Emdeon Inc.
Form 10-K
March 18, 2013
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2012

or

¨ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from _____ to _____

Commission file number 333-182786

EMDEON INC.

(Exact Name of Registrant as Specified in its Charter)

Delaware	20-5799664
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
3055 Lebanon Pike, Suite 1000	
Nashville, TN	37214
(Address of Principal Executive Offices)	(Zip Code)

(615) 932-3000

(Registrant s Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act: None

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 Section 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 x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. 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. (Check one):

Large accelerated filer ¨	Accelerated filer ¨
Non-accelerated filer x (Do not check if a smaller reporting company)	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 December 31, 2012, there were issued and outstanding 100 shares of common stock, par value $.01 per share. The registrant is a wholly owned subsidiary of Beagle Intermediate Holdings, Inc., which is a wholly owned subsidiary or Beagle Parent Corp.

DOCUMENTS INCORPORATED BY REFERENCE

None.

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EMDEON INC.

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CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K (the Annual Report) of Emdeon Inc. (the Company) includes certain forward-looking statements within the meaning of the federal securities laws regarding, among other things, our or our management s intentions, plans, beliefs, expectations or predictions of future events. These statements often include words such as may, will, should, believe, expect, anticipate, intend, plan, similar expressions. Forward-looking statements also may include information concerning our possible or assumed future results of operations, including descriptions of our revenues, profitability and outlook and our overall business strategy. These statements are subject to numerous uncertainties and factors relating to our operations and business environment, all of which are difficult to predict and many of which are beyond our control. Although we believe that these forward-looking statements are based on reasonable assumptions, readers should be aware that many factors could affect our actual financial results or results of operations and could cause actual results to differ materially from those in the forward-looking statements.

Other factors that may cause actual results to differ materially include those set forth in the risks discussed in Part I, Item 1A, Risk Factors, and Part II, Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations of this Annual Report.

All forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the foregoing cautionary statements. Readers should keep in mind that any forward-looking statement made by us in this Annual Report, or elsewhere, speaks only as of the date on which made. We caution against any undue reliance on these statements and expressly disclaim any intent, obligation or undertaking to update or revise any forward-looking statements made herein to reflect any change in our expectations with regard thereto or any change in events, conditions or circumstances on which any such statements are based.

Unless stated otherwise or the context otherwise requires, references in this Annual Report to we, us, our, Emdeon and the Company refer to Emdeon Inc. and its subsidiaries.

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PART I

ITEM 1. ***BUSINESS***

Overview

We are a leading provider of revenue and payment cycle management and clinical information exchange solutions connecting payers, providers and patients in the United States healthcare system. Our solutions integrate and automate key business and administrative functions of our payer and provider customers throughout the patient encounter. These solutions include pre-care patient eligibility and benefits verification and enrollment, clinical information exchange, claims management and adjudication, payment integrity, payment distribution, payment posting, denial management and patient billing and payment processing.

Through the use of our comprehensive suite of solutions, customers are able to improve efficiency, reduce costs, increase cash flow and more efficiently manage the complex revenue and payment cycle and clinical information exchange processes. Our solutions are delivered primarily through recurring, transaction-based processes that are designed to leverage our health information network, the single largest financial and administrative information exchange in the United States healthcare system. Our health information network currently reaches approximately 1,200 payers, 500,000 providers, 5,000 hospitals, 81,000 dentists, 60,000 pharmacies and 300 labs.

In 2012, we processed a total of approximately 7 billion healthcare-related transactions, including approximately one out of every two commercial healthcare claims delivered electronically in the United States. We have developed our network of payers and providers over 30 years and connect to virtually all private and government payers, claim-submitting providers and pharmacies. Our network and related solutions are designed to integrate with our customers existing technology infrastructures and administrative workflow and typically require minimal capital expenditure on the part of the customer, while generating significant savings and operating efficiencies.

Organizational Structure and Corporate History

The Company is a Delaware corporation.

On November 2, 2011, pursuant to the Agreement and Plan of Merger (the Merger Agreement) among Emdeon, Beagle Parent Corp. (Parent) and Beagle Acquisition Corp. (Merger Sub), Merger Sub merged with and into Emdeon, with Emdeon surviving the merger (the Merger). Subsequent to the Merger, we became an indirect wholly owned subsidiary of Parent, which is controlled by The Blackstone Group L.P. (Blackstone), Hellman & Friedman LLC (Hellman & Friedman) and certain investment funds affiliated with Blackstone and Hellman & Friedman (collectively, the Investor Group). The Merger was financed through a combination of cash and the incurrence of indebtedness, including a $1.224 billion senior secured term loan credit facility (the Term Loan Facility) and a $125.0 million senior secured revolving credit facility (the Revolving Facility ; and collectively with the Term Loan Facility, the Senior Credit Facilities), as well as $375.0 million in 11% senior notes due 2019 (the 2019 Notes) and $375.0 million in 11.25% senior notes due 2020 (the 2020 Notes , and collectively with the 2019 Notes, the Senior Notes). The preceding financing transactions, together with the Merger, are sometimes referred to as the 2011 Transactions .

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In July 2012, we filed a Registration Statement on Form S-4, as amended (File No. 333-182786) with the Securities and Exchange Commission (the SEC) related to an exchange offer of then outstanding unregistered Senior Notes for substantially identical Senior Notes that are freely tradable. The exchange offer expired on October 22, 2012, and following such expiration all of the unregistered Senior Notes were exchanged for registered Senior Notes.

Our Solutions

During 2012, we delivered our solutions and operated our business in three segments: (i) payer services, which provides solutions to commercial insurance companies, third party administrators and governmental payers; (ii) provider services, which provides solutions to hospitals, physicians, dentists and other healthcare providers, such as labs and home healthcare providers; and (iii) pharmacy services, which provides solutions to pharmacies, pharmacy benefit management companies and other payers. The selected financial information for each operating segment is provided in Note 20 in the accompanying Notes to Consolidated Financial Statements contained in Part IV, Item 15, beginning on Page F-1 of this Annual Report.

Through the payer services segment, we provide payment cycle solutions, both directly and through our network of channel partners, that help simplify the administration of healthcare. Our payer services offerings include insurance eligibility and benefits verification, claims management, payment integrity and claims and payment distribution. Additionally, we provide consulting services through the payer services segment.

Through the provider services segment, we provide revenue cycle and clinical information exchange solutions, both directly and through our network of channel partners, that help simplify providers workflow, reduce related costs and improve cash flows. Our provider services offerings include revenue cycle management solutions, patient billing and payment services, government program eligibility and enrollment services and clinical information exchange capabilities.

Through the pharmacy services segment, we provide electronic prescribing and other electronic solutions to pharmacies, pharmacy benefit management companies and government agencies related to prescription benefit claim filing, adjudication and management.

We have reorganized our reportable segments as payer services, revenue cycle solutions, ambulatory services and pharmacy services effective January 1, 2013.

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Payer Services Solutions

Pre-Care and Claims Management

Our pre-care solutions interface with the payer s systems, allowing providers to process insurance eligibility and benefits verification tasks prior to the delivery of care without the need for live payer/provider interaction. Our claims management solutions include electronic data interchange (EDI), paper-to-EDI conversion of insurance claims through high-volume imaging, batch and real-time healthcare transaction information exchanges and intelligent routing between payers and other business partners. We also perform payer-specific edits of claims for proper format, including standards in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), before submission to minimize manual processes associated with pending claims. Our healthcare payment integrity and fraud, waste and abuse management services combine sophisticated data analytics solutions and technology with an experienced team of investigators to help identify potential financial risks earlier in the revenue and payment cycle, prevent payment of fraudulent and improper claims and identify overpayments, creating efficiencies and cost savings for payers.

Payment Distribution

Our payment and remittance distribution solutions facilitate the paper and electronic distribution of payments and payment related information by payers to providers, including explanation of benefits (EOB) to patients. Because of the breadth and scale of our connectivity to both payers and providers, payer customers can realize significant print and operational cost savings through the use of either electronic payment and remittance solutions or high-volume co-operative print and mail solutions to reduce postage and material costs. In addition, we offer electronic solutions that integrate with our print and mail platform to facilitate the conversion to electronic payment and remittance. We expect to see further transition from paper based processes to electronic processes over time because of the substantial cost savings available to payers by adopting electronic payment, remittance advice and EOB distribution.

Consulting Services

Our consulting services solutions assist healthcare clients analyze, develop and implement business and technology strategies designed to align with healthcare trends and overall business goals. Our consultants combine extensive health industry knowledge with practical experience that can help solve many industry challenges, such as limited time and resources, disparate and out-of-date systems, antiquated processes and diverse perspectives, to assist clients with analysis, selection, procurement and implementation services in deploying healthcare information technology solutions quickly and cost-effectively.

Provider Services Solutions

Pre-Care/Medical Treatment

Our patient eligibility and verification solutions, including automated referral approval applications, assist our provider customers in determining a patient s current health benefits levels. Our eligibility and verification offerings also integrate other information to help determine a patient s ability to pay, as well as the likelihood of public assistance and charity care reimbursement. These solutions help mitigate a provider s exposure to bad debt expense by providing clarity into a patient s insurance coverage, ultimate out-of-pocket responsibility and ability to pay.

We also offer technology-enabled government program eligibility and enrollment services to uninsured and underinsured populations to assist our provider customers in lowering their incidence of uncompensated care and bad-debt expense and increasing overall cash flow.

As part of the medical treatment process, providers use our clinical information exchange capabilities to order and access lab reports and for electronic prescribing.

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Claims Management

Our claims management solutions can be delivered to a provider via our web-based direct solutions or through our network of channel partners. In either case, our claims management solutions leverage our industry leading payer connectivity to deliver consistent and reliable access to virtually every payer in the United States. Our solutions streamline reimbursement by providing (i) tools to improve provider workflow, edit claims prior to submission and identify errors that delay reimbursement and (ii) robust reporting to providers in order to track claims throughout their life-cycle and reduce claim rejections and denials.

Payment Posting/Denial Management

Our payment automation solutions allow providers to manage and automate the entire payment process. On behalf of our provider customers, we can accept paper payments from both third party payers and patients and convert them into automated workflows which can be reconciled and posted. Our web-based solutions allow providers to analyze remittance advice or payment data and reconcile it with the originally submitted claim to determine whether proper reimbursement has been received. These solutions also (i) allow providers to identify underpayments, efficiently appeal denials and resubmit claims in a timely manner, (ii) provide insight into patterns of denials and (iii) enable the establishment of procedures that can reduce the number of inaccurate claims submitted in the future. Our payment posting solution automates the labor intensive, paper-based payment reconciliation and manual posting process, which we believe saves providers time and improves accuracy.

We also provide technology solutions and professional services that enable providers to transform previously written-off government and commercial payer underpayments into realized revenue. Our provider payment integrity services not only help to identify the root cause, but also help to collect and prevent underpayments from happening with audit and recovery services, accounts receivable management, denial and appeals services and performance improvement and prevention.

Patient Billing and Payment

Our patient billing and payment solutions provide an efficient means for providers to bill their patients for outstanding balances due, including outsourced print and mail services for patient statements and other communications, as well as email updates to patients and online bill presentment and payment functionality. We believe our solutions are more timely, cost-effective and consistent than in-house print and mail operations and improve patient collections. Our patient payment lockbox allows providers to efficiently process patients paper payments, reconcile them to the original bill and automatically post these payments. Our eCashiering and merchant services solutions allow providers to collect payments from patients at the point-of-service or online.

Pharmacy Services Solutions

Prescription Benefits Administration (Payers)

Our prescription solutions provide claims processing and other administrative services for pharmacy payers that are conducted online, in real-time, according to client benefit plan designs and present a cost-effective alternative to an in-house pharmacy claims adjudication system. These offerings also allow payers to directly manage more of their pharmacy benefits and include pharmacy claims adjudication, network and payer administration, client call center service and support, reporting, rebate management, as well as implementation, training and account management.

Claims Management and Adjudication (Providers)

Our pharmacy claims, revenue management and electronic prescribing solutions provide pharmacies and providers with integrated tools for managing efficiency and profitability through claims management, business intelligence and network infrastructure. We believe our pharmacy provider solutions improve pharmacy workflow and customer service, increase operational efficiency and patient safety, and help build pharmacy revenue and customer loyalty.

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Payment Posting and Denial Management (Providers)

Our payment posting and denial management solutions offer pharmacies efficient ways to monitor and track remittance and third party payment information, as well as Medicaid and Medicare claim denials, which we believe allows our pharmacy customers to improve their collections.

Customers

We generally provide solutions to our payer, provider and pharmacy customers on either a per transaction, per document, per communication, or per member per month, monthly flat-fee, contingent fee or hourly basis. Our contracts with our payer, provider and pharmacy customers are generally one to three years in term and automatically renew for successive annual terms unless terminated. We also have entered into exclusive or other comprehensive management services agreements with more than 450 of our payer customers under which we provide exclusive or other comprehensive services for certain eligibility and benefits verification and/or claims management services. These comprehensive management services agreements generally have terms of three years and renew automatically for successive annual terms unless terminated.

Payer Services

The payer market is comprised of more than 1,200 payers across four main payer types: Medicare/Medicaid, Blue Cross Blue Shield, fiscal intermediaries and private insurance companies. We are directly connected and provide services to virtually all payers offering electronic transaction connectivity services. We also serve the payer market with payment and remittance distribution, payment integrity and consulting services solutions. For the year ended December 31, 2012, our top ten payer customers represented approximately 13% of our total revenues and no payer customer accounted for more than 3% of our total revenues.

Provider Services

The provider market is comprised of hospitals, physicians, dentists and other healthcare providers, such as lab and home healthcare providers. We currently have contractual or submitter relationships, directly or through channel partners, with approximately 340,000 physicians, 2,700 hospitals, 81,000 dentists and 300 labs. For the year ended December 31, 2012, our top ten provider customers represented approximately 9% of our total revenues and no provider customer accounted for more than 3% of our total revenues.

Pharmacy Services

The pharmacy market is comprised of more than 60,000 chains and independent pharmacies, as well as prescription benefits solutions marketed directly to payers. We are connected and provide services to virtually all pharmacies utilizing electronic transaction connectivity services. For the year ended December 31, 2012, no pharmacy services customer accounted for more than 2% of our total revenues.

Marketing and Sales

Marketing activities for our payer, provider and pharmacy services solutions include direct sales, targeted direct marketing, advertising, tradeshow exhibits and events, customer workshops, web-based marketing activities, e-newsletters and conference sponsorships. We have a dedicated sales force that supports each of our payer, provider and pharmacy services segments. We also deliver certain of our solutions through over 600 channel partner relationships. Our channel partners include physician and dental practice management system and electronic medical record vendors, hospital information system vendors, pharmacy system vendors and other vendors that provide software and services to providers and payers. We integrate our solutions into these channel partners software solutions for distribution to their provider customers.

