

Our 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 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 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 also 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.

We have several contracts subject to renewal in 2014 that individually represented more than 2% of our 2013 revenues and collectively represented 20% of our 2013 revenues. If our customers choose not to renew their contracts with us, our business and results of operations could be materially adversely affected.

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 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. A 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, whether the terms or 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 necessary to implement 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 risks which are different from or additional to 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 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 and July 1, 2013. On July 16, 2013, we completed a private placement 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, 2013, our long-term debt, including the current portion but excluding the debt discount, was $283.6 million.

Our ability to service our indebtedness (including 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 have a material adverse effect on 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 Note 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, 2013, we had approximately $338.8 million and $79.2 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.

The nature of our business involves the receipt and storage of a significant amount of health information about the participants of our programs. If we experience a data security breach, we could be exposed to government enforcement actions and private litigation. In addition, our customers could lose confidence in our ability to protect the health information of their members, which could cause them to discontinue usage of our services.

We rely upon our information systems for operating and monitoring all major aspects of our business. These systems and 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.

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 signficant 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 transformational period 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. All of 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 a continually evolving segment of the overall healthcare industry with many entities, whose financial, research, staff, and marketing resources may exceed our resources, marketing or announcing an intention to offer a variety of population health improvement services and other services to health plans, integrated healthcare systems, self-insured employers, and government entities.

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 such as those noted above.

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.

Our business could be negatively affected as a result of a proxy contest and the actions of activist stockholders.

We recently received a notice from North Tide Capital, LLC ("North Tide"), one of our stockholders, that indicates its intention to nominate four directors for election to our Board at our 2014 Annual Meeting of Stockholders. If a proxy contest involving North Tide or its affiliates ensues, or if we become engaged in a proxy contest with another activist stockholder in the future, our business could be adversely affected because:

- responding to proxy contests and other actions by activist stockholders can disrupt our operations, be costly and time-consuming, and divert the attention of our management and employees;

- perceived uncertainties as to our future direction may result in the loss of potential business opportunities, and may make it more difficult to attract and retain qualified personnel and business partners; and

- if individuals are elected to our Board to pursue an activist stockholder's particular agenda, it may adversely affect our ability to effectively implement our business strategy.

Compliance with new 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 regulations and may be subject to criminal or civil penalties for violations of these regulations. The regulations that implemented many of these ARRA requirements revised the standards for agreements with business associates and required, in most instances, amendments to existing agreements with our customers and subcontractors. Compliance with the final rule was required beginning September 23, 2013, except that existing business associate agreements may qualify for an extended compliance date of September 23, 2014. In addition, the regulations create a presumption that non-permitted uses and disclosures of unsecured individually identifiable health information constitute 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. This presumption and revised standard for determining whether a non-permitted use or disclosure constitutes a breach may result in a greater number of incidents being classified as breaches and, thus, a greater number of required notifications.

Although we continually monitor the extent to which federal and state legislation or regulations may govern our operations, new federal or state legislation or regulations in this area 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 that are subject to varying interpretations 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 provisions related to fraud and abuse, false claims and billing and reimbursement for services, and the federal False Claims Act.

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 would 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 plans and private insurance companies.

Among other things, PPACA decreases the number of uninsured individuals and expands coverage through the expansion of public programs and 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 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 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.

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.

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 seven other well-being improvement call center locations for an aggregate of approximately 160,000 square feet of space with lease terms expiring on various dates from 2014 to 2020. Our operations support and training offices contain approximately 66,000 square feet in aggregate and have lease terms expiring from 2014 to 2020.

Item 3. Legal Proceedings

Contract Disputes

We currently are involved in a contractual dispute with Blue Cross Blue Shield of Minnesota regarding fees paid to us as part of a former contractual relationship. On January 25, 2010, Blue Cross Blue Shield of Minnesota issued notice of arbitration with the American Arbitration Association in Minneapolis in accordance with the terms of the contract alleging violations of certain contract provisions and seeking recoupment of an unspecified amount of payments made to us under the contract. We believe we performed our services in compliance with the terms of our agreement and that the assertions made in the arbitration notice are without merit. On August 3, 2011, we asserted numerous counterclaims against Blue Cross Blue Shield of Minnesota. The arbitration hearing concluded on October 23, 2013. During and after the conclusion of the arbitration hearing in October, the parties entered into settlement negotiations to resolve all claims in dispute. The parties have jointly requested that the arbitrator not issue any award or decision while the parties are engaged in settlement discussions. We cannot predict whether these discussions will result in a settlement.

