HEALTHWAYS, INC
Form 10-K
March 15, 2011

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, 2010

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

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 Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

Yes ¨ 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, 2010, 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 $396.1 million based on the price at which the shares were last sold for such date on The NASDAQ Stock Market.

As of March 8, 2011, 34,032,985 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 May 26, 2011 are incorporated by reference into Part III of this Form 10-K.

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PART I.

Item 1. Business

Founded in 1981, Healthways, Inc. provides specialized, comprehensive solutions to help people improve physical, emotional and social well-being, reducing both direct healthcare costs and associated costs from the loss of employee productivity.

We provide highly specific and personalized interventions for each individual in a population, irrespective of health status, age or payor. Our evidence-based health, prevention and well-being services are made available to consumers via phone, mobile devices, direct mail, the Internet, face-to-face consultations and venue-based interactions.

In North America, our customers include health plans, governments, employers, pharmacy benefit managers, and hospitals in all 50 states, the District of Columbia and Puerto Rico. We also provide health improvement programs and services in Brazil and Australia. We operate care enhancement and coaching centers worldwide staffed with licensed health professionals. Our fitness center network encompasses approximately 15,000 U.S. locations. We also maintain an extensive network of over 39,000 complementary and alternative medicine and chiropractic 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 is 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 well-being by helping people to adopt or maintain healthy behaviors, reduce health-related risk factors, and optimize 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
- providing access to health improvement programs, such as fitness, weight management, and complementary and alternative medicine.

Our prevention programs focus on education, physical fitness, health coaching, and behavior change techniques and support. We believe this approach improves the well-being status of member populations and reduces the short- and long-term direct healthcare costs for participants, including associated costs from the loss of employee productivity.

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

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

We enable our customers to engage everyone in their covered populations through specific interventions that are sensitive to each individual's health risks and needs. 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 program or overcoming nicotine addiction through the QuitNet® on-line smoking cessation community.

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 with their healthcare providers;
- providing software licensing 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.

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 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 creating real and sustainable behavior change generates measurable, long-term cost savings and improved individual and business performance.

Change in Fiscal Year

In August 2008, our Board of Directors approved a change in our fiscal year-end from August 31 to December 31. Accordingly, our 2009 fiscal year began on January 1, 2009 following a four-month transition period ended December 31, 2008. References herein to fiscal 2009 refer to the year ended December 31, 2009; references herein to fiscal 2008 refer to the year ended August 31, 2008.

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 addition, some of our services, such as the SilverSneakers® fitness program, include fees that are based upon member participation.

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

Some of our contracts provide that a portion 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 3% of revenues recorded during 2010 were performance-based and were subject to final reconciliation as of December 31, 2010. We anticipate that this percentage will fluctuate due to the level of performance-based fees in new contracts and the timing and amount of revenue recognition associated with performance-based fees. Some contracts also provide for additional fees for incentive bonuses in excess of the contractual PMPM rate if we meet or exceed contractual performance targets.

Technology

Our solutions require sophisticated analytical, data management, Internet and computer-telephony solutions 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 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. We use sophisticated data analytical and reporting solutions 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 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 messaging using any method desired, including venue-based face-to-face; print; phone; mobile and remote devices; on-line; emerging modalities; and any combination thereof to motivate and sustain healthy behaviors.

Backlog

Backlog represents the estimated annualized revenue at target performance for business awarded but not yet started at December 31, 2010. Annualized revenue in backlog as of December 31, 2010 and 2009 was as follows:

(In 000s)	December 31, 2010	December 31, 2009
Annualized revenue in backlog	$ 37,100	$ 32,400

Demand for our services from self-insured employer accounts, which generally begin their benefit year on January 1, has often resulted in a disproportionate amount of our new business beginning on this date.

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 health and well-being, and as a result, reduce overall healthcare costs and improve workforce engagement, yielding better business performance for our customers. Our programs 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.

Through our solutions, we work to optimize the health and well-being of entire populations, one

person at a time, domestically and internationally, thereby creating value by reducing overall healthcare costs and improving productivity for individuals, families, health plans, governments, employers and communities.

We believe it is critical to impact an entire population's underlying health status and well-being in a long-term, cost effective way. Believing that what gets measured gets acted upon, in January 2008, we entered into an exclusive, 25-year relationship with Gallup to provide a national, daily pulse of individual and collective well-being. The Gallup-Healthways Well-Being IndexTM is the result of a unique partnership in well-being measurement and research that is based on surveys of 1,000 Americans every day, seven days a week. Under the agreement, Gallup evaluates and reports on the well-being of individuals of countries, states and communities; Healthways provides similar services for companies, families and individuals.

To enhance health and 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 health status and well-being regardless of their starting point. We believe we can achieve health and well-being improvements in a population and generate significant cost savings and increases in productivity by providing effective programs that support the individual throughout his or her health journey.

We are adding and enhancing solutions to extend our reach and effectiveness and to meet increasing demand for integrated solutions. The flexibility of our programs allows customers to provide those 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 includes as a priority the ongoing expansion of our value proposition through the introduction of our total population management solution. This solution, in addition to improving individuals' health and reducing direct healthcare costs, targets a much larger improvement in employer profitability by reducing the impact of lost productivity for health-related reasons. With the success of our total population management solution, we expect to gain an even greater competitive advantage in responding to employers' needs for a healthier, higher-performing and less costly workforce.