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Our Technology

Our technology platforms employ a standard enterprise services bus in a service-oriented architecture, configured for 24/7 operations. We maintain two secure, interconnected, environmentally-controlled primary data centers, one in Nashville, Tennessee and one in Memphis, Tennessee, each with emergency power generation capabilities. We also operate several satellite data centers that we plan to consolidate over time to our two primary data centers. Our software development life cycle methodology requires that all applications are able to run in both of our primary data centers. We use a variety of proprietary and licensed standards-based technologies to implement our platforms, including those which provide for orchestration, interoperability and process control. The platforms also integrate a data infrastructure to support both transaction processing and data warehousing for operational support and data analytics.

Our Industry

Healthcare expenditures are a significant component of the United States economy, representing approximately $2.6 trillion in 2010, or 17.9% of GDP, and are expected to grow at 5.8% per year to $4.6 trillion, or approximately 19.9% of GDP, in 2020. The cost of healthcare administration in the United States is approximately $360 billion per year, or 14% of total healthcare expenditures, and approximately one half of these costs was spent by payers and providers on billing and insurance-related activities. In addition, industry estimates indicate that between $68 billion and $226 billion in healthcare costs are attributable to fraud, waste and abuse each year. The growing need to slow the rise in healthcare expenditures, particularly during the recent period of United States economic weakness, increased financial pressures on payers and providers and public policy initiatives to reduce healthcare administrative inefficiencies should accelerate demand for solutions that simplify the business of healthcare.

Payer and Provider Landscape

Healthcare is generally provided through a fragmented industry of providers that have, in many cases, historically underinvested in administrative and clinical information systems. Within this universe of providers, there are currently over 5,700 hospitals and over 560,000 office-based doctors. Approximately 73% of the office-based doctors are in small physician practices consisting of six or fewer physicians and have fewer resources to devote to administrative and financial matters compared to larger practices. In addition, providers may maintain relationships with 50 or more individual payers, many of which have customized claim requirements and reimbursement procedures. The administrative portion of healthcare costs for providers is expected to continue to expand due in part to the increasing complexity in the reimbursement process and the greater administrative burdens being placed on providers for reporting and documentation relating to the care they provide. These complexities and other factors are compounded by the fact that many providers lack the technological infrastructure and human resources to bill, collect and obtain full reimbursement for their services, and instead rely on inefficient, labor-intensive processes to perform these functions. These manual and paper-based processes are more prone to human error and administrative inefficiencies, often resulting in increased costs and uncompensated care. As a result, providers are expected to continue to seek solutions that automate and simplify the administrative and clinical processes of healthcare.

Administrative burdens on providers also are being impacted by the introduction of increasingly complex rules by government payers to align payments with the appropriate care provided, including the expansion of Medicare diagnosis-related group codes and the implementation of the Recovery Audit Contractor, or RAC , program and similar pre- and post-payment review programs. These additional governmental requirements have increased administrative burdens on providers by requiring more detailed classification of patients and care provided in order to receive and retain associated Medicare and Medicaid reimbursement. Further, because we believe there is an increasing number of drug prescriptions authorized by providers and an industry-wide shortage of pharmacists, pharmacists must increasingly be able to efficiently process transactions in order to maximize their productivity and better control prescription drug costs.

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Increases in patient financial responsibility for healthcare expenses have put additional pressure on providers to collect payments from the patient at the point of care since more than half of every one percent increase in patient self-pay becomes bad debt. Several market trends have contributed to this growing bad debt problem, including the shift towards high-deductible health plans (HDHPs) and consumer-oriented plans (which grew to 13.5 million in January 2012, up from 8.0 million in January 2009 and 6.1 million in January 2008), higher deductibles and co-payments for privately insured individuals and the increasing ranks of the uninsured (48.6 million or 15.7% of the United States population in 2010). The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA), contains measures to reduce the number of uninsured individuals, but these provisions do not become effective until 2014.

Payers also are continually exploring new ways to increase administrative efficiencies to drive greater profitability and mitigate the impact of decelerating premium increases, increased governmental requirements and mandated cuts in federal funding to programs such as Medicare Advantage. Payment for healthcare services generally occurs through complex and frequently changing reimbursement mechanisms involving multiple parties. The proliferation of private-payer benefit plan designs and government mandates, such as HIPAA format and data content standards, continue to increase the complexity of the reimbursement process. For example, preferred provider organizations, health maintenance organizations, point of service plans and HDHPs now cover virtually all of employer-sponsored health insurance beneficiaries and are more complex than traditional indemnity plans, which covered 73% of healthcare beneficiaries in 1988. Despite significant consolidation among private payers in recent years, claims systems often have not been sufficiently integrated, resulting in persistently high costs associated with administering these plans.

The Revenue and Payment Cycle

The healthcare revenue and payment cycle consists of all the processes and efforts that providers undertake to ensure they are compensated properly by payers and patients for the medical services rendered to patients. For payers, the payment cycle includes all the processes necessary to facilitate provider compensation and use of medical services by members. These processes begin with the collection of relevant eligibility, financial and demographic information about the patient and co-pay amounts before care is provided and end with the collection of payment from payers and patients. Providers are required to send invoices, or claims, to a large number of different payers, including government agencies, managed care companies and private individuals in order to be reimbursed for the care they provide.

Major steps in this process include:

Pre-Care/Medical Treatment: The provider verifies insurance benefits available to the patient, ensures treatment will adhere to medical necessity guidelines and confirms patient personal financial and demographic information. For certain uninsured or underinsured populations, providers also may assist their patients with enrollment in government, charity and community benefit programs for which they may be eligible. Furthermore, in order to receive reimbursement for the care they provide, providers are often required by payers to obtain pre-authorizations before patient procedures or in advance of referring patients to specialists for care. Co-pay and other self-pay amounts are also collected. The provider then treats the patient and documents procedures conducted and resources used.

Claims Management/Adjudication: The provider prepares and submits paper or electronic claims to a payer for services rendered directly or through a clearinghouse. Before submission, claims are validated for payer-specific rules and corrected as necessary. The payer verifies accuracy, completeness and appropriateness of the claim and calculates payment based on the patient s health plan design, out of pocket payments relative to established deductibles and the existing contract between the payer and provider.

Payment Distribution: The payer sends a payment and a payment explanation (i.e., remittance advice) to the provider and sends an EOB to the patient.

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Payment Posting/Denial Management: The provider posts payments internally, reconciles payments with accounts receivable and submits any claims to secondary insurers if secondary coverage exists. The provider is responsible for evaluating denial/underpayment of a claim and re-submitting it to the payer if appropriate.

Patient Billing and Payment: The provider sends a bill to the patient for any remaining balance and posts payments received.

Competition

We compete on the basis of the size and reach of our network, our ability to offer a single-vendor solution, the breadth and functionality of solutions we offer and develop, and our pricing models. While we do not believe any single competitor offers a similarly expansive suite of solutions, our payer, provider and pharmacy services compete with:

Healthcare transaction processing companies, including those providing EDI and/or internet based services and those providing services through other means, such as paper and fax;

Healthcare information system vendors that support providers and payers and their revenue and payment cycle management and clinical information exchanges processes, including physician and dental practice management, hospital information and electronic medical record system vendors;

Large information technology and healthcare consulting service providers;

Health insurance companies, pharmacy benefit management companies, hospital management companies and pharmacies that provide or are developing electronic transaction and payment distribution services for use by providers and/or by their members and customers;

Healthcare focused print and mail vendors;

Financial institutions and payment processors that have invested in healthcare data management assets;

Government program eligibility and enrollment services companies; and

Payment integrity companies.

We also compete in some cases with alliances formed by our competitors. In addition, certain major software, hardware, information systems and business process outsourcing companies, both with and without healthcare companies as their partners, offer or have announced their intention to offer competitive products or services. Major competitors for our products and/or services include McKesson (RelayHealth) and UnitedHealth Group (OptumInsight), as well as other smaller competitors that typically compete in one or more product and/or service categories.

Recent Industry Trends and Developments

Substantially all of our business is directly or indirectly related to the healthcare industry and is affected by changes in the healthcare industry, including regulatory changes and fluctuations in healthcare spending. The healthcare industry is highly regulated at the federal and state levels and subject to changing political, legislative, regulatory and other influences. Although many regulatory and governmental requirements do not directly apply to our operations, these laws affect the business of our payer, provider and pharmacy customers and the demand for our solutions.

We also may be impacted by non-healthcare laws as a result of some of our solutions. For example, laws, regulations and industry standards regulating the banking and financial services industry may impact our operations as a result of the electronic payment and remittance services we offer directly or through third party vendors. For a discussion of the risks and uncertainties affecting our business related to compliance with federal, state and other laws and regulations, see Part I, Item 1A, Risk Factors of this Annual Report.

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PPACA

PPACA will significantly affect the regulatory environment in which we and our customers operate by changing how healthcare services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced federal healthcare program spending, increased efforts to link federal healthcare program payments to quality and efficiency and insurance market reforms. For example, PPACA will expand coverage through changes in Medicaid and private sector health insurance and other reforms, including the so-called individual mandate, under which individuals generally must obtain, and large employers generally must provide, insurance coverage or pay a penalty. In June 2012, the United States Supreme Court upheld the constitutionality of the individual mandate provisions of PPACA but struck down the provision of the law that would have allowed the United States Department of Health and Human Services (HHS) to penalize states that do not implement the Medicaid expansion provisions with the loss of existing federal Medicaid funding. States, therefore, may choose not to implement the Medicaid expansion. As a result, the full impact of PPACA is difficult to predict due to uncertainty regarding how many states will implement the Medicaid expansion, as well as the law s complexity, lack of implementing regulations or interpretive guidance, remaining or new court challenges and possible amendment or repeal.

Adoption of Healthcare Information Systems

We believe recent federal initiatives to control the rising cost of healthcare through the elimination of administrative and clinical inefficiencies will increase payer and provider adoption of healthcare information systems and increase the demand for our revenue and payment cycle and information exchange solutions. The American Recovery and Reinvestment Act of 2009 (ARRA) included approximately $19 billion in federal subsidies that began in 2011 for eligible hospitals and eligible professionals that adopt and meaningfully use certified electronic health record (EHR) technology. The meaningful use standard requires providers to successfully capture and exchange electronic clinical healthcare information, such as electronic prescriptions and lab orders. Beginning in 2015, eligible hospitals and eligible professionals who fail to attest to the meaningful use of EHR technology will face reductions in Medicare payments. In addition to initiatives supporting the meaningful use of EHR technology, federal law also provides for an electronic prescribing incentive program that uses a combination of Medicare incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals. The goal of these initiatives is, in part, to establish the capability to electronically move clinical information among disparate healthcare information systems to help improve patient outcomes.

Some industry reports estimate that the federal government will spend more than $35 billion on promoting healthcare information technology through ARRA over the next decade. In addition, the integration of EHR technology with computerized physician order entry applications, such as electronic prescribing, may promote greater use of electronic transactions. Industry estimates indicate that only approximately 36% of all prescriptions are currently transmitted electronically. As a result, we believe that increasing provider adoption of electronic prescribing will continue to make it one of the fastest growing transaction types in our industry.

Implementation of Electronic Standardized Transactions

A key component of recent healthcare reform initiatives is a focus on reducing inefficiency and increasing quality of care through administrative simplification and the adoption of electronic commerce in the healthcare industry. HIPAA and its implementing regulations mandate format, data content and provider identifier standards for certain electronic healthcare transactions, including claims, enrollment, payment and eligibility inquiries. In addition, PPACA requires the adoption of additional standardized electronic transactions and provides for the creation of operating rules to promote uniformity in the implementation of each standardized electronic transaction. Many of our solutions are designed to assist our customers in complying with these requirements.

Industry sources estimate that the implementation of electronic processing, including electronic processing of claims submissions, eligibility inquiries and requests, claims status requests, payment and remittance transactions, as well as taking other steps to streamline administrative processes, could provide approximately $40 billion annually in administrative cost savings. Payers and providers who are unable to exchange data in the required standard formats can achieve transaction standards compliance by contracting with a clearinghouse like us to translate between standard and non-standard formats. Under

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PPACA, payers and service contractors of payers, including, in some cases, us, will be required to certify compliance with these transaction standards to HHS. The compliance date for the certification requirement depends on the type of transaction, with the earliest certification required by December 31, 2013. Our solutions have allowed numerous payers and providers to establish compliance with the transaction standards independently and at different times, reducing transition costs and risks. We continue to work with payers and providers, healthcare information system vendors and other healthcare constituents to implement fully the transaction standards.

False or Fraudulent Claim Laws

Numerous state and federal laws govern various substantive aspects of the healthcare claims submission process for reimbursement and the receipt of payments for healthcare items or services. These laws generally prohibit an individual or entity from knowingly presenting or causing to be presented claims for payment to Medicare, Medicaid or other third party payers that are false or fraudulent. False or fraudulent claims include, but are not limited to, billing for services not rendered, failing to refund known overpayments, misrepresenting actual services rendered in order to obtain higher reimbursement and improper coding and billing for medically unnecessary goods and services. The application of these provisions is very broad and the federal False Claims Act (FCA) and state false claims laws provide for significant civil and criminal penalties. In addition, the FCA and some state false claims laws can be enforced by private individuals through whistleblower or qui tam actions on behalf of the government. To avoid liability, providers and their contractors must, among other things, carefully and accurately code and submit claims for reimbursement.

Industry estimates indicate that between $68 billion and $226 billion in healthcare costs are attributable to fraud, waste and abuse each year. We believe our historical claims data, combined with our healthcare payment integrity services, positions us to benefit from government proposals to promote cost effective healthcare and reduce fraud, waste and abuse and our customers initiatives designed to promote the detection and prevention of improper or fraudulent healthcare payments.

Reductions in Government Healthcare Spending

In recent years, legislative and regulatory changes have limited, and in some cases reduced, the levels of payment that our customers receive for various services under the Medicare, Medicaid and other federal healthcare programs. In some cases, commercial payers base their payment rates on Medicare policy, and therefore, adjustments that negatively impact Medicare payments also may negatively impact payments received by healthcare providers from other payers. PPACA provides for significant federal healthcare program spending reductions through 2019, including reductions in Medicare payments to most healthcare providers and Medicare Advantage plans. In addition to reductions required by PPACA, the Budget Control Act of 2011 (the BCA) requires automatic spending reductions of $1.2 trillion for federal fiscal years 2013 through 2021, minus any deficit reductions enacted by Congress and debt service costs. Under the BCA, the percentage reduction for Medicare may not be more than 2% for a fiscal year, with a uniform percentage reduction across all Medicare programs. The Medicaid program, however, is not included in the reductions. The BCA-mandated spending reductions are being implemented effective April 1, 2013 for the Medicare program and effective March 1, 2013 for other impacted programs. The President and Congress continue to consider deficit reduction measures and other changes to government healthcare programs that could adversely affect our customers and, as a result, our Company.

