HEALTHWAYS, INC
Form 10-K
October 29, 2007
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 August 31, 2007

or

o 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.)

3841 Green Hills Village Drive, Nashville, TN 37215
(Address of principal executive offices) (Zip code)

(615) 665-1122
(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 x No o

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

Yes o No x

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 o

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act.

Large accelerated filer x Accelerated filer o Non-accelerated filer o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).

Yes o No x

As of February 28, 2007, the last business day of the Registrant's most recently completed second fiscal quarter, the aggregate market value of the shares held by non-affiliates of the registrant was approximately $1.5 billion based on the closing bid price reported for such date on The NASDAQ Stock Market.

As of October 18, 2007, 35,633,057 shares of Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the Annual Meeting of Stockholders to be held February 14, 2008 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

Founded in 1981, Healthways, Inc. (the "Company") provides specialized, comprehensive Health and Care Support℠ solutions to help people maintain or improve their health and, as a result, reduce overall healthcare costs.

Designed to provide highly specific and personalized interventions for each individual in a population, irrespective of health status, age, or payor, Healthways' evidence-based services are made available to consumers by phone, mail, internet, and face-to-face interactions. To expand our Health Support offerings, on December 1, 2006 we acquired Axia Health Management, Inc. ("Axia"), a national provider of preventive health and wellness programs, for approximately $467.0 million in cash.

We deliver our programs to customers, which include health plans, governments, employers, and hospitals, in all 50 states, the District of Columbia, Puerto Rico, and Guam. These services include:

- fostering wellness and disease prevention through total population screening, health risk assessments, and supportive interventions;
- providing access to health improvement programs such as fitness, weight management, complementary and alternative medicine and smoking cessation;
- promoting the reduction of lifestyle behaviors that lead to poor health or chronic conditions;
- providing educational materials and personal interactions with highly trained nurses and other healthcare professionals that are designed to create and sustain healthier behaviors to members with chronic conditions;
- incorporating current 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; and
- coordinating members' care with local healthcare providers.

Our programs focus on prevention, education, physical fitness, health coaching, behavior change and evidence-based medicine to drive adherence to proven standards of care, medications and physicians' plans of care. The programs are designed to support better health and assist in providing more effective care, which we believe will optimize the health status of member populations and reduce both the short-term and long-term healthcare costs for members.

Health and Care Support services enable health plans and employers to reach and engage everyone in their covered populations through interventions that are both sensitive to and specific to each individual's health risks and needs. Health Support products are designed to motivate people to make positive lifestyle changes and accomplish individual goals, such as becoming more physically active through the Healthways SilverSneakers® Fitness Program, staying fit using on-line tools and a vast network of fitness centers, and quitting smoking through an on-line smoking cessation community, QuitNet®. The Care Support product line includes programs for people with chronic diseases or conditions, including diabetes, coronary artery disease, heart failure, asthma, chronic obstructive pulmonary disease, end-stage renal disease, cancer, chronic kidney disease, depression, high-risk obesity, metabolic syndrome, acid-related stomach disorders, atrial fibrillation, decubitus ulcer, fibromyalgia, hepatitis C, inflammatory bowel disease, irritable bowel syndrome, low-back pain, osteoarthritis, osteoporosis, and urinary incontinence. We also provide high-risk care management through our StatusOne® product for members at risk for hospitalization due to complex conditions. We believe that creating real and sustainable behavior change generates measurable long-term cost savings.

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Predicated on the fundamental belief that healthier people cost less, Healthways' programs are designed to help keep healthy individuals healthy, mitigate and delay the progression to disease associated with family or lifestyle risk factors, and promote the best possible health for those who are already affected by disease. At the same time, we recognize that each individual plays a variety of roles in his or her pursuit of health, often simultaneously. By providing the full spectrum of Health and Care Support services to meet each individual's needs, we believe that our interventions can be delivered both at scale and in a manner that reflects the unique needs of each consumer over time. Further, Healthways' extensive and fully accredited complementary and alternative provider network offers convenient access to the significant number of individuals who seek health services outside of the traditional healthcare system.

Customer Contracts

Contract Terms

We generally determine our contract fees by multiplying a contractually negotiated rate per member per month ("PMPM") by the number of members covered by our services during the month. We typically set the 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 some contracts, the PMPM rates may differ between a customer's lines of business [e.g. Preferred Provider Organizations ("PPO"), Health Maintenance Organizations ("HMO"), Medicare Advantage]. In addition, some of our services are billed on a fee for service basis.

Our contracts generally range from three to five years with provisions for subsequent renewal; contracts with self-insured employers, either direct or through their health plans, typically have one-year terms. Some contracts allow the customer to terminate early.

Some of our contracts provide that a portion (up to 100%) of our fees may be refundable to the customer ("performance-based") if our programs do not achieve, when compared to a baseline year, a targeted percentage reduction in the customer's healthcare costs and selected clinical and/or other criteria that focus on improving the health of the members. Approximately 4% of revenues recorded during fiscal 2007 were performance-based and were subject to final reconciliation as of August 31, 2007. We anticipate that this percentage will fluctuate due to the level of performance-based fees in new contracts, revenue recognition associated with performance-based fees, and the timing of data reconciliation, which varies according to contract terms. A limited number of contracts also provide opportunities for us to receive incentive bonuses in excess of the contractual PMPM rate if we exceed contractual performance targets.

We are participating in two Medicare Health Support ("MHS") pilots awarded under the Chronic Care Improvement Program authorized by the Medicare Modernization Act of 2003. The pilots are scheduled to operate for 36 months but may be terminated by either party with six months written notice. We began operating one pilot in August 2005 to serve 20,000 Medicare fee-for-service beneficiaries in Maryland and the District of Columbia. All fees under this pilot are performance-based. In addition, in September 2005 we began serving 20,000 beneficiaries in Georgia in collaboration with CIGNA HealthCare, Inc ("CIGNA"). The majority of our fees under our contract with CIGNA are performance-based. Both of the pilots are for complex diabetes and congestive heart failure disease management services and, while operationally similar to our programs for commercial and Medicare Advantage health plan populations, have been modified for the special needs and conditions of this population.