We are involved in a contractual dispute with Plastipak Packaging, Inc. ("Plastipak"). On September 10, 2012, Plastipak filed suit in the Circuit Court for Wayne County, Michigan seeking damages relating to an alleged breach of a services agreement with us. The case is currently in the discovery phase of litigation. We deny Plastipak's claims and intend to vigorously defend the action.

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.

Outlook

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 will have a material adverse effect on our liquidity or financial condition. 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 14, 2014. Executive officers of the Company serve at the pleasure of the Board.

Officer	Age	Position
Ben R. Leedle, Jr.	53	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	54	Chief Commercial Officer of the Company since October 2012. Navvis & Company Chief Executive Officer from 2004 to September 2012.
Alfred Lumsdaine	48	Chief Financial Officer of the Company since January 2011. Chief Accounting Officer of the Company from February 2002 until January 2011.
Peter Choueiri	48	President, Healthways International, since January 2012 and Chief Operating Officer, Healthways International, from June 2011 through January 2012. Head of Global Markets for North America, Middle East/Africa, and Southern Europe/Latin America for Munich Reinsurance Company in Germany from May 2009 to May 2011 and Head of Divisional Unit Healthcare from October 2005 to May 2009.
Glenn Hargreaves	47	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	47	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, 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
Year ended December 31, 2012		
First quarter	$8.49	$6.66
Second quarter	8.00	6.21
Third quarter	11.96	7.73
Fourth quarter	11.94	8.58

Unregistered Sales of Equity Securities

On November 7, 2013, Ben R. Leedle, Jr., our Chief Executive Officer, and Alfred Lumsdaine, our Chief Financial Officer, purchased 20,000 and 4,000 unregistered shares of common stock, respectively, from the Company for consideration of $235,000 and $47,000, respectively. The issuance of the shares 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.

On July 15, 2013, we entered into an exclusive partnership with Dean Ornish, M.D., to operate and license his Lifestyle Management Programs. In partial consideration for this exclusive partnership, we issued 45,362 unregistered shares of our common stock to Dean Ornish, M.D., and Ed McCall. The number of shares of our common stock issued in this transaction was calculated based on the average closing trading price per share of our common stock on NASDAQ over the 30 trading days immediately prior to the effective date of this transaction. The issuance of the shares 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 1, 2014, there were approximately 10,600 holders of our common stock, including 217 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, 2013	Year Ended December 31, 2012	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Operating Results:					
Revenues	$ 663,285	$ 677,170	$ 688,765	$ 720,333	$ 717,426
Cost of services (exclusive of depreciation and amortization included below)	547,387	533,880	510,724	493,713	522,999
Selling, general and administrative expenses	61,205	60,888	64,843	72,830	71,535
Depreciation and amortization	52,791	51,734	49,988	52,756	49,289
Impairment loss	—	—	183,288	—	—
Restructuring and related charges	—	1,773	9,036	10,258	—
Operating income (loss)	$ 1,902	$ 28,895	$ (129,114)	$ 90,776	$ 73,603
Gain on sale of investment	—	—	—	(1,163)	(2,581)
Interest expense	16,079	14,149	13,193	14,164	15,717
Legal settlement and related costs	—	—	—	—	39,956
Income (loss) before income taxes	$ (14,177)	$ 14,746	$ (142,307)	$ 77,775	$ 20,511
Income tax expense (benefit)	(5,636)	6,722	15,386	30,445	10,137
Net income (loss)	$ (8,541)	$ 8,024	$ (157,693)	$ 47,330	$ 10,374
Basic income (loss) per share:	$ (0.25)	$ 0.24	$ (4.68)	$ 1.39	$ 0.31
Diluted income (loss) per share: [1]	$ (0.25)	$ 0.24	$ (4.68)	$ 1.36	$ 0.30
Weighted average common shares and equivalents:					
Basic	34,489	33,597	33,677	34,129	