Our Intellectual Property

We rely upon a combination of trade secret, copyright and trademark laws, license agreements, confidentiality procedures, nondisclosure agreements and technical measures to protect the intellectual property used in our business. We generally enter into confidentiality agreements with our employees, consultants, vendors and customers. We also seek to control access to and distribution of our technology, documentation and other proprietary information.

We use numerous trademarks, trade names and service marks for our solutions. We also rely on a variety of intellectual property rights that we license from third parties. Although we believe that alternative technologies are generally available to replace such licensed intellectual property, these third party technologies may not continue to be available to us on commercially reasonable terms.

We also have several patents and patent applications covering solutions we provide, including software applications. Due to the nature of our applications, we believe that patent protection is less significant than our ability to further develop, enhance and modify our current solutions.

The steps we have taken to protect our copyrights, trademarks, servicemarks and other intellectual property may not be adequate, and third parties could infringe, misappropriate or misuse our intellectual property. If this were to occur, it could harm our reputation and adversely affect our competitive position or results of operations.

Our Employees

As of March 1, 2013, we had approximately 3,500 employees. None of our employees are represented by a labor union. We consider our relationship with our employees to be good.

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ITEM 1A. RISK FACTORS

Overview

You should consider carefully the specific risks and uncertainties described below, and all information contained in this Annual Report, in evaluating our Company and our business. The occurrence of any of the following risks or uncertainties described below could significantly and adversely affect our business, prospects, financial condition and operating results.

Risks Related to our Business

We face significant competition for our solutions.

The markets for our various solutions are intensely competitive, continually evolving and, in some cases, subject to rapid technological change. We face competition from many healthcare information systems companies and other technology companies within segments of the healthcare information technology and services markets. We also compete with certain of our customers that provide internally some of the same solutions that we offer. Our key competitors include: (i) healthcare transaction processing companies, including those providing EDI, and/or internet-based services and those providing services through other means, such as paper and fax; (ii) healthcare information system vendors that support providers and payers and their revenue and payment cycle management and clinical information exchange processes, including physician and dental practice management, hospital information and electronic medical record system vendors; (iii) large information technology and healthcare consulting service providers; (iv) health insurance companies, pharmacy benefit management companies, hospital management companies and pharmacies that provide or are developing electronic transaction and payment distribution services for use by providers and/or by their members and customers; (v) healthcare focused print and mail vendors; (vi) financial institutions and payment processors that have invested in healthcare data management assets; (vii) government program eligibility and enrollment services companies; and (viii) payment integrity companies. In addition, major software, hardware, information systems and business process outsourcing companies, both with and without healthcare companies as their partners, offer or have announced their intention to offer products or services that are competitive with solutions that we offer.

Within certain of the markets in which we operate, we face competition from entities that are significantly larger and have greater financial resources than we do and have established reputations for success. Other companies have targeted these markets for growth, including by developing new technologies utilizing internet-based systems. We may not be able to compete successfully with these companies and these or other competitors may commercialize products, services or technologies that render our products, services or technologies obsolete or less marketable.

Some of our customers compete with us and some, instead of using a third party provider, perform internally some of the same services that we offer.

Some of our existing customers compete with us or may plan to do so or belong to alliances that compete with us or plan to do so, either with respect to the same solutions we provide to them or with respect to some of our other lines of business. For example, some of our payer customers currently offer through affiliated clearinghouses, web portals and other means electronic data transmission services to providers that allow the provider to bypass third party EDI service providers such as us, and additional payers may do so in the future. The ability of payers to replicate our solutions may adversely affect the terms and conditions we are able to negotiate in our agreements with them and our transaction volume with them, which directly relates to our revenues. We may not be able to maintain our existing relationships for connectivity services with payers or develop new relationships on satisfactory terms, if at all. In addition, some of our solutions allow payers and providers to outsource business processes that they have been or could be performing internally and, in order for us to be able to compete, use of our solutions must be more efficient for them than use of internal resources.

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If we are unable to retain our existing customers, our business, financial condition and results of operations could suffer.

Our success depends substantially upon the retention of our customers, particularly due to our transaction-based, recurring revenue model. We may not be able to retain some of our existing customers if we are unable to continue to provide solutions that our payer customers believe enable them to achieve improved efficiencies and cost-effectiveness, and that our provider and pharmacy customers believe allow them to more effectively manage their revenue cycle, increase reimbursement rates and improve cash flows. We also may not be able to retain customers if our electronic and/or paper-based solutions contain errors or otherwise fail to perform properly, if our pricing structure is no longer competitive or upon expiration of our contracts. Historically, we have enjoyed high customer retention rates; however, we may not be able to maintain high retention rates in the future. Our transaction-based, recurring revenues depend in part upon maintaining this high customer retention rate, and if we are unable to maintain our historically high customer retention rate, our business, financial condition and results of operations could be adversely impacted.

If we are unable to connect to a large number of payers and providers, our solutions would be limited and less desirable to our customers.

Our business largely depends upon our ability to connect electronically to a substantial number of payers, such as insurance companies, Medicare and Medicaid agencies and pharmacy benefit managers, and providers, such as hospitals, physicians, dentists, laboratories and pharmacies. The attractiveness of some of the solutions we offer to providers, such as our claims management and submission services, depends in part on our ability to connect to a large number of payers, which allows us to streamline and simplify workflows for providers. These connections either may be made directly or through a clearinghouse. We may not be able to maintain our links with a large number of payers on terms satisfactory to us and we may not be able to develop new connections, either directly or through other clearinghouses, on satisfactory terms. The failure to maintain these connections could cause our solutions to be less attractive to our provider customers. In addition, our payer customers view our connections to a large number of providers as essential in allowing them to receive a high volume of transactions and realize the resulting cost efficiencies through the use of our solutions. Our failure to maintain existing connections with payers, providers and other clearinghouses or to develop new connections as circumstances warrant, or an increase in the utilization of direct links between payers and providers, could cause our electronic transaction processing systems to be less desirable to healthcare constituents, which would reduce the number of transactions that we process and for which we are paid, resulting in a decrease in revenues and an adverse effect on our financial condition and results of operations.

The failure to maintain our relationships with our channel partners or significant changes in the terms of the agreements we have with them may have an adverse effect on our ability to successfully market our solutions.

We have entered into contracts with our channel partners to market and sell some of our solutions. Most of these contracts are on a non-exclusive basis. However, under contracts with some of our channel partners, we may be bound by provisions that restrict our ability to market and sell our solutions to potential customers. Our arrangements with some of these channel partners involve negotiated payments to them based on percentages of revenues they generate. If the payments prove to be too high, we may be unable to realize acceptable margins, but if the payments prove to be too low, the channel partners may not be motivated to produce a sufficient volume of revenues. The success of these contractual arrangements will depend in part upon the channel partners own competitive, marketing and strategic considerations, including the relative advantages of using alternative products being developed and marketed by them or our competitors. If any of these channel partners are unsuccessful in marketing our solutions or seek to amend the financial or other terms of the contracts we have with them, we will need to broaden our marketing efforts to increase focus on the solutions they sell and alter our distribution strategy, which may divert our planned efforts and resources from other projects. In addition, as part of the packages these channel partners sell, they may offer a choice to their customers between solutions that we supply and similar solutions offered by our competitors or by the channel partners directly. If our solutions are not chosen for inclusion in these packages, the revenues we earn from our channel partner relationships will decrease. Lastly, we could be subject to claims and liability, as a result of the activities, products or services of these channel partners or other resellers of our solutions. Even if these claims do not result in liability to us, investigating and defending these claims could be expensive, time-consuming and result in adverse publicity that could harm our business.

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Our business and future success may depend on our ability to cross-sell our solutions.

Our ability to generate revenue and growth partly depends on our ability to cross-sell our solutions to our existing customers and new customers. We expect our ability to successfully cross-sell our solutions will be one of the most significant factors influencing our growth. We may not be successful in cross-selling our solutions because our customers may find our additional solutions unnecessary or unattractive. Our failure to sell additional solutions to existing customers could affect our ability to grow our business.

We have faced and will continue to face increasing pressure to reduce our prices, which may reduce our margins, profitability and competitive position.

As electronic transaction processing further penetrates the healthcare market or becomes highly standardized, competition among electronic transaction processors is increasingly focused on pricing. This competition has placed, and could place further, intense pressure on us to reduce our prices in order to retain market share. If we are unable to reduce our costs sufficiently to offset declines in our prices, or if we are unable to introduce new innovative offerings with higher margins, our results of operations could decline.

In addition, many healthcare industry constituents are consolidating to create integrated healthcare delivery systems with greater market power. As provider networks, such as hospitals, and payer organizations, such as private insurance companies, consolidate, competition to provide the types of solutions we provide will become more intense and the importance of establishing and maintaining relationships with key healthcare industry constituents will become more significant. These healthcare industry constituents have, in the past, and may, in the future, try to use their market power to negotiate price reductions for our solutions. If we are forced to reduce prices, our margins will decrease and our results of operations will decline, unless we are able to achieve corresponding reductions in expenses.

Our ability to generate revenue could suffer if we do not continue to update and improve our existing solutions and develop new ones.

We must improve the functionality of our existing solutions in a timely manner and introduce new and valuable healthcare information technology and service solutions in order to respond to technological and regulatory developments and, thereby, retain existing customers and attract new ones. For example, from time to time, government agencies may alter format and data code requirements applicable to electronic transactions. We may not be successful in responding to technological and regulatory developments and changing customer needs. The pace of change in the markets we serve is rapid, and there are frequent new product and service introductions by our competitors and channel partners who use our solutions in their offerings. If we do not respond successfully to technological and regulatory changes and evolving industry standards, our solutions may become obsolete. Technological changes also may result in the offering of competitive solutions at lower prices than we are charging for our solutions, which could result in our losing sales unless we lower the prices we charge. If we do lower our prices on some of our solutions, we will need to increase our margins on these solutions in order to maintain our overall profitability. In addition, the solutions we develop or license may not be able to compete with the alternatives available to our customers.

Our business will suffer if we fail to successfully integrate acquired businesses and technologies or to appropriately assess the risks in particular transactions.

We have historically acquired and, in the future, plan to acquire, businesses, technologies, services, product lines and other assets. The successful integration of any businesses and assets we acquire into our operations, on a cost-effective basis, can be critical to our future performance. The amount and timing of the expected benefits of any acquisition, including potential synergies, are subject to significant risks and uncertainties. These risks and uncertainties include, but are not limited to, those relating to:

our ability to maintain relationships with the customers of the acquired business;

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- our ability to cross-sell solutions to customers with which we have established relationships and those with which the acquired businesses have established relationships;
- our ability to retain or replace key personnel of the acquired business;
- potential conflicts in payer, provider, pharmacy, vendor or marketing relationships;
- our ability to coordinate organizations that are geographically diverse and may have different business cultures; and
- compliance with regulatory requirements.

We cannot guarantee that any acquired businesses will be successfully integrated with our operations in a timely or cost-effective manner, or at all. Failure to successfully integrate acquired businesses or to achieve anticipated operating synergies, revenue enhancements or cost savings could have an adverse effect on our business, financial condition and results of operations.

Although our management attempts to evaluate the risks inherent in each transaction and to evaluate acquisition candidates appropriately, we may not properly ascertain all such risks and the acquired businesses and assets may not perform as we expect or enhance the value of our company as a whole. Acquired companies or businesses also may have larger than expected liabilities that are not covered by the indemnification, if any, that we are able to obtain from the sellers. Furthermore, the historical financial statements of the companies we have acquired or may acquire in the future are prepared by management of such companies and are not independently verified by our management. In addition, any pro forma financial statements prepared by us to give effect to such acquisitions may not accurately reflect the results of operations of such companies that would have been achieved had the acquisition of such entities been completed at the beginning of the applicable periods. Finally, there are no assurances that we will continue to acquire businesses at valuations consistent with our prior acquisitions or that we will complete acquisitions at all.

Achieving market acceptance of new or updated solutions is necessary in order for them to become profitable and will likely require significant efforts and expenditures.

Our future financial results will depend in part on whether our new or updated solutions receive sufficient customer acceptance. These solutions include, without limitation:

- electronic billing, payment and remittance services for payers and providers that complement our existing paper-based patient billing and payment and payment distribution services;
- electronic prescriptions from healthcare providers to pharmacies and pharmacy benefit managers;
- our other pre- and post-adjudication services for payers and providers;
- payment integrity and fraud, waste and abuse services for payers and providers;
- government program eligibility and enrollment services for providers;
- accounts receivable management, denial management, appeals and collection improvement services for providers;

healthcare and information technology consulting services for payers; and

decision support, clinical information exchange or other business intelligence solutions.

Achieving market acceptance for new or updated solutions is likely to require substantial marketing efforts and expenditure of significant funds to create awareness and demand by constituents in the healthcare industry. In addition, deployment of new or updated solutions may require the use of additional resources for training our existing sales force and customer service personnel and for hiring and training additional salespersons and customer service personnel. Failure to achieve broad penetration in target markets with respect to new or updated solutions could have an adverse effect on our business prospects and financial results.

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An economic downturn or volatility could have a material adverse effect on our business, financial condition and results of operations.

The United States economy has experienced significant economic uncertainty and volatility during recent years. A weakening of economic conditions could lead to reductions in demand for our solutions. For example, our revenues can be adversely affected by the impact of lower healthcare utilization trends driven by high unemployment and other economic factors. Further, weakened economic conditions or another recession could reduce the amount of income patients are able to spend on healthcare services. As a result, patients may elect to delay or forgo seeking healthcare services, which could further reduce healthcare utilization and our transaction volumes or decrease payer and provider demand for our solutions. Also, high unemployment rates could cause commercial payer membership to decline which also could lessen healthcare utilization and decrease our transaction volumes. In addition, as a result of volatile or uncertain economic conditions, we may experience the negative effects of increased financial pressures on our payer and provider customers. For instance, our business, financial condition and results of operations could be negatively impacted by increased competitive pricing pressure and a decline in our customers credit worthiness, which could result in us incurring increased bad debt expense. If we are not able to timely and appropriately adapt to changes resulting from a weak economic environment, our business, results of operations and financial condition may be materially and adversely affected.

There are increased risks of performance problems during times when we are making significant changes to our solutions or to systems we use to provide services. In addition, implementation of our solutions and cost savings initiatives may cost more, may not provide the benefits expected, may take longer than anticipated or may increase the risk of performance problems.

In order to respond to technological and regulatory changes and evolving industry standards, our solutions must be continually updated and enhanced. The software and systems that we sell and use to provide services are inherently complex and, despite testing and quality control, we cannot be certain that errors will not be found in any changes, enhancements, updates and new versions that we market or use. Even if new or modified solutions do not have performance problems, our technical and customer service personnel may have difficulties in installing them or in providing any necessary training and support to customers.