In June 2006, we signed an amendment to our cooperative agreement with the Centers for Medicare & Medicaid Services ("CMS") for our MHS stand-alone pilot in Maryland and the District of Columbia, which, among other things, enabled us to provide congestive heart failure programs to approximately 4,500 additional Medicare fee-for-service beneficiaries for two years beginning on August 1, 2006 (the "refresh population"). All fees for the refresh population are performance-based.

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Technology

Our customer contracts require sophisticated analytical, data management, Internet and computer-telephony solutions based on state-of-the-art technology. These solutions help us deliver Health and Care Support services to large populations within our customer base. Our predictive modeling capabilities 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 such as face-to-face, telephonic, print materials and web portals to facilitate consumer preferences for engagement and convenience. Sophisticated data analytical and reporting solutions are used to validate the impact of our programs on clinical and financial outcomes. We continue to invest heavily in technology and are continually expanding and improving our proprietary clinical, data management, and reporting systems to continue to meet the information management requirements of our Health and Care Support services.

Billed Lives and Available Lives

Following the acquisition of Axia on December 1, 2006, we introduced new metrics to replace the “actual lives under management” metric historically used to measure our Care Support business. The first new metric was “billed lives”, which is the total number of lives for which we receive fees under our contracts and equates to our historical metric “actual lives under management”. The second new metric was “available lives”, which measures the entire population covered by our domestic customers. The number of available lives and billed lives as of August 31, 2007 and 2006 were as follows:

(In 000s)	**August 31, 2007**	**August 31, 2006**
Available lives[(1)]	188,500	76,900
Billed lives	27,446	2,426

(1) Estimated based on the Atlantic Information Services, Inc. (AIS) Directory of Health Plans and publicly available information.

Backlog

Backlog represents the estimated annualized revenue at target performance associated with signed contracts at August 31, 2007 for which we have not yet begun providing services. Annualized revenue in backlog as of August 31, 2007 and 2006 was as follows:

(In 000s)	**August 31, 2007**	**August 31, 2006**
Annualized revenue in backlog	$ 39,900	$ 6,625

We continue to see increasing demand for our Health and Care Support services from self-insured employer accounts, most of which are contracted through the Administrative Services Only (ASO) line of business with our health plan customers and for which our health plan customers do not assume medical cost risk but provide primarily administrative claim and health network access services. Signed contracts between these self-insured employers and our health plan customers are incorporated in our contracts with our health plan customers, and these program-eligible members are included in the available and billed lives or in the annualized revenue in backlog reported in the table above, as appropriate.

This increasing demand for our Health and Care Support services from self-insured employer accounts, which generally begin their benefit year on January 1, has typically resulted in a disproportionate amount of our growth occurring in our second fiscal quarter.

Business Strategy

Our primary strategy is to optimize the health of entire populations as well as the quality and affordability of healthcare through our Health and Care Support solutions both domestically and internationally, thereby creating value for individuals, health plans, governments, and employers. We plan to continue using our scalable state-of-the-art care enhancement centers, medical information content, behavior change processes and techniques, strategic relationships, health provider networks and proprietary technologies to gain a competitive advantage in delivering our Health and Care Support services.

We expect to continue adding and enhancing solutions to extend our reach and effectiveness for entire populations. The flexibility of our programs allows customers to enter the Health and Care Support market at the level of services that they deem appropriate for their organization. Customers may select from a single prevention program or chronic disease to a total-population approach, in which all members of the customer's population receive the benefit of our programs.

We deliver programs that engage consumers in their health. We believe that we can achieve health improvements and generate significant cost savings by addressing consumer and customer needs for effective programs that support the individual throughout his or her lifetime.

We anticipate that we will incur significant costs during fiscal 2008 to enhance and expand our Health and Care Support capabilities, pursue opportunities in domestic government and international markets, enhance our information technology support, integrate the operations of Axia, and open additional or expand current capacity as needed. We may add some of these new capabilities and technologies through internal development, strategic alliances with other entities and/or through selective acquisitions or investments.

Segment Information

We have one reportable segment, Health and Care Support services. During fiscal 2007, CIGNA HealthCare, Inc. comprised approximately 22% of our revenues. No other customer accounted for more than 10% of our revenues in fiscal 2007.

Competition

The health-care 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 care support, health support, and other services to health plans and self-insured employers, or have announced an intention to offer such services. These entities include disease management companies, major pharmaceutical companies, health plans, health care organizations, providers, pharmacy benefit management companies, health care information technology companies and other entities that provide services to health plans and self-insured employers.

We believe we have advantages over our competitors because of our state-of-the-art care enhancement center technology linked to our proprietary information technology, predictive modeling capabilities, behavior-change techniques, the comprehensive recruitment, pre-testing and training of our clinical colleagues, the comprehensive clinical nature of our product offerings, our established reputation for providing care to members with chronic diseases, and the proven financial and clinical outcomes of our programs; however, we cannot assure you that we can compete effectively with these companies.

Consolidation has been, and may continue to be, an important factor in all aspects of the health care industry, including the Health and Care Support 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 customers if they are acquired by other health plans which already have or are not interested in Health and Care Support programs.

Governmental Regulation

Governmental regulation impacts us in a number of ways in addition to those regulatory risks presented under the “Risk Factors” below.