Our strategy also includes the further enhancement and deployment of our proprietary next generation 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 any method desired, including venue-based face-to-face; print; phone; mobile and remote devices; on-line; emerging modalities; and any combination thereof.

We plan to increase our competitive advantage in delivering our services by leveraging our scalable, state-of-the-art call centers, medical information content, behavior change processes and techniques, strategic relationships, health provider networks, fitness center relationships, and proprietary technologies and techniques. We may add new capabilities and technologies through internal development, strategic alliances with other entities and/or through selective acquisitions or investments.

We anticipate continuing to enhance, expand and integrate additional capabilities with health plans and to pursue opportunities with domestic government entities and communities as well as the public and private sectors of healthcare in international markets. In addition, the significant changes in government regulation of healthcare (see "Industry Integration and Consolidation" and "Government Regulation" below) may afford us expanded opportunities to provide services to health plans and employers as well as collaborate with and/or directly provide solutions to

integrated medical systems and provider groups in the post healthcare

reform marketplace.

Segment and Major Customer Information

We have one reportable segment, well-being improvement services. During 2010, CIGNA HealthCare, Inc. comprised approximately 19% of our revenues. No other customer accounted for 10% or more of our revenues in 2010.

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 well-being improvement services 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, health and wellness companies, retail drug stores, major pharmaceutical companies, health plans, healthcare organizations, providers, pharmacy benefit management companies, medical device and diagnostic companies, healthcare information technology companies, web-based medical content companies, and other entities that provide services to health plans, 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 call center technology linked to our 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.

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 or employer customers if they are acquired by other health plans or employers which already have, or are not interested in, our programs.

In March 2010, President Obama signed the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, “PPACA”), into law. Among other things, PPACA requires 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”) beginning no later than January 1, 2012. The program will allow 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. Further, PPACA requires HHS to establish voluntary national bundled payment programs under which participating groups of providers would 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.

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Governmental Regulation

Governmental regulation impacts us in a number of ways in addition to those regulatory risks presented under the "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, as enacted, seeks to decrease the number of uninsured individuals and expand coverage through the expansion of public programs and private sector health insurance in addition to a number of health insurance market reforms. In addition, PPACA contains several provisions that encourage utilization of preventative services and wellness programs, such as those provided by the Company. However, PPACA also contains various provisions that directly affect the customers or prospective customers that contract for our services and may increase their costs and/or reduce their revenues. For example, as enacted, 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 coverage and 85% for large group coverage and Medicare Advantage plans, with policyholders receiving rebates if the actual loss ratios fall below these minimums. We anticipate that a substantial majority of our services will qualify as medical expenses; however, regulations implementing MLR requirements have yet to be finalized.

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, pending court challenges, and possible amendment. Implementation of PPACA, particularly those provisions expanding health insurance coverage, could be delayed or even blocked due to court challenges and efforts to repeal or amend the law. Some federal district courts have upheld the constitutionality of PPACA or dismissed cases on procedural grounds. Others have found unconstitutional the requirement that individuals maintain health insurance or pay a penalty and have either declared PPACA void in its entirety or left the remainder of the law intact. These lawsuits are subject to appeal, and it is unclear how federal lawsuits challenging the constitutionality of PPACA will be resolved or what the effect will be on any resulting changes to the law.

Changes in laws governing reimbursement to health plans providing services under governmental programs such as Medicare and Medicaid may affect us. As enacted, 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 the Centers for Medicare & Medicaid Services ("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 the Company's business is not yet clear.

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 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 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. We are required to comply with certain aspects of the HIPAA privacy and security regulations as a result of the American Recovery and Reinvestment Act of 2009 ("ARRA"), the services we provide, and our customer contracts. We may be subject to civil and criminal penalties for violations of the regulations. 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 protected health information, we are subject to contractual obligations and state and federal requirements that may require us to notify our customers or individuals affected by the breach. These requirements may also require us or our customers to notify regulatory agencies and the media of the data breach.

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. Liability under the False Claims Act 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. 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 "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 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, 2011, we had approximately 2,800 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 Securities and Exchange Commission.

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 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 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 wellness and disease prevention and provide access to 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 on 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.

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

Because of the size of its membership and the breadth of the services purchased from us, CIGNA HealthCare, Inc. comprised approximately 19% of our revenues in 2010. Our contract with CIGNA continues into 2013. The loss of, or the restructuring of a contract with, this or other large customers could have a material adverse effect on our business and results of operations. No other customer accounted for 10% or more of our revenues in 2010.

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 to adopt or maintain healthy behaviors, reducing health-related risk factors, and optimizing care for identified health conditions. While we have considerable experience in 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 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, 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 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.

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 financial savings, clinical performance targets, and productivity improvements under our existing contracts and to favorably resolve contract billing and interpretation issues with our customers. Certain customer contracts provide that a portion of our fees may be refundable to the customer if our programs do not achieve targeted savings performance. There is no guarantee that we will achieve 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. 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 financial 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 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 disbursed. 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 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 ability to recognize estimated annualized revenue in backlog is based on certain estimates.

Our ability to recognize 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 have reduced the demand and/or the timing of purchases for certain of our services from customers and potential customers. A loss of a 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, current 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 expansion of our services into international markets subjects us to additional business, regulatory and financial risks.

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 relatively immature 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 time frames contemplated 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 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