Implementation of changes in our technology and systems may cost more or take longer than originally expected and may require more testing than initially anticipated. While new hardware and software will be tested before it is used in production, we cannot be sure that the testing will uncover all problems that may occur in actual use. If significant problems occur as a result of these changes, we may fail to meet our contractual obligations to customers, which could result in claims being made against us or in the loss of customer relationships. In addition, changes in our technology and systems may not provide the additional functionality or other benefits that were expected.

In addition, we also periodically implement efficiency measures and other cost saving initiatives to improve our operating performance. These efficiency measures and other cost saving initiatives may not provide the benefits anticipated or do so in the time frame expected. Implementation of these measures also may increase the risks of performance problems due to unforeseen impacts on our organization, systems and processes.

Disruptions in service or damages to our data or other operation centers, or other software or systems failures, could adversely affect our business.

Our data centers and operation centers are essential to our business. Our operations depend on our ability to maintain and protect our computer systems, many of which are located in our primary data centers that we operate in Memphis and Nashville, Tennessee. We have consolidated several satellite data centers to our primary data centers and plan to continue such consolidation. Our business and results of operations are also highly dependent on our print and mail operations, which

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are primarily conducted in Bridgeton, Missouri and Toledo, Ohio. We conduct business continuity planning and maintain insurance against fires, floods, other natural disasters and general business interruptions to mitigate the adverse effects of a disruption, relocation or change in operating environment; however, the situations we plan for and the amount of insurance coverage may not be adequate in any particular case. The occurrence of any of these events could result in interruptions, delays or cessations in service to users of our solutions, which could impair or prohibit our ability to provide our solutions, reduce the attractiveness of our solutions to our customers and adversely impact our financial condition and results of operations.

In addition, despite the implementation of security measures, our infrastructure, data centers or systems that we interface with, including the internet and related systems, may be vulnerable to physical break-ins, hackers, improper employee or contractor access, computer viruses, programming errors, denial-of-service attacks, terrorist attacks or other attacks by third parties or similar disruptive problems. Any of these events can cause system failure, including network, software or hardware failure, which can result in service disruptions or increased response time for our solutions. As a result, we may be required to expend significant capital and other resources to protect against security breaches and hackers or to alleviate problems caused by such breaches. The occurrence of any of these events also could disrupt our business and operations or harm our brand and reputation, either of which could adversely affect our financial condition and operating results.

We also rely on a limited number of suppliers and contractors to provide us with a variety of solutions, including telecommunications and data processing services necessary for our transaction services and processing functions and software developers for the development and maintenance of certain software products we use to provide our solutions. If these suppliers do not fulfill their contractual obligations or choose to discontinue their products or services, our business and operations could be disrupted, our brand and reputation could be harmed and our financial condition and operating results could be adversely affected.

We may be liable to our customers and may lose customers if we provide poor service, if our solutions do not comply with our agreements or if our software solutions or transmission systems contain errors or experience failures.

We must meet our customers service level expectations and our contractual obligations with respect to our solutions. Failure to do so could subject us to liability, as well as cause us to lose customers. In some cases, we rely upon third party contractors to assist us in providing our solutions. Our ability to meet our contractual obligations and customer expectations may be impacted by the performance of our third party contractors and their ability to comply with applicable laws and regulations. For example, our electronic payment and remittance solutions depend in part on the ability of our vendors to comply with applicable banking, financial service and payment card industry requirements and their failure to do so could cause an interruption in the solutions we provide or require us to seek alternative solutions or relationships.

Errors in the software and systems we provide to customers or use to provide our solutions also could cause serious problems for our customers. In addition, because of the large amount of data we collect and manage, it is possible that hardware failures and errors in our systems would result in data loss or corruption or cause the information that we collect to be incomplete or contain inaccuracies that our customers could regard as significant. For example, errors in our transaction processing systems can result in payers paying the wrong amount, making payments to the wrong payee or delaying payments. Since some of our solutions relate to laboratory ordering and reporting and electronic prescriptions, an error in our systems also could result in injury to a patient. If problems like these occur, our customers may seek compensation from us or may seek to terminate their agreements with us, withhold payments due to us, seek refunds from us of part or all of the fees charged under our agreements, request a loan or advancement of funds or initiate litigation or other dispute resolution procedures. In addition, we may be subject to claims against us by others affected by any such problems.

Our activities and the activities of our third party contractors involve the storage, use and transmission of financial and personal health information. Accordingly, security breaches of our or their computer systems or at our print and mail operation centers could expose us to a risk of loss or litigation, government enforcement actions and contractual liabilities. We cannot be certain that contractual provisions attempting to limit our liability in these areas will be successful or

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enforceable, or that other parties will accept such contractual provisions as part of our agreements. Any security breaches also could impact our ability to provide our solutions, as well as impact the confidence of our customers in our solutions, either of which could have an adverse effect on our business, financial condition and results of operations.

We attempt to limit, by contract, our liability for damages arising from our negligence, errors, mistakes or security breaches. However, contractual limitations on liability may not be enforceable or may otherwise not provide sufficient protection to us from liability for damages. We maintain liability insurance coverage, including coverage for errors and omissions. It is possible, however, that claims could exceed the amount of our applicable insurance coverage, if any, or that this coverage may not continue to be available on acceptable terms or in sufficient amounts. Even if these claims do not result in liability to us, investigating and defending against them could be expensive and time consuming and could divert management s attention away from our operations. In addition, negative publicity caused by these events may negatively impact market acceptance of our solutions, including unrelated solutions, or may harm our reputation and our business.

Recent and future developments in the healthcare industry could adversely affect our business.

Almost all of our revenue is either derived from the healthcare industry or could be affected by changes in healthcare spending. The healthcare industry is highly regulated and subject to changing political, legislative, regulatory and other influences. In March 2010, the President signed PPACA into law. PPACA will change how healthcare services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced Medicare program spending and insurance market reforms. In June 2012, the United States Supreme Court upheld the constitutionality of PPACA except for provisions that would have allowed HHS to penalize states that did not implement the Medicaid expansion provisions of the law with the loss of existing federal Medicaid funding.

PPACA increases health insurance coverage through a number of measures that become effective in 2014, including expanding Medicaid significantly, requiring the establishment of health insurance exchanges to facilitate the purchase of health insurance by individuals and small employers and imposing penalties on individuals who do not obtain health insurance and employers that do not provide health insurance to their employees. Because states may opt out of the Medicaid expansion provisions, how many states will participate or under what terms is not clear. PPACA insurance market reforms include increased dependent coverage, prohibitions on excluding individuals based on pre-existing conditions and mandated minimum medical loss ratios for health plans. In addition, PPACA provides for significant new taxes, including an industry user tax paid by health insurance companies beginning in 2014, as well as an excise tax on health insurers and employers offering high cost health coverage plans. PPACA also imposes significant Medicare Advantage funding cuts and material reductions to Medicare and Medicaid program spending. PPACA further provides for additional resources to combat healthcare fraud, waste and abuse and also requires HHS to adopt additional standards for electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

While many of the provisions of PPACA will not be directly applicable to us, PPACA will affect the business of our payer, provider and pharmacy customers and also will affect the Medicaid programs of the states with which we have contracts. Accordingly, because our customers are required to comply with such laws, we may be impacted as a result of our contractual obligations. For many of these requirements, there is little history of regulatory or judicial interpretation upon which to rely. The provisions of PPACA that are designed to expand health coverage potentially could result in an overall increase in transactions for our business and demand for our solutions; however, our customers may attempt to reduce spending to offset the increased costs associated with meeting the various PPACA insurance market reforms. Likewise, as the Medicare payment reductions and other reimbursement changes impact our customers, our customers may attempt to seek price concessions from us or reduce their use of our solutions. Thus, PPACA may result in a reduction of expenditures by customers or potential customers in the healthcare industry, which could have an adverse effect on our business, financial condition and results from operations. Further, we may experience increased costs from responding to new standardized transaction and implementation rules and our customers needs. In addition, several states have announced their intent not to participate in the Medicaid expansion and are considering, or may consider, legislative proposals that could affect our business or that of our customers.

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Moreover, there are currently numerous federal, state and private initiatives and studies seeking ways to increase the use of information technology in healthcare as a means of improving care and reducing costs. For example, ARRA included approximately $19 billion in federal subsidies that began in 2011 for eligible hospitals and eligible professionals that adopt and meaningfully use certified EHR technology. These initiatives may result in additional or costly legal or regulatory requirements that are applicable to us and our customers, may encourage more companies to enter our markets, may provide advantages to our competitors and may result in the development of technology solutions that compete with ours. Any such initiatives also may result in a reduction of expenditures by customers or potential customers in the healthcare industry, which could have an adverse effect on our business.

In addition, other general reductions in expenditures by healthcare industry constituents could result from, among other things:

- government regulation or private initiatives that affect the manner in which providers interact with patients, payers or other healthcare industry constituents, including changes in pricing or means of delivery of healthcare solutions;
- reductions in governmental funding for healthcare, in addition to reductions required by PPACA, such as reductions resulting from the BCA, which requires automatic spending reductions of $1.2 trillion for federal fiscal years 2013 through 2021, minus any deficit reductions enacted by Congress and debt service costs; and
- adverse changes in business or economic conditions affecting payers, providers, pharmaceutical companies, medical device manufacturers or other healthcare industry constituents.

Even if general expenditures by healthcare industry constituents remain the same or increase, other developments in the healthcare industry may result in reduced spending on information technology and services or in some or all of the specific markets we serve or are planning to serve. In addition, our customers expectations regarding pending or potential healthcare industry developments also may affect their budgeting processes and spending plans with respect to the types of solutions we provide. For example, use of our solutions could be affected by:

- changes in the billing patterns of providers;
- changes in the design of health insurance plans;
- changes in the contracting methods payers use in their relationships with providers;
- decreases in marketing expenditures by pharmaceutical companies or medical device manufacturers, as a result of governmental regulation or private initiatives that discourage or prohibit promotional activities by pharmaceutical or medical device companies; and
- successful implementation of government programs that streamline and standardize eligibility enrollment processes could result in decreased pricing or demand for our eligibility and enrollment solutions.

The healthcare industry has changed significantly in recent years, and we expect that significant changes will continue to occur. The timing and impact of developments in the healthcare industry are difficult to predict. Furthermore, we are unable to predict how providers, payers, pharmacies and other healthcare market participants will respond to the various reform provisions contained in PPACA, many of which will not be fully implemented for several years and could be delayed, repealed or blocked. We cannot be sure that the markets for our solutions will continue to exist at current levels or that we will have adequate technical, financial and marketing resources to react to changes in those markets.

Government regulation creates risks and challenges with respect to our compliance efforts and our business strategies.

The healthcare industry is highly regulated and subject to changing political, legislative, regulatory and other influences. Many healthcare laws are complex, and their application to specific services and relationships may not be clear. In particular, many existing healthcare laws and regulations, when enacted, did not anticipate the healthcare information solutions that we provide, and these laws and regulations may be applied to our solutions in ways that we do not anticipate. PPACA and other federal and state proposals to reform or revise aspects of the healthcare industry or to revise or create additional statutory and regulatory requirements could impact our operations, the use of our solutions and our ability to market new solutions, or could create unexpected liabilities for us. We also may be impacted by non-healthcare laws as a result of some of our

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solutions. For example, laws, regulations and industry standards regulating the banking and financial services industry may impact our operations as a result of the electronic payment and remittance services we offer directly or through third party vendors. We are unable to predict what changes to laws or regulations might be made in the future or how those changes could affect our business or the costs of compliance.

We have attempted to structure our operations to comply with legal requirements applicable to us directly and to our customers and third party contractors, but there can be no assurance that our operations will not be challenged or impacted by enforcement initiatives. Any determination by a court or agency that our solutions violate, or cause our customers to violate, applicable laws or regulations could subject us or our customers to civil or criminal penalties. Such a determination also could require us to change or terminate portions of our business, disqualify us from serving customers who are or do business with government entities or cause us to refund some or all of our service fees or otherwise compensate our customers. In addition, failure to satisfy laws or regulations could adversely affect demand for our solutions and could force us to expend significant capital, research and development and other resources to address the failure. Even an unsuccessful challenge by regulatory authorities or private whistleblowers could result in loss of business, exposure to adverse publicity and injury to our reputation and could adversely affect our ability to retain and attract customers. Laws and regulations impacting our operations include the following:

HIPAA Privacy and Security Requirements. There are numerous federal and state laws and regulations related to the privacy and security of personal health information. In particular, regulations promulgated pursuant to HIPAA establish privacy and security standards that limit the use and disclosure of individually identifiable health information (known as protected health information) and require the implementation of administrative, physical and technological safeguards to protect the privacy of protected health information and ensure the confidentiality, integrity and availability of electronic protected health information. We are directly subject to the HIPAA privacy and security regulations as a Covered Entity with respect to our operations as a healthcare clearinghouse and, as a result of ARRA, are directly subject to certain provisions of the regulations as a Business Associate through our relationships with customers. HHS published a final rule implementing many provisions of ARRA in January 2013, and we must generally comply with this rule by September 23, 2013. We intend to revise our policies and processes to comply with this rule. In addition, we will be required to revise many of our Business Associate agreements with customers and our subcontractors that govern the safeguarding and permitted use and disclosure of protected health information by at least September 23, 2014.

The privacy regulations established under HIPAA also provide patients with rights related to understanding and controlling how their health information is used and disclosed. ARRA imposes strict limitations on certain types of uses and disclosures, such as additional restrictions on marketing communications and the sale of protected health information. To the extent permitted by applicable privacy regulations, ARRA and our contracts with our customers, we may use and disclose protected health information to perform our services and for other limited purposes, such as creating de-identified information, but other uses and disclosures, such as marketing communications, require written authorization from the individual or must meet an exception specified under the privacy regulations. Determining whether data has been sufficiently de-identified to comply with the HIPAA privacy standards and our contractual obligations may require complex factual and statistical analyses and may be subject to interpretation.

If we are unable to properly protect the privacy and security of protected health information entrusted to us, we could be found to have breached our contracts with our customers. Further, if we fail to comply with applicable HIPAA privacy and security standards, we could face civil and criminal penalties. ARRA also increased the penalties for HIPAA violations and strengthened the enforcement provisions of HIPAA. The HHS final rule released in January 2013 implemented many of these provisions. Accordingly, effective September 23, 2013, HHS has the discretion to impose penalties without being required to attempt to resolve violations through informal means, such as implementing a corrective action plan. In recent years, HHS enforcement activities appear to have increased. For example, HHS conducted a pilot program of HIPAA compliance audits in 2012

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and has announced its intent to continue HIPAA compliance audits in 2013. Although we have implemented and maintain policies and processes to assist us in complying with these regulations and our contractual obligations, we cannot provide assurance regarding how these standards will be interpreted, enforced or applied to our operations.