While many of the governmental and regulatory requirements affecting health-care delivery generally do not directly affect us, our customers must comply with a variety of regulations including 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 health-care employees, such as nurses must comply with individual licensing requirements. All of our health-care 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 care enhancement center. Multiple state licensing requirements for health-care professionals who provide services telephonically over state lines may require us to license some of our health-care 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 care enhancement center health professionals, which would increase our costs of services.

Changes in laws governing reimbursement to health plans providing services under governmental programs such as Medicare and Medicaid may affect us. Legislative and regulatory bodies may continue to reduce the funding of the Medicare and Medicaid programs in an effort to reduce overall federal health care spending. In recent years, federal legislation has reduced or significantly altered Medicare and Medicaid reimbursements to most hospitals. These changes, future legislative initiatives or government regulation and/or changes in the administration could adversely affect our operations or reduce the demand for our 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 health-care 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. We are contractually required to comply with certain aspects of the HIPAA privacy and security regulations. In addition, we are contractually obligated to comply with any applicable state laws or regulations related to privacy that are more restrictive than the federal privacy regulations. We may also be directly subject to state requirements related to the confidentiality and security of confidential personal information.

Various federal and state laws regulate the relationships among providers of health-care services, other health-care businesses and physicians. The "fraud and abuse" provisions of the Social Security Act provide civil and criminal penalties and potential exclusion from the Medicare and Medicaid programs for persons or businesses who offer, pay, solicit or receive remuneration in order to induce referrals of patients

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covered by federal health-care programs (which include Medicare, Medicaid, TriCare and other federally funded health programs). While we believe that our business arrangements with our customers comply with these statutes, these fraud and abuse provisions are broadly written, and the full extent of their application is not yet known. Therefore, we are unable to predict the effect, if any, of broad enforcement interpretation of these fraud and abuse provisions.

Further, the health care industry is highly regulated at the federal and state levels. For example, federal law contains various prohibitions related to false statements and false claims, some of which apply to private payors as well as federal programs. Our participation in the MHS program being administered by CMS may subject us directly to various laws and regulations applicable to entities contracting to provide services to federal programs, including but not limited to provisions related to billing and reimbursement and the False Claims Act. Violations of the False Claims Act are punishable by treble damages and penalties of up to $11,000 per false claim. Actions may be brought under the 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.

When a private party brings an action under the whistleblower provisions of the False Claims Act, the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. There are many potential bases for liability under the False Claims Act. Although liability under the False Claims Act arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term “knowingly” broadly. Thus, although simple negligence generally will not give rise to liability under the False Claims Act, submitting a claim with reckless disregard for its truth or falsity can constitute “knowingly” submitting a claim. In some cases, whistleblowers, the federal government, and some courts have taken the position that entities who allegedly have violated other statutes, such as the “fraud and abuse” provisions of the Social Security Act, have thereby submitted false claims under the False Claims Act. From time to time, participants in the health care industry, including our company, may be subject to actions under the False Claims Act, and it is not possible to predict the impact of such actions.

Insurance

We maintain the following types of insurance for all of our locations and operations: professional liability (including errors and omissions), directors and officers, property, and general liability. While we believe our insurance coverage is adequate for our current operations, it might not be sufficient to cover all future claims. Such insurance might not continue to be available in adequate amounts or at a reasonable cost. These policies contain relatively standard commercial terms and conditions. We also maintain workers compensation insurance for all of our employees.

Employees

As of October 19, 2007, we had approximately 3,800 employees. Our employees are not subject to any collective bargaining agreements. We believe we have a good relationship 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, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC.

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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 our 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 ("Form 10-K") contain additional information concerning these and other risks.

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

The health care 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 and increasing underlying medical care costs. We believe that these pressures will continue and possibly intensify.

We believe that our Health and Care Support solutions, which are geared to foster wellness and disease prevention and deliver interventions for people with chronic diseases and conditions, 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. In addition, this focus on cost reduction may cause our customers to focus on contract restructurings that reduce the fees we receive for our services. 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 which already have or are not interested in Health and Care Support programs. In addition, a reduction in the number of covered lives enrolled with our health plan customers could adversely affect our results of operations.

We currently derive a large percentage of our revenues from one customer. The loss of, or the restructuring of a contract with, this customer could have a material adverse effect on our business and results of operations.

Because of the size of its membership and the number of programs purchased from us, CIGNA HealthCare, Inc. comprised approximately 22% of our revenues in fiscal 2007. No other customer accounted for more than 10% of our revenues in fiscal 2007. Although we believe that the full-year impact of other contracts signed in 2007 and new contracts anticipated to be signed in 2008 will reduce our current revenue concentration, our results of operations, cash flows, and financial condition could be negatively and materially impacted by the loss or restructuring of a contract with a single large customer.

The Health and Care Support industry is a relatively new segment of the health-care industry.

The rapidly growing Health and Care Support industry is a relatively new segment of the overall health-care industry with many entrants marketing various services and products labeled as Health and Care Support. Companies have used the generic label of health and/or care support to characterize a wide range of activities, from the sale of medical supplies and drugs to demand management services. Because the industry is somewhat new, purchasers of these services have not had significant experience purchasing, evaluating or monitoring such services, which generally results in a lengthy sales cycle for new contracts. As the industry matures, the number of programs that customers have been purchasing has generally expanded from one or two programs to a more comprehensive suite of programs, while also typically increasing the terms from

between three to five years. These changes result in a more sizable contract commitment that generally requires approval from the customer's executive management and frequently the customer's board of directors.