Other Privacy and Security Requirements. In addition to HIPAA, numerous other state and federal laws govern the collection, dissemination, use, access to and confidentiality of personal health information and healthcare provider information. Some states also are considering new laws and regulations that further protect the confidentiality, privacy and security of medical records or other types of medical information. In many cases, these state laws are not preempted by the HIPAA privacy standards and may be subject to interpretation by various courts and other governmental authorities. Further, the United States Congress and a number of states have considered or are considering prohibitions or limitations on the disclosure of medical or other information to individuals or entities located outside of the United States.

Data Protection and Breaches. In recent years, there have been a number of well-publicized data breaches involving the improper dissemination of personal information of individuals both within and outside of the healthcare industry. Many states have responded to these incidents by enacting laws requiring holders of personal information to maintain safeguards and take certain actions in response to a data breach, such as providing prompt notification of the breach to affected individuals. In many cases, these laws are limited to electronic data, but states are increasingly enacting or considering stricter and broader requirements. Under ARRA, Covered Entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days following discovery of the breach by a Covered Entity or its agents. Notification also must be made to HHS and, in certain circumstances involving large breaches, to the media. Business Associates must report breaches of unsecured protected health information to Covered Entities within 60 days of discovery of the breach by the Business Associate or its agents. The January 2013 HHS final rule also changed the standard for determining whether or not a breach of protected health information occurred. Accordingly, effective September 23, 2013, a non-permitted use or disclosure is presumed to be a breach unless the Covered Entity or Business Associate establishes that there is a low probability the protected health information has been compromised. This presumption and revised standard for determining whether a non-permitted use or disclosure constitutes a breach will likely result in a greater number of incidents involving the non-permitted use and disclosure of unsecured protected health information being classified as breaches and, thus, a greater number of required notifications.

In addition, the Federal Trade Commission (FTC) has prosecuted certain data breach cases as unfair and deceptive acts or practices under the Federal Trade Commission Act. Further, by regulation, the FTC requires creditors, which may include some of our customers, to implement identity theft prevention programs to detect, prevent and mitigate identity theft in connection with customer accounts. Although Congress passed legislation that restricts the definition of creditor and exempts many healthcare providers from complying with this rule, we may be required to apply additional resources to our existing process to assist our affected customers in complying with this rule.

We have implemented and maintain physical, technical and administrative safeguards intended to protect all personal data and have processes in place to assist us in complying with all applicable laws and regulations regarding the protection of this data and properly responding to any security breaches or incidents; however, we cannot be sure that these safeguards are adequate to protect all personal data or assist us in complying with all applicable laws and regulations regarding the protection of personal data and responding to any security breaches or incidents.

HIPAA Transaction and Identifier Standards. HIPAA and its implementing regulations mandate format and data content standards and provider identifier standards (known as the National Provider Identifier) that must be used in certain electronic transactions, such as claims, payment advice and eligibility inquiries. As required by PPACA, HHS has established standards that health plans must use by no later than January 1, 2014 for electronic fund transfers with providers and is in the process of establishing operating rules to promote uniformity in the implementation of each type of standardized electronic transaction. Covered Entities were required to comply with operating rules for health plan eligibility and health care claim status transactions by March 1, 2013, and must comply with operating rules for electronic funds transfers and remittance advices transactions by January 1, 2014. PPACA also requires HHS to establish standards for health claims attachment transactions.

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In 2012, Covered Entities became required to comply with changes to the formats used for electronic transactions known as Version 5010. Further, HHS has published a final rule adopting updated standard code sets for diagnoses and procedures known as the ICD-10 code sets. The use of the ICD-10 code sets is required by October 1, 2014.

HHS has established a unique health plan identifier that health plans must obtain by November 5, 2014 and that Covered Entities must use to identify health plans in standardized transactions beginning on November 7, 2016. HHS also has established an other entity identifier that entities involved in health care transactions that are not health plans, providers or individuals may opt to obtain and use.

Although our systems are capable of transmitting transactions that comply with requirements currently in effect, we will be required to modify our systems to accommodate new requirements. We have been modifying and will continue to modify our systems and processes to prepare for and implement changes to the transaction standards, code sets operating rules and identifier requirements; however, we may not be successful in responding to these changes and any responsive changes we make to our systems and software may result in errors or otherwise negatively impact our service levels. In addition, the compliance dates for ICD-10 code sets, new or modified transaction standards, operating rules and identifiers may overlap, which may further burden our resources.

We also may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance or enforcement date. Some payers and healthcare clearinghouses with which we conduct business interpret HIPAA transaction and ARRA requirements differently than we do or may require us to use legacy formats or include legacy identifiers as they transition to full compliance. For example, we continue to process transactions using legacy identifiers for non-Medicare claims that are sent to us to the extent that the intended recipients have not instructed us to suppress those legacy identifiers. Where payers or healthcare clearinghouses require conformity with their interpretations or require us to accommodate legacy transactions or identifiers as a condition of successful transactions, we seek to comply with their requirements, but may be subject to enforcement actions as a result. We continue to work with payers, providers, practice management system vendors and other healthcare industry constituents to implement the transaction standards and identifier standards. We cannot provide assurance regarding how the Centers for Medicare and Medicaid Services (CMS) will enforce the transaction and identifier standards or how CMS will view our practice of accommodating requests to process transactions that include legacy formats or identifiers for non-Medicare claims. Any regulatory change, clarification or enforcement action by CMS that prohibited the processing by healthcare clearinghouses or private payers of transactions containing legacy formats or identifiers could have an adverse effect on our business.

Electronic Health Records. ARRA provides for Medicare and Medicaid incentive payments for eligible hospitals and eligible professionals to adopt and meaningfully use EHR technology. Beginning in 2015, eligible hospitals and eligible professionals who fail to attest to the meaningful use of EHR technology will face reductions in Medicare payments. These incentives and the risk of reduced Medicare payments promote the adoption of EHR technology which may impact our business.

Anti-Kickback and Anti-Bribery Laws. A number of federal and state laws govern patient referrals, financial relationships with physicians and other referral sources and inducements to providers and patients, including restrictions contained in amendments to the Social Security Act, commonly known as the federal Anti-Kickback Law. The federal Anti-Kickback Law prohibits any person or entity from offering, paying, soliciting or receiving, directly or indirectly, anything of value with the intent of generating referrals of patients covered by Medicare, Medicaid or other federal healthcare programs. Violation of the federal Anti-Kickback Law is a felony. The Anti-Kickback Law contains a limited number of exceptions, and the Office of the Inspector

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General of HHS has created regulatory safe harbors to the federal Anti-Kickback Law. Activities that comply precisely with a safe harbor are deemed protected from prosecution under the federal Anti-Kickback Law. Failure to meet a safe harbor does not automatically render an arrangement illegal under the Anti-Kickback Law. The arrangement, however, does risk increased scrutiny by government enforcement authorities, based on its particular facts and circumstances. Our contracts and other arrangements may not meet an exception or a safe harbor.

Many states also have similar anti-kickback laws that are not necessarily limited to items or services for which payment is made by a federal healthcare program. The laws in this area are both broad and vague and generally are not subject to frequent regulatory or judicial interpretation. We review our practices with regulatory experts in an effort to comply with all applicable laws and regulatory requirements. However, we are unable to predict how these laws will be interpreted or the full extent of their application, particularly to services that are not directly reimbursed by federal healthcare programs, such as transaction processing services. Any determination by a state or federal regulatory agency that any of our activities or those of our customers or vendors violate any of these laws could subject us to civil or criminal penalties, could require us to change or terminate some portions of our business, could require us to refund a portion of our service fees, could disqualify us from providing services to customers who are or do business with government programs and could have an adverse effect on our business. Even an unsuccessful challenge by regulatory authorities of our activities could result in adverse publicity and could require a costly response from us.

False or Fraudulent Claim Laws. We provide claims processing and other solutions to providers that relate to, or directly involve, the reimbursement of health services covered by Medicare, Medicaid, other federal healthcare programs and private payers. In addition, as part of our data transmission and claims submission services, we may employ certain edits, using logic, mapping and defaults, when submitting claims to third party payers. Such edits are utilized when the information received from providers is insufficient to complete individual data elements requested by payers.

As a result of these aspects of our business, we may be subject to, or contractually required to comply with, numerous federal and state laws that prohibit false or fraudulent claims. False or fraudulent claims include, but are not limited to, billing for services not rendered, failing to refund known overpayments, misrepresenting actual services rendered, improper coding and billing for medically unnecessary items or services. Some of these laws, including restrictions contained in amendments to the Social Security Act, commonly known as the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud, waste and abuse laws. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the various criminal healthcare fraud provisions.

In addition, the FCA and some state false claims laws provide significant civil and criminal penalties for noncompliance and can be enforced by private individuals through whistleblower or qui tam actions on behalf of the government alleging that the defendant has defrauded the government. For example, the federal Civil Monetary Penalty Law provides for penalties ranging from $10,000 to $50,000 per prohibited act and assessments of up to three times the amount claimed or received. Further, violations of the FCA are punishable by treble damages and penalties of up to $11,000 per false claim, and whistleblowers may receive a share of amounts recovered. Under PPACA, civil penalties also may now be imposed for the failure to report and return an overpayment made by the federal government within 60 days of identifying the overpayment and also may result in liability under the FCA. Whistleblowers, the federal government and some courts have taken the position that entities that have violated other statutes, such as the federal Anti-Kickback Law, have thereby submitted false claims under the FCA. PPACA clarifies this issue with respect to the federal Anti-Kickback Law by providing that submission of a claim for an item or service generated in violation of the Anti-Kickback Law constitutes a false or fraudulent claim under the FCA. We rely on our customers to provide us with accurate and complete information.

From time to time, constituents in the healthcare industry, including us, may be subject to actions under the FCA or other fraud, waste and abuse provisions, such as the federal Civil Monetary Penalty Law. Errors and the unintended consequences of data manipulations by us or our systems with respect to entry, formatting, preparation or transmission of claim information may be determined or alleged to be in violation of these laws

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and regulations or could adversely impact the compliance of our customers. Although we believe our editing processes are consistent with applicable reimbursement rules and industry practice, a court, enforcement agency or whistleblower could challenge these practices. In addition, we cannot guarantee that state and federal agencies will regard any billing errors we process as inadvertent or will not hold us responsible for any compliance issues related to claims we handle on behalf of providers and payers. We cannot predict the impact of any enforcement actions under the various false claims and fraud, waste and abuse laws applicable to our operations. Even an unsuccessful challenge of our practices could cause adverse publicity and cause us to incur significant legal and related costs.

Financial Services Related Laws and Rules. Financial services and electronic payment processing services are subject to numerous laws, regulations and industry standards. These laws may subject us, our vendors and our customers to liability as a result of our payment distribution and processing solutions. Although we do not act as a bank, we offer solutions that involve banks, or vendors who contract with banks and other regulated providers of financial services. As a result, we may be impacted by banking and financial services industry laws, regulations and industry standards, such as licensing requirements, solvency standards, requirements to maintain the privacy and security of nonpublic personal financial information and Federal Deposit Insurance Corporation deposit insurance limits. In addition, our patient billing and payment distribution and processing solutions may be impacted by payment card association operating rules, certification requirements, state prompt payment laws and other rules governing electronic funds transfers. If we fail to comply with applicable payment processing rules or requirements, we may be subject to fines and changes in transaction fees and may lose our ability to process credit and debit card transactions or facilitate other types of billing and payment solutions. Moreover, payment transactions processed using the Automated Clearing House Network are subject to network operating rules promulgated by the National Automated Clearing House Association and to various federal laws regarding such operations, including laws pertaining to electronic funds transfers, and these rules and laws may impact our billing and payment solutions. Further, our solutions may impact the ability of our payer customers to comply with state prompt payment laws. These laws require payers to pay healthcare claims meeting the statutory or regulatory definition of a clean claim within a specified time frame.

United States Postal Service Laws and Regulations. Our patient statements and payment services solutions provide mailing services primarily delivered through the United States Postal Service (USPS). Although we generally pass these costs through to our customers, postage is the largest component of our costs of operations. Postage rates are dependent on the operating efficiencies of the USPS and legislative and regulatory mandates imposed on the USPS as a result of various fiscal and political factors. Accordingly, new USPS laws or regulations, including changes in the interpretation of existing regulations, changes in the operations of USPS and recent or future rate increases, may negatively impact our business and results of operations. For example, if the recently announced measures taken by the USPS to reduce its operating costs, including the elimination of Saturday delivery, are not effective, additional postage rate increases or other operational changes may occur. We also rely on significant discounts from the basic USPS postage rate structure, which could be changed or discontinued at any time. While we cannot predict the timing or magnitude of such changes, the current economic and political environment is likely to lead to further rate increases and/or changes in the operations, policies and regulatory interpretations of the USPS. Because we may be unable to implement changes mandated by the USPS in our operations or pass future rate increases through to our customers, any failure or alleged failure to comply with applicable laws and regulations, or any adverse applications of, or changes in, the USPS laws and regulations affecting our business, could have a material adverse effect on our operating results and/or financial condition.

Legislative changes may impede our ability to utilize our offshore service capabilities.

In our operations, we have contractors located outside of the United States who may have access to personal health information in order to assist us in performing services for our customers. From time to time, the United States Congress considers legislation that would restrict the transmission of personal health information regarding a United States resident to any foreign affiliate, subcontractor or unaffiliated third party without adequate privacy protections or without providing notice to the identifiable individual of the transmission and an opportunity to opt out. Some of the proposals considered would have required patient consent and imposed liability on healthcare businesses arising from the improper sharing or other misuse of personal health information. Congress also has considered creating a private civil cause of action that would allow an injured party to recover damages sustained as a result of a violation of these proposed restrictions. Furthermore, a number of states have considered, or are in the process of considering, prohibitions or limitations on the disclosure of medical

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or other personal information to individuals or entities located outside of the United States. If legislation of this type is enacted, our ability to utilize offshore resources may be impeded, and we may be subject to sanctions for failure to comply with the new mandates of the legislation. In addition, the enactment of such legislation could result in such work being performed at a lower margin of profitability, or even at a loss. Further, as a result of concerns regarding the possible misuse of personal health information, some of our customers have contractually limited our ability to use our offshore resources. Use of offshore resources may increase our risk of violating our contractual obligations to our customers to protect the privacy and security of personal health information provided to us, which could adversely impact our reputation and operating results.

Failure by our customers to obtain proper permissions or provide us with accurate and appropriate data may result in claims against us or may limit or prevent our use of data which could harm our business.