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

Our growth strategy focuses on developing new Health and Care Support programs to address chronic diseases and medical conditions as well as the overall health of all members. While we have considerable experience in Health and Care Support solutions with a broad range of medical conditions, any new or modified programs will involve inherent risks of execution, such as our ability to implement our Health and Care Support programs within expected cost estimates; our ability to obtain adequate financing to provide the capital that may be necessary to support the growth of our operations; and our ability to deliver outcomes on any new products or services. In addition, as part of our business strategy, we expect to enter into relationships, such as our strategic relationship with Medco Health Solutions, Inc., to establish additional distribution channels through which we may offer our products and services. As we begin to offer new 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.

If we do not manage our growth successfully, our growth and profitability may slow or decline.

We have expanded and expect to continue to expand our products and services as well as our overall operations, both organically and through the acquisition of businesses and technologies that complement our Health and Care Support solutions. This expansion has created significant demands on our administrative, operational and financial personnel and other resources. The inability to obtain and/or properly allocate sufficient resources or personnel to manage our growth may have an adverse effect on our growth and profitability.

Our inability to perform well under our Health and Care Support contracts could have a material adverse effect on our business and results of operations.

Our ability to continue to grow and expand our business is contingent upon our ability to continue to achieve desired financial savings and clinical performance targets under our existing contracts and to favorably resolve contract billing and interpretation issues with our customers. Unusual and unforeseen patterns of health care utilization by individuals with diabetes, cardiac, respiratory and/or other diseases or conditions for which we provide services could adversely affect our ability to achieve desired financial savings and clinical outcomes.

We depend on the timely receipt of accurate data from ourcustomers and ouraccurateanalysis of such data.

Identifying which members are eligible to receive 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 impact on our ability to recognize revenues.

Our MHS pilots and certain other customer contracts are performance-based and a portion (up to 100%) of our fees may be refundable if certain performance targets are not achieved.

Our cooperative agreements with CMS for the MHS pilots and certain other customer contracts provide that a portion of our fees (up to 100%) may be refundable to the customer if our programs do not

achieve targeted savings performance. There is no guarantee that we will effect the necessary cost savings and clinical outcomes improvements under our contracts within the time frames contemplated and reach mutual agreement with customers with respect to cost savings. In addition, our ability to provide financial guidance with respect to performance-based contracts is contingent upon our ability to accurately forecast performance and the timing of revenue recognition under the terms of our contracts ahead of data collection and reconciliation.

The expansion of our Health and Care Support services into international markets may subject us to additional regulatory and financial risks.

We have recently expanded our Health and Care Support services into countries other than the United States and 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 Health and Care Support solutions and the individual market dynamics and regulatory requirements in potential international markets. The failure to accurately forecast the costs necessary to implement our strategy of establishing a presence in these markets could have an 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 the Company faces 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, most of which 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 which 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 integration of acquired businesses or technologies.

We may face substantial difficulties, costs and delays in effectively integrating any businesses and technologies that may be acquired as part of our overall growth strategy into our Health and Care Support platform. Integrating newly acquired organizations and technologies could be costly and time-consuming and may strain our resources. Consequently, we may not be successful in integrating these acquired businesses or technologies and may not achieve anticipated revenue and cost benefits.

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 August 31, 2007, we had approximately $483.6 million and $119.4 million of goodwill and intangible assets, respectively. On an ongoing basis, we evaluate whether the carrying values of goodwill and intangible assets are impaired. 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.

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Our level of indebtedness could adversely affect our future financial condition.

On December 1, 2006, we entered into a Third Amended and Restated Revolving Credit and Term Loan Agreement (the "Third Amended Credit Agreement") in conjunction with the acquisition of Axia. The Third Amended Credit Agreement contains various financial covenants, restricts the payment of dividends, and limits the amount of repurchases of our common stock. As of August 31, 2007, our total long-term debt, including the current portion, was $299.3 million.

Our indebtedness could have a material adverse effect on our financial condition by, among other things:

- increasing our vulnerability to a downturn in general economic conditions 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.

Our ability to service our indebtedness 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.

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

Our ability to deliver Health and Care Support services depends on effectively using information technology. We believe that our state-of-the-art electronic health record and care enhancement center technology provides us with a competitive advantage in the industry; however, we expect to continually invest in updating and expanding our information technology. 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.

Our revenues are subject to seasonal pressure from the disenrollment processes of employer customers of our contracted health plans. In addition, some of our contracts with employers, either direct or through their health plans, are one year in length, often beginning on January 1.

Employers typically make decisions on which health insurance carriers they will offer to their employees and also may allow employees to switch between health plans on an annual basis. These annual membership disenrollment and re-enrollment processes of employers (whose employees are the health plan members) from health plans can result in a seasonal reduction in billed lives during our second fiscal quarter.

Historically, we have found that a majority of employers and employees make these decisions effective December 31 of each year. An employer's change in health plans or employees' changes in health plan elections may cause a decrease in our billed lives for existing contracts as of January 1. Although these decisions may also result in a gain in enrollees as new employers sign on with our customers, the identification of new members eligible to participate in our programs is based on the submission of health-care claims, which lags enrollment by an indeterminate period.

As a result, historically, billed lives for our existing fully insured customers have decreased by up to 8% on January 1 and have not been restored through new member identification until later in the fiscal year,

thereby negatively affecting our revenues on existing contracts in our second fiscal quarter. However, the increasing demand for our Health and Care Support services from self-insured employer accounts, which generally begin their benefit year on January 1, has typically resulted in a net increase in total billed lives on January 1.

Another seasonal impact on billed lives could occur if a health plan decided to withdraw coverage altogether for a specific line of business, such as Medicare Advantage, or in a specific geographic area, thereby automatically disenrolling previously covered members. Historically, we have experienced minimal covered life disenrollment from such decisions.

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

We compete with other health-care and services providers in recruiting qualified management and staff personnel for the day-to-day operations of our business and care enhancement centers, including nurses and other health-care professionals. In some markets, the scarcity of nurses and other medical support personnel has become a significant operating issue to health-care businesses. This shortage may require us to enhance wages and benefits to recruit and retain qualified nurses and other health-care professionals.

Because a significant percentage of our existing contracts consist of a fixed fee per member, we have a limited ability to pass along increased labor costs to existing customers. A failure to recruit and retain qualified management, nurses and other health-care professionals, or to control labor costs, could have a material adverse effect on profitability.

We may face costly litigation that could force us to pay damages and/or harm our reputation.

In the course of our business, we are subject to lawsuits, which may involve large claims and significant defense costs (see Item 3, “Legal Proceedings”). Any of these claims, whether with or without merit, could result in costly litigation, and divert the time, attention, and resources of our management. Although we currently maintain 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 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 consolidated results of operations in a particular financial reporting period. In addition, legal expenses associated with the defense of these matters may be material to our consolidated results of operations in a particular financial reporting period.

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. The current focus on regulatory and legislative efforts to protect the confidentiality and security of individually-identifiable health information, as evidenced by HIPAA, is one such example.

We believe that federal regulations governing the confidentiality of individually-identifiable health information permit us to obtain individually-identifiable health information for Health and Care Support purposes from a health plan customer; however, state legislation or regulation could preempt federal legislation if it is more restrictive. Our customers must comply with federal regulations governing the security of electronic individually-identifiable health information. We are contractually required to comply with certain aspects of these confidentiality and security regulations.

Although we continually monitor the extent to which specific state legislation or regulations may govern our operations, new federal or state legislation or regulation in this area that restricts our ability to obtain and handle individually-identifiable health information would have a material negative impact on our 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, such as the civil lawsuit filed against us in 1994 as discussed under Item 3, “Legal Proceedings.” We believe that our operations have not violated and do not violate the provisions of the fraud and abuse statutes and regulations; however, private individuals acting on behalf of the United States government, or government enforcement agencies themselves, could pursue a claim against us under a new or differing interpretation of these statutes and regulations.

Expanding the Health and Care Support industry to Medicare fee-for-service beneficiaries in the MHS pilots awarded under the Medicare Modernization Act of 2003 and to Medicare beneficiaries enrolled in Medicare Advantage plans could lead to increased direct regulation of Health and Care Support services. Further, our participation in the MHS program and 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 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. Little guidance is available to determine the scope of some of these prohibitions. 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.

Changes in laws governing reimbursement to health plans providing services under governmental programs such as Medicare and Medicaid may affect us.

Legislative and regulatory bodies may continue to reduce the funding of the Medicare and Medicaid programs in an effort to reduce overall federal health-care spending. In recent years, federal legislation has reduced or significantly altered Medicare and Medicaid reimbursements. These changes, future legislative initiatives or government regulation could adversely affect our operations or reduce the demand for our services.

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

All of our health-care 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 care enhancement center. Multiple state licensing requirements for health-care professionals who provide services telephonically over state lines may require us to license some of our health-care 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 care enhancement center health professionals, which would increase our costs of services.

Item 1B. Unresolved Staff Comments

Not applicable.

Item 2. Properties

Our corporate offices located in the Nashville, Tennessee area contain approximately 180,000 square feet of office space, which we lease pursuant to agreements that expire from December 2007 to March 2011. In May 2006, we entered into an office lease agreement for our new corporate headquarters to be located near Nashville, Tennessee, containing approximately 255,000 square feet of rentable area, which we expect to occupy by March 1, 2008. The term of the lease is 15 years.

We also lease office space for our 13 call center locations for an aggregate of approximately 331,000 square feet of space with lease terms expiring on various dates from 2009 to 2013. Our operations support and training offices contain approximately 94,000 square feet in aggregate and have lease terms expiring from 2008 to 2015.

Item 3. Legal Proceedings

In June 1994, a former employee whom we dismissed in February 1994 filed a “whistle blower” action on behalf of the United States government. Subsequent to its review of this case, the federal government determined not to intervene in the litigation. The employee sued Healthways, Inc. and our wholly-owned subsidiary, American Healthways Services, Inc. (“AHSI”), as well as certain named and unnamed medical directors and one named client hospital, West Paces Medical Center (“WPMC”), and other unnamed client hospitals.

Healthways, Inc. has since been dismissed as a defendant; however, the case is still pending against AHSI before the United States District Court for the District of Columbia. In addition, WPMC has settled claims filed against it as part of a larger settlement agreement that WPMC’s parent organization, HCA Inc., reached with the United States government.

The complaint alleges that AHSI, the client hospitals and the medical directors violated the federal False Claims Act by entering into certain arrangements that allegedly violated the federal anti-kickback statute and provisions of the Social Security Act prohibiting physician self-referrals. Although no specific monetary damage has been claimed, the plaintiff, on behalf of the federal government, seeks treble damages plus civil penalties and attorneys’ fees. The plaintiff also has requested an award of 30% of any judgment plus expenses. The plaintiff recently agreed to dismiss its claims against the medical directors with prejudice, and on February 7, 2007 the court granted the plaintiff’s motion and dismissed all claims against all named medical directors.

In the action by the former employee, discovery is substantially complete but no trial date has been set. The parties have had initial discussions regarding their respective positions in the case; however, no resolution of this case has been reached or can be assured prior to the case proceeding to trial.

In a related matter, in February 2006, WPMC filed an arbitration claim seeking indemnification from us for certain costs and expenses incurred by it in connection with the case. In the action by WPMC, initial arbitration proceedings were commenced during the third quarter of fiscal 2006. During September 2007, the parties to this matter agreed to place the arbitration on hold for an indefinite period.