We require our customers to provide necessary notices and obtain necessary permissions for the use and disclosure of the information that we receive. If they do not provide necessary notices or obtain necessary permissions, then our use and disclosure of information that we receive from them or on their behalf may be limited or prohibited by state or federal privacy or other laws. Such failures by our customers could impair our functions, processes and databases that reflect, contain or are based upon such data. For example, as part of our claims submission services, we rely on our customers to provide us with accurate and appropriate data and directives for our actions. While we have implemented features and safeguards designed to maximize the accuracy and completeness of claims content, these features and safeguards may not be sufficient to prevent inaccurate claims data from being submitted to payers. In addition, such failures by our customers could interfere with or prevent creation or use of rules, analyses or other data-driven activities that benefit us. Accordingly, we may be subject to claims or liability for inaccurate claims data submitted to payers or for use or disclosure of information by reason of lack of valid notice or permission. These claims or liabilities could damage our reputation, subject us to unexpected costs and adversely affect our financial condition and operating results.

Certain of our solutions present the potential for embezzlement, identity theft or other similar illegal behavior by our employees or contractors with respect to third parties.

Among other things, our solutions include printing and mailing checks and/or facilitating electronic funds transfers for our payer customers and handling mail and payments from payers and from patients for many of our provider customers. These services frequently include handling original checks, payment card information, banking account information and occasionally may include currency. Even in those cases in which we do not facilitate payments or handle original documents or mail, our services also involve the use and disclosure of personal and business information that could be used to impersonate third parties or otherwise gain access to their data or funds. If any of our employees or contractors takes, converts or misuses such funds, documents or data, or we experience a data breach creating a risk of identity theft, we could be liable for damages, and our business reputation could be damaged or destroyed. In addition, we could be perceived to have facilitated or participated in illegal misappropriation of funds, documents or data and, therefore, be subject to civil or criminal liability. Federal and state regulators may take the position that a data breach or misdirection of data constitutes an unfair or deceptive act or trade practice. We also may be required to notify individuals affected by any data breaches. Further, a data breach or similar incident could impact the ability of our customers that are creditors to comply with the federal red flags rules, which require the implementation of identity theft prevention programs to detect, prevent and mitigate identity theft in connection with customer accounts.

Contractual relationships with customers that are governmental agencies or are funded by government programs may impose special burdens on us and provide special benefits to those customers.

A portion of our revenues comes from customers that are governmental agencies or are funded by government programs. Our contracts and subcontracts may be subject to some or all of the following:

termination when appropriated funding for the current fiscal year is exhausted;

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termination for the governmental customer s convenience, subject to a negotiated settlement for costs incurred and profit on work completed, along with the right to place contracts out for bid before the full contract term, as well as the right to make unilateral changes in contract requirements, subject to negotiated price adjustments;

compliance and reporting requirements related to, among other things, agency specific policies and regulations, information security, equal employment opportunity, affirmative action for veterans and workers with disabilities and accessibility for the disabled;

broad audit rights; and

specialized remedies for breach and default, including setoff rights, retroactive price adjustments and civil or criminal fraud penalties, as well as mandatory administrative dispute resolution procedures instead of state contract law remedies.

In addition, certain violations of federal and state law may subject us to having our contracts terminated and, under certain circumstances, suspension and/or debarment from future government contracts. We also are subject to conflict-of-interest rules that may affect our eligibility for some federal, state and local government contracts, including rules applicable to all United States government contracts, as well as rules applicable to the specific agencies with which we have contracts or with which we may seek to enter into contracts.

The protection of our intellectual property requires substantial resources.

We rely upon a combination of trade secret, copyright and trademark laws, license agreements, confidentiality procedures, nondisclosure agreements and technical measures to protect the intellectual property used in our business. The steps we have taken to protect and enforce our proprietary rights and intellectual property may not be adequate. For instance, we may not be able to secure trademark or service mark registrations for marks in the United States or in foreign countries or take similar steps to secure patents for our proprietary applications. Third parties may infringe upon or misappropriate our copyrights, trademarks, service marks and other intellectual property rights. If we believe a third party has misappropriated our intellectual property, litigation may be necessary to enforce and protect those rights, which would divert management resources, would be expensive and may not effectively protect our intellectual property. As a result, if anyone infringes or misappropriates our intellectual property, it may have an adverse effect on our business, financial condition and results of operations.

Third parties may claim that we are infringing their intellectual property, and we could suffer significant litigation or licensing expenses or be prevented from selling certain solutions.

We could be subject to claims that we are misappropriating or infringing intellectual property or other proprietary rights of others. These claims, even if not meritorious, could be expensive to defend and divert management s attention from our operations. If we become liable to third parties for infringing these rights, we could be required to pay a substantial damage award and to develop non-infringing technology, obtain a license or cease selling the solutions or services that use or contain the infringing intellectual property. We may be unable to develop non-infringing solutions or obtain a license on commercially reasonable terms, or at all. We also may be required to indemnify our customers if they become subject to third party claims relating to intellectual property that we license or otherwise provide to them, which could be costly.

A write-off of all or a part of our identifiable intangible assets or goodwill would adversely affect our operating results and reduce our net worth.

We have significant identifiable intangible assets and goodwill, which represent the excess of the total consideration transferred in connection with the Merger and subsequent acquisitions over the estimated fair value of the net assets acquired. As of December 31, 2012, we had $1,730.1 million of identifiable intangible assets and $1,481.9 million of goodwill on our balance sheet, which represented in excess of 85.0% of our total assets. We amortize identifiable intangible assets over their estimated useful lives which range from 1 to 20 years. We also evaluate our goodwill for impairment at least annually. We are not permitted to amortize goodwill under United States generally accepted accounting principles. In the event an

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impairment of goodwill is identified, a charge to earnings would be recorded. Although it would not affect our cash flow, a write-off in future periods of all or a part of these assets would adversely affect our financial condition and operating results. See Part II, Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Estimates Goodwill and Intangible Assets of this Annual Report.

Our success depends in part on our ability to identify, recruit and retain skilled management, including our executive officers, and technical personnel. If we fail to recruit and retain suitable candidates or if our relationship with our employees changes or deteriorates, there could be an adverse effect on our business.

Our future success depends upon our continuing ability to identify, attract, hire and retain highly qualified personnel, including skilled management, product, technology, sales and marketing personnel, all of whom are in high demand and are often subject to competing offers. In particular, our executive officers are critical to the management of our business. The loss of any of our executive officers could impair our ability to execute our business plan and growth strategy, reduce revenues, cause us to lose customers, or lead to employee morale problems and/or the loss of key employees. Competition for qualified personnel in the healthcare information technology and services industry is intense, and we may not be able to hire or retain a sufficient number of qualified personnel to meet our requirements, or be able to do so at salary, benefit and other compensation costs that are acceptable to us. A loss of a substantial number of qualified employees, or an inability to attract, retain and motivate additional highly skilled employees required for expansion of our business, could have an adverse effect on our business. In addition, while none of our employees are currently unionized, unionization of our employees is possible in the future. Such unionizing activities could be costly to address and, if successful, likely would adversely impact our operations.

Lengthy sales, installation and implementation cycles for some of our solutions may result in delays or an inability to generate revenues from these solutions.

Sales of certain complex solutions and applications may result in longer sales, contracting and implementation cycles for our customers. These sales may be subject to delays due to customers internal procedures for deploying new technologies and processes and implementation may be subject to delays based on the availability of the internal customer resources needed. The use of our solutions also may be delayed due to reluctance to change or modify existing procedures. We are unable to control many of the factors that will influence the timing of the buying decisions of potential customers or the pace at which installation and training may occur. If we experience longer sales, contracting and implementation cycles for our solutions, we may experience delays in generating, or an inability to generate revenue from these solutions, which could have an adverse effect on our financial results.

We may be a party to legal, regulatory and other proceedings that could result in unexpected adverse outcomes.

From time to time, we are a party to legal and regulatory proceedings, including matters involving governmental agencies with whom we do business and other proceedings arising in the ordinary course of business. In addition, there are an increasing number of investigations and proceedings in the health care industry generally that seek recovery under HIPAA, the federal Anti-Kickback Law, the FCA and other statutes and regulations applicable to our business. We also may be subject to legal proceedings under non-healthcare laws affecting our business, such as employment, banking and financial services and USPS laws and regulations. We evaluate our exposure to these legal and regulatory proceedings and establish reserves for the estimated liabilities in accordance with United States generally accepted accounting principles. Assessing and predicting the outcome of these matters involves substantial uncertainties. Unexpected outcomes in these legal proceedings, or changes in management s evaluations or predictions and accompanying changes in established reserves, could have an adverse impact on our financial results.

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Risks Related to our Organization and Structure

We are a holding company and our principal asset is our ownership of equity interests in our subsidiaries; accordingly, we are dependent upon distributions from our subsidiaries to pay any dividends, taxes and any other expenses.

We are a holding company and our principal asset is our ownership of equity interests in our subsidiaries. We have no independent means of generating revenue. We intend to cause our subsidiaries to make distributions to us as the direct or indirect holder of 100% of the equity interests of such subsidiaries in amounts sufficient to make payments in respect of our outstanding indebtedness, including the Term Loan Facility, the Revolving Facility and the Senior Notes, as well as payments required under our tax receivable agreements (as discussed below). To the extent that we need funds and our subsidiaries are unable or otherwise restricted from making such distributions under applicable law or regulation, as a result of the terms in our credit agreements or are otherwise unable to provide such funds, our liquidity and financial condition could be adversely affected.

The amounts we will be required to pay under our tax receivable agreements could be significant and, in certain circumstances, could differ significantly (in both timing and amount) from the underlying tax benefits we actually realize.

The Company is a party to tax receivable agreements which obligate the Company to make payments to certain current and former owners of the Company, including affiliates of Blackstone, Hellman & Friedman and certain members of management, equal to 85% of the applicable cash savings that the Company realizes as a result of tax attributes arising from certain previous transactions, including the 2011 Transactions (Blackstone, together with affiliates of Hellman & Friedman and certain current and former members of management, are hereinafter sometimes referred to collectively as the TRA Members).

The payments we are required to make under the tax receivable agreements could be substantial. The amount and timing of any payments under the tax receivable agreements will vary depending upon a number of factors, including the amount and timing of the taxable income we generate in the future and the tax rate then applicable. We expect that, assuming no material changes in tax law and that we earn sufficient taxable income to realize the full potential tax benefit, future payments will range from $0.9 million to $69.8 million per year over the next 16 years. It is possible that future transactions or events could increase or decrease the actual tax benefits realized and the corresponding payments due under the tax receivable agreements. As of December 31, 2012, we expected total payments under the tax receivable agreements of approximately $354.1 million. $126.1 million of this amount, which included the initial fair value of the tax receivable agreement obligations at the time of the Merger plus accretion to date, was reflected as an obligation on the balance sheet at December 31, 2012.

There may be circumstances in which the payments under the tax receivable agreements may differ significantly (in both timing and amount) from the underlying tax benefits we actually realize. Pursuant to the tax receivable agreements, upon a covered change of control, we could be required to make payments that significantly exceed our actual cash tax savings from the tax benefits giving rise to such payments. Moreover, upon a covered change of control or initial public offering, we will have the option to terminate the tax receivable agreements in exchange for a lump-sum payment (based on an assumption that all expected potential tax benefits actually will be realized). In addition, under the tax receivable agreements, the TRA Members will not reimburse us for any payments previously made if such tax benefits are subsequently disallowed, except that excess payments made to the TRA Members will be netted against payments otherwise to be made, if any, after our determination of such excess. As a result, in such circumstances, we could make payments under the tax receivable agreements that are greater than our actual cash tax savings and may not be able to recoup those payments. Any difference between the payments we are required to make under the tax receivable agreements and the underlying tax benefits we actually realize could adversely affect our results of operations and/or our liquidity. Furthermore, because we are a holding company with no operations of our own, our ability to make payments under the tax receivable agreements is substantially dependent on the ability of our subsidiaries to make distributions to us. To the extent that we are unable to make payments under the tax receivable agreements for any reason, such payments will be deferred and will accrue interest until paid.

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We are controlled by the Investor Group, whose interests may conflict with ours or our creditors.

We are controlled by the Investor Group, which includes affiliates of Blackstone and Hellman & Friedman. The Investor Group controls the election of our directors and thereby has the power to control our affairs and policies, including the appointment of management. Circumstances may occur in which the interests of the Investor Group could be in conflict with our interests. The Investor Group may have an interest in pursuing acquisitions, divestitures, financing or other transactions, including, but not limited to, the issuance of additional debt or equity and the declaration and payment of dividends, that, in their judgment, could enhance their equity investments, even though such transactions may involve risk to us or to our creditors. Additionally, the Investor Group may make investments in businesses that directly or indirectly compete with us, or may pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. For information concerning our arrangements with the Investor Group, including affiliates of Blackstone and Hellman & Friedman, see Part III, Item 13 Certain Relationships and Related Transactions, and Director Independence of this Annual Report.

Risks Related to Our Indebtedness

Our substantial leverage could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of our variable rate debt and prevent us from meeting our obligations under the Senior Credit Facilities or Senior Notes.

As of December 31, 2012, our total debt was $2,068.0 million (before the deduction of unamortized debt discount of $51.3 million), comprised of $1,291.2 million of senior secured indebtedness under our Term Loan Facility, $375.0 million of indebtedness under the 2019 Notes, $375.0 million of indebtedness under the 2020 Notes and $26.9 million of indebtedness under our data sublicense agreement. Additionally, we had $125.0 million of unutilized capacity under our Revolving Facility. If we cannot generate sufficient cash flow from operations to service our debt, we may need to refinance our debt, dispose of assets or issue equity to obtain necessary funds. We do not know whether we will be able to take any of such actions on a timely basis or on terms satisfactory to us or at all.

Our high degree of leverage could have important consequences, including:

- making it more difficult for us to make payments on the Senior Credit Facilities and the Senior Notes;
- increasing our vulnerability to general economic and industry conditions;
- requiring a substantial portion of cash flow from operations to be dedicated to the payment of principal and interest on our indebtedness, thereby reducing our ability to use our cash flow to fund our operations, capital expenditures and future business opportunities;
- exposing us to the risk of increased interest rates as certain of our borrowings under our Senior Credit Facilities are at variable rates of interest;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, debt service requirements, acquisitions and general corporate or other purposes;
- limiting our ability to adjust to changing market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged; and

increasing our cost of borrowing.

Borrowings under our Senior Credit Facilities are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness may increase even though the amount borrowed remained the same, and our net income and cash flows, including cash available for servicing our indebtedness, will correspondingly decrease. Due to a floor on the floating rate index of 1.25% under the Term Loan Facility, a 0.125% increase in the floating rates on the funded amounts under our Senior Credit Facilities would have had only a negligible impact on our annual cash interest expense. Assuming all revolving loans are drawn under the Revolving Facility, a 0.125% change in the floating rate would result in an additional $0.2 million increase in our annual cash interest expense. In January 2012, we entered into interest rate swaps that involve the exchange of floating for fixed rate interest payments that partially reduced our

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exposure to interest rate volatility. However, we may not maintain these interest rate swaps as currently structured with respect to our variable rate indebtedness, and any future additional swaps we enter into may not fully mitigate our interest rate risk.