We believe that we have conducted our operations in full compliance with applicable statutory requirements and that we have meritorious defenses to the claims made in the case and the related arbitration proceeding, and intend to contest the claims vigorously. Nevertheless, it is possible that resolution of these

legal matters could have a material adverse effect on our consolidated results of operations in a particular financial reporting period. We believe that we will continue to incur legal expenses associated with the defense of these matters which may be material to our consolidated results of operations in a particular financial reporting period. However, we believe that any resolution of this case and all related matters will not have a material effect on our liquidity or financial condition.

We are also subject to other claims and suits that arise from time to time in the ordinary course of our business. While management currently believes that resolving claims against us, individually or in the aggregate, will not have a material adverse impact on our financial position, our results of operations, or our cash flows, these matters are subject to inherent uncertainties, and management's view of these matters may change in the future.

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

Not applicable.

Executive Officers of the Registrant

The following table sets forth certain information regarding our executive officers as of August 31, 2007. Executive officers of the Company serve at the pleasure of the Board of Directors.

Officer	Age	Position
Thomas G. Cigarran	65	Chairman of the Company since September 1988, a director since 1981, President September 1981 until June 2001, Chief Executive Officer September 1988 until September 2003. Chairman of AmSurg Corp.
Ben R. Leedle, Jr.	46	Chief Executive Officer and director of the Company since September 2003, President since May 2002, Executive Vice President and Chief Operating Officer of the Health Plan Group from 2000 until May 2002. Senior Vice President from 1996 until 2000.
Mary A. Chaput	57	Executive Vice President, Chief Financial Officer and Secretary of the Company since October 2001. Ms. Chaput is the spouse of the Company's Executive Vice President and Chief Information Officer, Robert L. Chaput.
Robert L. Chaput	57	Executive Vice President and Chief Information Officer of the Company since December 2005. Founder and CEO of American Technology Group from July 2002 to December 2005. Mr. Chaput is the spouse of the Company's Executive Vice President and Chief Financial Officer, Mary A. Chaput.
Mary D. Hunter	62	Executive Vice President of the Company since 2001. Chief Operating Officer of the Hospital Group from 2001 until July 2003. Senior Vice President from 1994 until 2001.

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Matthew E. Kelliher	52	Executive Vice President, International Business, of the Company since September 2004. Executive Vice President since September 2003. President of StatusOne Health Systems, LLC from November 1997 until September 2003.
Alfred Lumsdaine	42	Senior Vice President of the Company since February 2003. Controller and Chief Accounting Officer from February 2002 to present.
James E. Pope	54	Executive Vice President and Chief Operating Officer of the Company since May 2006. Executive Vice President and Chief Medical Officer of the Company from October 2003 until May 2006. Member of Medical Advisory Committee since February 1999.
Robert E. Stone	61	Executive Vice President and Chief Strategy Officer of the Company since 2005. Executive Vice President from 1999 to 2005. Senior Vice President from 1981 until 1999. President of Disease Management Association of America from October 2002 to October 2003.
Donald B. Taylor	49	Executive Vice President, Sales and Marketing, of the Company since December 2006. Executive Vice President, Alliances from May 2006 to December 2006. Chief Operating Officer of the Company from December 2003 until May 2006. Executive Vice President since February 2002.

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 over-the-counter on The NASDAQ Stock Market ("NASDAQ") under the symbol HWAY.

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

	High	Low
Year ended August 31, 2007		
First quarter	$ 52.37	$ 37.55
Second quarter	49.58	42.64
Third quarter	48.76	41.58
Fourth quarter	56.90	42.77
Year ended August 31, 2006		
First quarter	$ 46.77	$ 36.99
Second quarter	48.39	42.28
Third quarter	54.63	39.26
Fourth quarter	54.98	46.08

Holders

At October 22, 2007, there were approximately 38,650 holders of our Common Stock, including 173 stockholders of record.

Dividends

We have never declared or paid a cash dividend on our Common Stock. We intend to retain our 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. The Board of Directors will review our dividend policy from time to time and may declare dividends at its discretion. Our Third Amended Credit Agreement restricts the payment of dividends. For further discussion of the Third Amended Credit Agreement, see "Management's Discussion and Analysis of Financial Condition and Results of Operation - Liquidity and Capital Resources."

Repurchases of Common Stock

The following table contains information for shares of our Common Stock that we repurchased during the fourth quarter of 2007:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)	Maximum Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1)
June 1 through 30	—	—	—	—
July 1 through 31	50,000	$45.48	50,000	$97,726,000
August 1 through 31	76,583	$44.14	126,583	$94,345,889
Total	126,583			

(1) All share repurchases between June 1, 2007 and August 31, 2007 were made pursuant to a share repurchase program authorized by the Company's Board of Directors and publicly announced on July 5, 2007, which allows for the repurchase of up to $100 million of our common stock from time to time in the open market or in privately negotiated transactions through July 5, 2009.

Item 6. Selected Financial Data

(In thousands, except per share data)

Year ended and at August 31,	2007 (4) (5) (6)	2006 (4) (5)	2005 (4)	2004 (4)	2003
Operating Results: [1]					
Revenues	$ 615,586	$ 412,308	$ 312,504	$ 245,410	$ 165,471
Cost of services (exclusive of depreciation and amortization included below)	417,721	281,161	205,253	156,462	106,130
Selling, general and administrative expenses	67,352	44,417	28,418	23,686	16,511
Depreciation and amortization	37,044	24,517	22,408	18,450	10,950
Operating income	$ 93,469	$ 62,213	$ 56,425	$ 46,812	$ 31,880
Interest expense	18,185	1,053	1,630	3,509	569
Income before income taxes	$ 75,284	$ 61,160	$ 54,795	$ 43,303	$ 31,311
Income tax expense	30,163	24,009	21,711	17,245	12,837
Net income	$ 45,121	$ 37,151	$ 33,084	$ 26,058	$ 18,474
Basic income per share: [2]	$ 1.29	$ 1.08	$ 1.00	$ 0.81	$ 0.60
Diluted income per share: [2]	$ 1.22	$ 1.02	$ 0.93	$ 0.75	$ 0.56
Weighted average common shares and equivalents: [2]					
Basic	35,049	34,348	33,241	32,264	31,048
Diluted	37,002	36,379	35,691	34,632	33,010
Balance Sheet Data: [1]					
Cash and cash equivalents	$ 47,655	$ 154,792	$ 63,467	$ 45,147	$ 35,956
Working capital	10,792	124,469	70,644	55,462	47,047
Total assets	828,845	382,386	270,954	253,449	140,013
Long-term debt	297,059	236	416	36,562	109
Other long-term liabilities	14,388	10,853	9,055	7,694	4,662
Stockholders' equity	362,750	274,873	206,930	155,435	112,431
Other Operating Data:					
Billed lives [3]	27,446	2,426	1,883	1,335	852
Annualized revenue in backlog	$ 39,900	$ 6,625	$ 32,578	$ 15,200	$ 12,200

[1] Certain items in prior periods have been reclassified to conform to current classifications.
[2] Restated to reflect the effect of the December 2003 two-for-one stock split.
[3] Restated to include the Company's hospital-based diabetes patients.
[4] Includes operating results, balance sheet data, and other operating data of StatusOne Health Systems, LLC since the date of the acquisition, which was S

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(5) Includes $21.0 million in fiscal 2007 and $15.3 million in fiscal 2006 of costs related to equity-based awards expensed under Statement of Financial Ac
(6) Includes operating results, balance sheet data, and other operating data of Axia Health Management, Inc. ("Axia") since the date of the acquisition, whic

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

Overview

Founded in 1981, Healthways, Inc. (the "Company") provides specialized, comprehensive Health and Care Support℠ solutions to help people maintain or improve their health and, as a result, reduce overall healthcare costs.

Designed to provide highly specific and personalized interventions for each individual in a population, irrespective of health status, age, or payor, Healthways' evidence-based services are made available to consumers by phone, mail, internet, and face-to-face interactions. To expand our Health Support offerings, on December 1, 2006 we acquired Axia Health Management, Inc. ("Axia"), a national provider of preventive health and wellness programs, for approximately $467.0 million in cash.

We deliver our programs to customers, which include health plans, governments, employers, and hospitals, in all 50 states, the District of Columbia, Puerto Rico, and Guam. These services include:

- fostering wellness and disease prevention through total population screening, health risk assessments, and supportive interventions;
- providing access to health improvement programs such as fitness, weight management, complementary and alternative medicine and smoking cessation;
- promoting the reduction of lifestyle behaviors that lead to poor health or chronic conditions;
- providing educational materials and personal interactions with highly trained nurses and other healthcare professionals that are designed to create and sustain healthier behaviors to members with chronic conditions;
- incorporating current 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; and
- coordinating members' care with local healthcare providers.

Our programs focus on prevention, education, physical fitness, health coaching, behavior change and evidence-based medicine to drive adherence to proven standards of care, medications and physicians' plans of care. The programs are designed to support better health and assist in providing more effective care, which we believe will optimize the health status of member populations and reduce both the short-term and long-term healthcare costs for members.

Health and Care Support services enable health plans and employers to reach and engage everyone in their covered populations through interventions that are both sensitive to and specific to each individual's health risks and needs. Health Support products are designed to motivate people to make positive lifestyle changes and accomplish individual goals, such as becoming more physically active through the Healthways SilverSneakers® Fitness Program, staying fit using on-line tools and a vast network of fitness centers, and quitting smoking through an on-line smoking cessation community, QuitNet®. The Care Support product line includes programs for people with chronic diseases or conditions, including diabetes, coronary artery disease, heart failure, asthma, chronic obstructive pulmonary disease, end-stage renal disease, cancer, chronic kidney disease, depression, high-risk obesity, metabolic syndrome, acid-related stomach disorders, atrial fibrillation, decubitus ulcer, fibromyalgia, hepatitis C, inflammatory bowel disease, irritable bowel syndrome, low-back pain, osteoarthritis, osteoporosis, and urinary incontinence. We also provide high-risk care management through our StatusOne® product for members at risk for hospitalization due to complex conditions. We believe that creating real and sustainable behavior change generates measurable long-term cost savings.

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Predicated on the fundamental belief that healthier people cost less, Healthways' programs are designed to help keep healthy individuals healthy, mitigate and delay the progression to disease associated with family or lifestyle risk factors, and promote the best possible health for those who are already affected by disease. At the same time, we recognize that each individual plays a variety of roles in his or her pursuit of health, often simultaneously. By providing the full spectrum of Health and Care Support services to meet each individual's needs, we believe that our interventions can be delivered both at scale and in a manner that reflects the unique needs of each consumer over time. Further, Healthways' extensive and fully accredited complementary and alternative provider network offers convenient access to the significant number of individuals who seek health services outside of the traditional healthcare system.

We continue to see increasing demand for our Health and Care Support services from self-insured employer accounts, most of which are contracted through the Administrative Services Only (ASO) line of business with our health plan customers and for which our health plan customers do not assume medical cost risk but provide primarily administrative claim and health network access services. Signed contracts between these self-insured employers and our health plan customers are incorporated in our contracts with our health plan customers, and these program-eligible members are included in available and billed lives or annualized revenue in backlog, as appropriate.

Highlights of Fiscal 2007 Performance

- On December 1, 2006 we acquired Axia, a national provider of preventive health and wellness programs, to expand our Health Support offerings.
- Revenues increased 49.3% over fiscal 2006.
- Net income increased 21.5% over fiscal 2006.
- Available lives and billed lives increased to 188.5 million and 27.4 million, respectively, at August 31, 2007 compared to 76.9 million and 2.4 million, respectively, at August 31, 2006.