Despite our substantial indebtedness, we may still be able to incur significantly more debt. The incurrence of additional debt could increase the risks associated with our substantial leverage, including our ability to service our indebtedness.

We and our subsidiaries may be able to incur significant additional indebtedness in the future, including additional tranches of term loans, increased commitments under the Revolving Facility or the Term Loan Facility or one or more incremental Revolving Facility tranches. Although the indentures governing the Senior Notes and the credit agreement (the Senior Credit Agreement) governing the Senior Credit Facilities contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the additional indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. If we incur additional indebtedness or other obligations, the current risks related to our substantial leverage would increase and could have a negative impact on us or our credit ratings.

The Senior Credit Agreement provides that, subject to certain conditions, we may request additional tranches of term loans, increase commitments under the Revolving Facility or the Term Loan Facility or add one or more incremental revolving facility tranches (provided that the revolving credit commitments outstanding at any time have no more than three different maturity dates) in an aggregate amount not to exceed (a) $300.0 million plus (b) an unlimited amount at any time, subject to compliance on a pro forma basis with a first lien net leverage ratio of no greater than 4.00:1.00. Availability of such additional tranches of term loans or revolving facilities and/or increased commitments is subject to, among other conditions, the absence of any default under the Senior Credit Agreement and the receipt of commitments by existing or additional financial institutions.

The Senior Credit Agreement and the indentures governing our Senior Notes restrict our ability and the ability of most of our subsidiaries to engage in some business and financial transactions.

The Senior Credit Agreement requires us to comply with certain financial covenants, including a quarterly maximum consolidated first lien net leverage ratio test and a quarterly minimum consolidated cash interest coverage ratio test, which financial covenants will become more restrictive over time. In addition, our Senior Credit Facilities include negative covenants that, among other things and subject to certain significant exceptions, limit our ability and the ability of our restricted subsidiaries to:

- incur indebtedness or guarantees;
- incur liens;
- make investments, loans and acquisitions;
- consolidate or merge;
- sell assets, including capital stock of our subsidiaries;
- pay dividends on our capital stock or redeem, repurchase or retire our capital stock;
- alter the business we conduct;

amend, prepay, redeem or purchase subordinated debt;

engage in transactions with our affiliates; and

enter into agreements limiting subsidiary dividends and distributions.

Our ability to borrow additional amounts under our Senior Credit Facilities depends upon satisfaction of these and numerous additional covenants related to our financial condition covenants. Events beyond our control can affect our ability to meet these covenants.

The indentures governing our Senior Notes also contain a number of restrictive covenants that impose significant operating and financial restrictions on us and may limit our ability to engage in acts that may be in our long-term best interest, including restrictions on our ability and the ability of our restricted subsidiaries to:

pay dividends on our capital stock or redeem, repurchase or retire our capital stock;

incur additional indebtedness or issue certain capital stock;

incur certain liens;

make investments, loans, advances and acquisitions;

consolidate, merge or transfer all or substantially all of our assets and the assets of our subsidiaries;

prepay subordinated debt;

engage in certain transactions with our affiliates; and;

enter into agreements restricting our restricted subsidiaries ability to pay dividends.

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If we or our restricted subsidiaries engage in certain asset sales, we generally must either invest the net proceeds from such sales in our business within a period of time, prepay certain debt (including indebtedness outstanding under our Senior Credit Facilities) or make an offer to purchase a principal amount of the Senior Notes equal to the excess net proceeds, subject to certain exceptions.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which are subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness, including the Senior Credit Facilities and the Senior Notes. If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, seek additional capital, restructure or refinance our indebtedness, including the Senior Credit Facilities and the Senior Notes, or sell assets. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. The Senior Credit Agreement and the indentures governing our Senior Notes restrict our ability to use the proceeds from asset sales. We may not be able to consummate those asset sales to raise capital or sell assets at prices that we believe are fair and proceeds that we do receive may not be adequate to meet any debt service obligations then due. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit ratings, which could harm our ability to incur additional indebtedness.

ITEM 1B. *UNRESOLVED STAFF COMMENTS*

None.

ITEM 2. *PROPERTIES*

We do not own any real property. We lease approximately 178,000 square feet of office space in Nashville, Tennessee, that serves as our corporate headquarters, and such lease is due to expire in October 2018.

In addition to our corporate headquarters, we lease 55,000 total square feet in Nashville, Tennessee that houses a data center and adjoining office space. The initial term on our lease for this space expires in August 2025, and we have the option to extend the lease by two five-year renewal terms. Another primary data center, containing approximately 20,000 square feet of data center space, is located in Memphis, Tennessee, and is subject to a lease agreement due to expire in January 2017.

We also lease approximately 93,000 square feet of office space at a facility in Toledo, Ohio for our provider patient statement operations, which is subject to a lease agreement due to expire in February 2015. In addition, in the first quarter of 2013, we moved certain of our payer distribution services to a new location in Bridgeton, Missouri consisting of approximately 116,000 square feet, which is subject to a lease agreement due to expire in November 2023.

We also lease a number of other data centers, operations, business and sales offices in several states. We believe that our facilities are generally adequate for current and anticipated future use, although we may from time to time lease or vacate additional facilities as our operations require.

ITEM 3. *LEGAL PROCEEDINGS*

In the normal course of business, the Company is subject to claims, lawsuits and legal proceedings. While it is not possible to ascertain the ultimate outcome of such matters, in management s opinion, the liabilities, if any, in excess of amounts provided or covered by insurance, are not expected to have a material adverse effect on our consolidated financial position, results of operations or liquidity.

ITEM 4. ***MINE SAFETY DISCLOSURES***

Not applicable.

PART II

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

We are an indirect wholly owned subsidiary of Parent, which in turn is wholly owned by the Investor Group. Accordingly, there is no public trading market for our common stock.

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ITEM 6. ***SELECTED FINANCIAL DATA***

The selected historical consolidated financial data set forth below should be read in conjunction with, and are qualified by reference to, Management s Discussion and Analysis of Financial Condition and Results of Operations and our historical consolidated financial statements and related notes included in this Annual Report.

The following table sets forth our selected historical consolidated financial data at the dates and for the periods indicated. The selected historical consolidated financial data as of December 31, 2012 and 2011, and for the year ended December 31, 2012, for the periods from November 2, 2011 to December 31, 2011 and January 1, 2011 to November 1, 2011 and for the year ended December 31, 2010 presented in this table, have been derived from the historical audited consolidated financial statements included in this Annual Report. The selected historical consolidated financial data as of December 31, 2010, 2009 and 2008 and for the years ended December 31, 2010, 2009 and 2008 presented in this table have been derived from our historical audited consolidated financial statements not included in this Annual Report.

On November 2, 2011, Merger Sub merged with and into Emdeon, which resulted in a change in basis of the Company s assets and liabilities. Periods prior to the Merger and this change in basis are referred to as Predecessor and periods after the Merger are referred to as Successor. As a result of the Merger and the resulting change in basis of the Company s assets and liabilities, the Predecessor and Successor period financial data is not comparable.

	Successor		Predecessor			
	Fiscal Year Ended December 31, 2012	November 2, 2011 through December 31, 2011	January 1, 2011 through November 1, 2011	Fiscal Year Ended December 31, 2010	Fiscal Year Ended December 31, 2009	Fiscal Year Ended December 31, 2008
	(In thousands)					
Statement of Operations Data:[1]						
Revenues	$ 1,178,271	$ 190,384	$ 929,264	$ 1,002,152	$ 918,448	$ 853,599
Costs and expenses:						
Cost of operations	731,525	117,421	572,541	612,367	562,636	541,138
Development and engineering	31,794	5,153	26,090	30,638	30,539	22,391
Sales, marketing, general and administrative	142,186	21,778	111,463	116,947	118,996	100,952
Depreciation and amortization	187,225	29,094	128,761	124,721	105,321	97,864
Accretion	8,666	2,459				
Transaction related costs	1,250	17,857	66,625			
Total costs and expenses	1,102,646	193,762	905,480	884,673	817,492	762,345
Operating income (loss)	75,625	(3,378)	23,784	117,479	100,956	91,254
Interest expense, net	172,253	29,343	43,201	61,017	70,171	70,754
Loss on extinguishment of debt	21,853					
Other		(5,843)	(8,036)	(9,284)	(519)	
Income (loss) before income taxes	(118,481)	(26,878)	(11,381)	65,746	31,304	20,500
Income tax provision	(40,146)	(10,185)	8,201	32,579	17,301	8,567
Net income (loss)	(78,335)	(16,693)	(19,582)	33,167	14,003	11,933
Net income attributable to noncontrolling interest			5,109	13,621	4,422	2,702
Net income (loss) attributable to Emdeon Inc.	$ (78,335)	$ (16,693)	$ (24,691)	$ 19,546	$ 9,581	$ 9,231

	As of December 31,				
	2012	2011	2010	2009	2008
Balance Sheet Data:[1]					

Cash and cash equivalents	$ 31,763	$ 37,925	$ 99,188	$ 211,999	$ 71,478
Total assets	3,767,888	3,832,067	2,491,565	2,229,413	2,000,279
Total debt[2]	2,016,722	1,961,108	946,243	840,682	825,230
Tax receivable obligations to related parties[3]	126,142	117,810	142,279	142,044	
Total equity	$ 1,032,151	$ 1,103,789	$ 1,055,288	$ 979,869	$ 878,153

(1) As a result of our history of business combinations, our financial position and results of operations may not be comparable for each of the periods presented.

(2) Our debt at December 31, 2012, 2011 and 2010 is reflected net of unamortized debt discount of approximately $51.3 million, $58.5 million and $42.6 million, respectively, related to original loan fees and purchase accounting adjustments to discount the debt to fair value. Total debt as of December 31, 2012, 2011 and 2010 includes an obligation of approximately $26.9 million, $30.6 million and $40.3 million, respectively related to our data sublicense agreement.

(3) In connection with the Merger, the tax receivable obligation to related parties was recorded at fair value with future payments expected to total $354.1 million. In the Predecessor periods, the liability was recorded at total expected payments.

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

You should read the following discussion in conjunction with Selected Financial Data and our consolidated financial statements and related notes included elsewhere in this Annual Report. Some of the statements in the following discussion are forward-looking statements. See Cautionary Statement Regarding Forward-Looking Statements elsewhere in this Annual Report.

As a result of the 2011 Transactions and the change in basis of the Company s assets and liabilities, periods prior to the 2011 Transactions are referred to as Predecessor and periods after the 2011 Transactions are referred to as Successor .

Overview

We are a leading provider of revenue and payment cycle management and clinical information exchange solutions connecting payers, providers and patients in the U.S. healthcare system. Our solutions integrate and automate key business and administrative functions of our payer and provider customers throughout the patient encounter, including pre-care patient eligibility and benefits verification and enrollment, clinical information exchange, claims management and adjudication, payment integrity, payment distribution, payment posting and denial management and patient billing and payment processing. Our customers are able to improve efficiency, reduce costs, increase cash flow and more efficiently manage the complex revenue and payment cycle and clinical information exchange processes by using our comprehensive suite of solutions.

During 2012, we delivered our solutions and operated our business in three business segments: (i) payer services, which provides solutions to commercial insurance companies, third party administrators and governmental payers; (ii) provider services, which provides solutions to hospitals, physicians, dentists and other healthcare providers, such as labs and home healthcare providers; and (iii) pharmacy services, which provides solutions to pharmacies, pharmacy benefit management companies, government agencies and other payers. Through our payer services segment, we provide payment cycle solutions, both directly and through our network of channel partners, that help simplify the administration of healthcare related to insurance eligibility and benefits verification, claims management, payment integrity and claims and payment distribution. Additionally, we provide consulting services through our payer services segment. Through our provider services segment, we provide revenue cycle management solutions, patient billing and payment services, government program eligibility and enrollment services and clinical information exchange capabilities, both directly and through our channel partners, that simplify providers revenue cycle and workflow, reduce related costs and improve cash flow. Through our pharmacy services segment, we provide electronic prescribing and other electronic solutions to pharmacies, pharmacy benefit management companies and government agencies related to prescription benefit claim filing, adjudication and management.

There are a number of company-specific initiatives and industry trends that may affect our transaction volumes, revenues, cost of operations and margins. As part of our strategy, we encourage our customers to migrate from paper-based claim, patient statement, payment and other transaction processing to electronic, automated processing in order to improve efficiency. Our business is aligned with our customers to support this transition, and as they migrate from paper-based transaction processing to electronic processing, even though our revenues for an applicable customer generally will decline, our margins and profitability will typically increase. For example, because the cost of postage is included in our revenues for patient statement and payment services (which is then also deducted as a cost of operations), when our customers transition to electronic processing, our revenues and costs of operations are expected to decrease as we will no longer incur or be required to charge for postage. As another example, as our payer customers migrate to exclusive or other comprehensive management services agreements with us, our electronic transaction volume usually increases while the rebates we pay and the per transaction rates we charge under these agreements are typically reduced.

Part of our strategy also includes the development and introduction of new solutions. Our new and updated solutions are likely to require us to incur development and engineering expenditures and related sales and marketing costs at levels greater than recent years expenditures in order to successfully develop and achieve market acceptance of such solutions. We also may acquire, or enter into agreements with third parties to assist us in providing, new solutions. For example, we offer our electronic payment solutions through banks or vendors who contract with banks and other financial service firms. The costs

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of these initiatives or the failure to achieve broad penetration in target markets with respect to new or updated solutions may negatively affect our results of operations and margins. Because newly introduced solutions generally will have lower margins initially as compared to our existing and more mature solutions, our margins and margin growth may be adversely affected on a percentage basis until these new solutions achieve scale and maturity.

In addition to our internal development efforts, we actively evaluate opportunities to improve and expand our solutions through strategic acquisitions. Our acquisition strategy focuses on identifying acquisitions that improve and streamline the business and administrative functions of healthcare. We believe our broad customer footprint allows us to deploy acquired solutions into our installed base, which, in turn, can help accelerate growth of our acquired businesses. We also believe our management team s ability to identify acquisition opportunities that are complementary and synergistic to our business, and to integrate them into our existing operations with minimal disruption, will continue to play an important role in the expansion of our business and our growth. Our success in acquiring and integrating acquired businesses into our existing operations, the associated costs of such acquisitions, including integration costs, and the operating characteristics of the acquired businesses also may impact our results of operations and margins. Because the businesses we acquire sometimes have lower margins than our existing businesses, primarily as a result of their lack of scale and maturity, our margins on a percentage basis may be adversely affected in the periods subsequent to an acquisition from revenue mix changes and integration activities associated with these acquisitions.