Recent Developments

In August 2007, we signed our first international contract with a statutory health insurance company in Germany to provide Health and Care Support solutions for a portion of its members with chronic diseases.

Forward-Looking Statements

Management's Discussion and Analysis of Financial Condition and Results of Operation contains forward-looking statements, which are based upon current expectations and involve a number of risks and uncertainties. Forward-looking statements include all statements that do not relate solely to historical or current facts, and can be identified by the use of words like "may," "believe," "will," "expect," "project," "estimate," "anticipate," "p "continue." In order for us to use the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995, we caution you that the following important factors, among others, may affect these forward-looking statements. Consequently, actual operations and results may differ materially from those expressed in the forward-looking statements. The important factors include but are not limited to:

- our ability to sign and implement new contracts for Health and Care Support services;
- our ability to accurately forecast performance and the timing of revenue recognition under the terms of our contracts and/or our cooperative agreement with the Centers for Medicare & Medicaid Services ("CMS") ahead of data collection and reconciliation in order

to provide forward-looking guidance;

- the effect of any new or proposed legislation, regulations and interpretations relating to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, including the potential expansion to Phase II for Medicare Health Support ("MHS") programs;

- our ability to effect the financial, clinical, and satisfaction outcomes under our cooperative agreement with CMS and reach mutual agreement with CMS with respect to results necessary to achieve success under Phase I of the MHS pilots;
- our ability to anticipate the rate of market acceptance of Health and Care Support solutions;
- the impact of individual market dynamics in potential international markets on our ability to sign an international contract within the timeframes contemplated by us and our ability to accurately forecast the costs necessary to implement our strategy of establishing a presence in these markets;
- the risks associated with foreign currency exchange rate fluctuations and our ability to hedge against such fluctuations;
- the potential adverse effects of additional regulatory requirements imposed by foreign governments and other regulatory bodies;
- our ability to effectively manage any growth that we might experience;
- our ability to retain existing health plan customers if they decide to take programs in-house or are acquired by other health plans which already have or are not interested in Health and Care Support programs;
- the risks associated with a significant concentration of our revenues with a limited number of customers;
- our ability to effect cost savings and clinical outcomes improvements under Health and Care Support contracts and reach mutual agreement with customers with respect to cost savings, or to effect such savings and improvements within the time frames contemplated by us;
- our ability to collect contractually earned performance incentive bonuses;
- 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;
- increased leverage incurred in conjunction with the acquisition of Axia and our ability to service our debt and make principal and interest payments as those payments become due;
- our ability to integrate the operations of Axia and other acquired businesses or technologies into our business and to achieve the results provided in our guidance with respect to Axia;
- our ability to develop new products and deliver outcomes on those products, including those anticipated from our strategic relationship with Medco, Inc.;
- our ability to effectively integrate new technologies and approaches, such as those encompassed in our Health and Care Support initiatives or otherwise licensed or acquired by us, into our Health and Care Support platform;
- 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 implement our Health and Care Support strategy within expected cost estimates;
- our ability to obtain adequate financing to provide the capital that may be necessary to support the growth of our operations and to support or guarantee our performance under new contracts;
- unusual and unforeseen patterns of health care utilization by individuals with diabetes, cardiac, respiratory and/or other 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;
- our ability to attract and/or retain and effectively manage the employees required to implement our agreements;
- the impact of litigation involving us and/or our subsidiaries;
- the impact of future state and federal health care and other applicable legislation and regulations 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 and the continuing threat of domestic or international terrorism;
- general worldwide and domestic economic conditions and stock market volatility; and

- other risks detailed in this Annual Report on Form 10-K, including those risk factors set forth in Item 1A of Part I.

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

Critical Accounting Policies

We describe our accounting policies in Note 1 of the Notes to the Consolidated Financial Statements. We prepare the consolidated financial statements in conformity with U.S. generally accepted accounting principles, which require 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 generally determine our contract fees by multiplying a contractually negotiated rate per member per month ("PMPM") by the number of members covered by our services during the month. We typically set the 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 some contracts, the PMPM rates may differ between a customer's lines of business (e.g., PPO, HMO, Medicare Advantage). In addition, some of our services are billed on a fee for service basis.

Some of our contracts provide that a portion (up to 100%) of our fees may be refundable to the customer ("performance-based") if our programs do not achieve, when compared to a baseline year, a targeted percentage reduction in the customer's healthcare costs and selected clinical and/or other criteria that focus on improving the health of the members. Approximately 4% of revenues recorded during fiscal 2007 were performance-based and were subject to final reconciliation as of August 31, 2007. We anticipate that this percentage will fluctuate due to the level of performance-based fees in new contracts, revenue recognition associated with performance-based fees, and the timing of data reconciliation, which varies according to contract terms. A limited number of contracts also provide opportunities for us to receive incentive bonuses in excess of the contractual PMPM rate if we exceed contractual performance targets.

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. Deferred revenues can arise from contracts which permit upfront billing and collection of fees covering the entire contractual service period, generally 12 months. Contractually, we cannot bill for any incentive bonus until after contract settlement. Fees for service are typically billed in the month after the services are provided.

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; 2) we recognize the performance-based portion of the monthly fees 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; and

3) we recognize additional incentive bonuses based on the most recent assessment of our performance, to the extent we consider such amounts collectible.

We assess our level of performance for our contracts based on medical claims and other data that the customer is contractually required to supply. A minimum of four to six 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 and a medical cost trend compared to a baseline year. In addition, we may also provide contractual reserves, when appropriate, for billing adjustments at contract reconciliation.

Substantially all of the fees under the MHS pilots in which we are participating are performance-based. The pilots require that, by the end of the third year