We also expect to continue to be affected by general economic, regulatory and demographic factors affecting the healthcare industry. For several years, there has been pricing pressure in our industry, which has led and is expected to continue to lead to reduced prices for the same services. We have sought in the past and will continue to seek to mitigate pricing pressure by providing additional value-added solutions, increasing the volume of solutions we provide and managing our costs. In addition, significant changes in regulatory schemes, such as HIPAA, ARRA, PPACA and other federal healthcare policy initiatives, impact our customers healthcare activities and generally result in increased operating costs and capital expenditures for us. In particular, we believe the PPACA will significantly affect the regulatory environment in which we and our customers operate by changing how healthcare services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced federal healthcare program spending, increased efforts to link federal healthcare program payments to quality and efficiency and insurance market reforms. Also, changes in federal and state reimbursement patterns and rates can impact the revenues in certain of our business lines, particularly our government program eligibility and enrollment solutions.

Demographic trends affecting the healthcare industry, such as population growth and aging or continued high unemployment rates as a result of recent adverse economic conditions, also could affect the frequency and nature of our customers healthcare transactional activity. The impact of such changes could impact our revenues, cost of operations and infrastructure expenses and thereby affect our results of operations and the way we operate our business. For example, an increase in the U.S. population, if such increase is accompanied by an increase in the U.S. population that has health benefits, or the aging of the U.S. population, which requires an overall increased need for healthcare services, may result in an increase in our transaction volumes which, in turn, may increase our revenues and cost of operations. Alternatively, a recurrence of the recent general economic downturn, which reduces the number of discretionary health procedures by patients, or a persistent high unemployment rate, which lessens healthcare utilization, may decrease or offset other growth in our transaction volumes, which, in turn, may adversely impact our revenues and cost of operations.

Recent Developments

We reorganized our segments as payer services, revenue cycle solutions, ambulatory services and pharmacy services effective January 1, 2013. This discussion and analysis with respect to past periods reflects our segments as managed during the periods presented.

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Our Revenues and Expenses

We generate most of our revenue by using technology solutions to provide services to our customers that automate and simplify business and administrative functions for payers, providers and pharmacies, generally on either a per transaction, per document, per communication, per member per month, monthly flat-fee, contingent fee or hourly basis.

Cost of operations consists primarily of costs related to services we provide to customers and costs associated with the operation and maintenance of our networks. These costs include postage and materials costs related to our patient statements and payment services, rebates paid to our channel partners and data communications costs, all of which generally vary with our revenues and/or volumes and are discussed in the following four paragraphs. Cost of operations also includes personnel costs associated with production, network operations, customer support and other personnel, facilities expenses and equipment maintenance, some of which can vary less directly with our revenue and/or volumes due to the fixed or semi-fixed nature of these expenses.

The largest component of our cost of operations is currently postage which is incurred in our patient statements and payment services businesses and which is also a component of our revenue in those businesses. Our postage costs increase as our patient statements and payment services volumes increase and also when the USPS increases postage rates. U.S. postage rate increases, while generally billed as pass-through costs to our customers, affect our cost of operations as a percentage of revenue. In prior years, we have offset the impact of postage rate increases through cost reductions from efficiency measures, including data communication expense reductions and production efficiencies. Though we plan to continue our efficiency measures, we may not be able to offset the impact of postage rate increases in the future and, as a result, cost of operations as a percentage of revenue may increase if postage rate increases continue**.** Although the USPS historically has increased postage rates annually in most recent years, including January 2013, the frequency and nature of such increases may not occur as regularly in the future.

Rebates are paid to channel partners for electronic and other volumes delivered through our network to certain payers and can be impacted by the number of exclusive or other comprehensive management services agreements we execute with payers, the associated rate structure with our payer customers, the success of our direct sales efforts for provider revenue cycle management solutions and the extent to which direct connections to payers are developed by our channel partners.

Our data communication expense consists of telecommunication and transaction processing charges. Over the last several years, we have been able to reduce our data communication expense due to efficiency measures and contract pricing changes. Due to the significance of these past reductions in recent years, further reductions may have a lesser impact in future periods.

Our material costs relate primarily to our patient statements and payment services volumes, and consist primarily of paper and printing costs.

Development and engineering expense consists primarily of personnel costs related to the development, management and maintenance of our current and future solutions. We may invest more in this area in the future as we develop new and enhance existing solutions.

Sales, marketing, general and administrative expense (excluding corporate expense described in the next paragraph) consists primarily of personnel costs associated with our sales, account management and marketing functions and management and administrative services related to the operations of our business segments. We will likely invest more in sales and marketing in the future to further promote our new and existing solutions.

Our corporate expense relates to personnel and other costs associated with management, administrative, finance, human resources, legal, marketing, public and investor relations, compliance and other corporate service functions, as well as professional services, costs incurred in connection with acquisitions, costs incurred in connection with the 2011 Transactions, accretion expense under our tax receivable agreement obligations, certain facilities costs, insurance, regulatory compliance and other expenses related to our overall business operations.

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Our development and engineering expense, sales, marketing, general and administrative expense and corporate expense, while related to our current operations, also are affected and influenced by our future plans including the development of new solutions, business strategies and enhancement and maintenance of our infrastructure.

Our depreciation and amortization expense is related to depreciation of our property and equipment, including technology assets, and amortization of intangible assets acquired and recorded in conjunction with acquisition method accounting. As a result, the amount of depreciation and amortization expense is affected by the level of our recent investment in property and equipment and the level of our recent acquisition activity. Additionally, as described under Significant Items Affecting Comparability-Effect of the 2011 Transactions below, our depreciation and amortization expense increased significantly subsequent to and as a result of acquisition method adjustments in connection with the 2011 Transactions.

Our interest expense consists principally of cash interest associated with our long-term debt obligations and non-cash interest associated with the amortization of borrowing costs and discounts related to debt issuance. Prior to the 2011 Transactions, interest expense also included cash interest on our prior interest rate swap agreement and non-cash interest related to discontinued cash flow hedges and changes in the fair value of our prior interest rate swap agreement during periods when the prior interest rate swap agreement was not subject to hedge accounting. Additionally, as described under Significant Items Affecting Comparability Effect of the 2011 Transactions below, our interest expense increased significantly subsequent to and as a result of the additional debt incurred to help finance the 2011 Transactions. If market interest rates on the variable portion of our long-term debt increase in the future, our interest expense may increase. Accordingly, as described in Significant Items Affecting Comparability Interest Rate Swaps , we executed three new interest rate swap agreements in January 2012 to reduce the variability of interest payments associated with our new Term Loan Facility.

Our income taxes consist of federal and state income taxes. These amounts include current income taxes payable, as well as income taxes for which the payment is deferred to future periods and dependent on the occurrence of future events. Our income tax expense may vary from the expense that would be expected based on statutory rates due principally to our organizational structure and differences in the book and tax basis of our investment in EBS Master LLC (EBS Master). The recognition of valuation allowances related to certain net operating loss carryovers also can affect our income tax expense. For additional information, see the discussion of income taxes in the section Significant Items Affecting Comparability-Income Taxes .

Significant Items Affecting Comparability

Certain significant items or events should be considered to better understand differences in our results of operations from period to period. We believe that the following items or events have had a significant impact on our results of operations for the periods discussed below or may have a significant impact on our results of operations in future periods:

Effect of the 2011 Transactions

The 2011 Transactions have had and are expected to continue to have a significant effect on our financial condition and results of operations. These significant effects include those related to acquisition method adjustments, additional debt, 2011 Transactions related costs and income tax effects.

Acquisition Method Adjustments

In connection with the Merger, we were required to adjust our assets and liabilities to their respective fair values. These adjustments included the following:

Recognition of the fair value of tangible and intangible assets. The fair value of our tangible and intangible assets exceeded the previously recorded amounts. As a result, for periods following the Merger, we have reported and expect to continue to report increased depreciation and amortization expense.

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Reduction in the carrying value of our tax receivable agreement obligations to fair value. For periods prior to the Merger, our tax receivable agreement obligations were reported at the amount that was both probable of payment and reasonably estimable. In connection with the Merger, we were required to adjust these obligations to their fair value. Our tax receivable agreement obligations fair value reflects three significant factors that were not previously considered in the carrying value: (i) the impact of a restructuring, effective December 31, 2011, to simplify our corporate structure, (ii) the exchange of units of EBS Master (EBS Units) for cash or stock of Parent and (iii) discounting of the tax receivable agreement obligations for the time value of money. The effect of these additional factors resulted in a significant increase in the total payments due under the tax receivable agreements. We currently expect the cumulative payments to total $354.1 million. After discounting the obligations for the time value of money, however, the fair value of the obligations at the time of the Merger was $115.0 million. As a result, our consolidated statement of operations for periods following the Merger will reflect accretion expense to adjust the fair value of our tax receivable agreement obligations to the total expected payments. Such accretion expense for the year ended December 31, 2012 and for the period from November 2, 2011 to December 31, 2011 totaled approximately $8.7 million and $2.5 million, respectively.

Reduction to fair value of our deferred revenue related to outstanding products and services to be provided in periods following the Merger. In connection with the Merger, we reduced our deferred revenue to the amount attributable to our remaining contractual obligations at the time of the Merger. As a result of this reduction, our revenue in periods following the Merger will be reduced, as compared to what would have been recognized without this adjustment. This reduction of revenue for the year ended December 31, 2012 and for the period from November 2, 2011 to December 31, 2011 was approximately $4.9 million and $2.2 million, respectively.

Additional Debt

In connection with the 2011 Transactions, we borrowed an aggregate of approximately $2.0 billion, a portion of which was used to repay all amounts due under our prior credit agreements and interest rate swap agreement and to help finance the Merger. As a result of this additional debt, our interest expense in periods following the Merger has been, and will be, substantially greater than amounts reported in periods prior to the Merger.

2011 Transactions Related Costs

In connection with the 2011 Transactions, we also incurred certain nonrecurring charges that have been included within transaction related costs in our consolidated statement of operations. Transaction related costs for the respective periods are presented below (in thousands):

	Successor		Predecessor
	Year Ended December 31, 2012	November 2 through December 31, 2011	January 1, 2011 through November 1, 2011
Accelerated vesting of equity compensation	$	$	$ 35,285
Professional and other advisory fees			27,573
Expenses incurred in connection with the refinancing of existing debt	1,250	16,857	
Transaction-related bonuses and severance		1,000	3,767
Total	$ 1,250	$ 17,857	$ 66,625

Income Tax Effects

In connection with the 2011 Transactions, all EBS Units that were not previously controlled by us were exchanged for cash, or cash and shares of Parent. Additionally, effective December 31, 2011, we simplified our corporate structure. These transactions resulted in additional basis in our assets and will impact income tax expense and cash payments for income taxes in subsequent periods. Pursuant to our tax receivable agreement obligations, however, 85% of such tax savings must be paid to the parties to our tax receivable agreements.

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Acquisitions and Divestitures

We actively evaluate opportunities to improve and expand our business through targeted acquisitions that are consistent with our strategy. On occasion, we also may dispose of certain components of our business that no longer fit within our overall strategy. Because of our acquisition and divestiture activity, our results of operations may not be directly comparable among periods. The following summarizes our acquisition transactions since January 1, 2010 and affected segments:

Date	Business	Description	Affected Segment
January 2010	Future Vision Investment Group, L.L.C. (FVTech)	Electronic data conversion and management solutions	Provider; Payer
March 2010	Healthcare Technology Management Services, Inc. (HTMS)	Consulting solutions	Payer
April 2010	Data Rights	Acquired certain additional rights to specified uses of data	N/A
June 2010	Chapin Revenue Cycle Management, LLC (Chapin)	Accounts receivable denial and recovery services	Provider
October 2010	Chamberlin Edmonds & Associates, Inc. (CEA)	Government program eligibility and enrollment services	Provider
May 2011	EquiClaim, LLC (EquiClaim)	Technology-enabled provider of healthcare audit and recovery solutions	Payer
May 2012	TC3 Health, Inc. (TC3)	Technology-enabled provider of cost containment and payment integrity solutions	Payer

For certain of our prior acquisitions, we agreed to transfer additional consideration to the sellers of the acquired businesses in the event that specified performance measures are achieved. United States generally accepted accounting principles generally require us to recognize the initial fair value of the expected amount to be paid under such contingent consideration arrangements as a component of the total consideration transferred. Subsequent changes in the fair value of the amounts expected to be paid, however, are generally required to be recognized as a component of net income. Such changes in fair value may occur based on changes in the expected timing or amount of payments or the effect of discounting the liability for the time value of money. We recognized an increase in pretax income of $2.2 million, $3.6 million and $5.8 million in the periods from November 2, 2011 to December 31, 2011 and January 1, 2011 to November 1, 2011 and the year ended December 31, 2010, respectively, related to changes in fair value of contingent consideration related to acquisitions.

Efficiency Measures

We evaluate and implement efficiency measures and other cost savings initiatives on an ongoing basis to improve our financial and operating performance through reorganization, cost savings, productivity improvements and other process improvements. For instance, we are consolidating our data centers, consolidating our networks and outsourcing certain information technology and operations functions. The implementation of these measures often involve upfront costs related to severance, professional fees, contractor costs and/or capital expenditures, with the cost savings or other improvements not realized until the measures are successfully completed.

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Income Taxes

Our blended statutory federal and state income tax rate ranges from 37% to 40%. Our effective income tax rate, however, is affected by several factors. The following table and subsequent commentary reconciles our federal statutory rate to our effective income tax rate and the subsequent commentary describes the more significant of the reconciling factors:

	Successor		Predecessor	
	Fiscal Year end December 31, 2012	November 2 through December 31, 2011	January 1 through November 1, 2011	Fiscal Year end December 31, 2010
Statutory U.S. federal tax rate	35.00%	35.00%	35.00%	35.00%
State income taxes (net of federal benefit)	(2.95)	3.68	52.49	2.78
Meals and entertainment	(0.29)	(0.65)	(3.36)	0.63
2011 Transactions related costs		(0.49)	(34.77)	
Other	(0.05)	(0.64)	1.54	(1.38)
Tax credits	0.16	0.53	11.14	(0.63)
Equity compensation			(62.26)	2.06
Non-timing basis differences	0.19	0.37	(89.58)	12.49
Noncontrolling interest			15.71	(7.20)
Domestic production activities	2.85			
Uncertain tax positions	(1.23)			
Foreign loss not benefited	0.20	0.09	2.03	(0.34)
Return to provision adjustments				1.34
Change in valuation allowance				4.80
Effective income tax rate	33.88%	37.89%	(72.06)%	49.55%

Equity compensation Prior to the Company s August 2009 initial public offering (IPO), certain members of our senior management team and board of directors held profits interest in EBS Master which had only a nominal, if any, value at the date they were originally granted. Because of this nominal value, each of the profits interest holders made an election to pay income taxes based on the fair value of the profits interest on the grant date. As a result, while the Company recognized compensation expense related to these awards as they vested, the Company received no tax deduction related to these awards.

Non-timing basis differences Due to our organizational structure prior to the 2011 Transactions, certain items, including a portion of our equity compensation, other comprehensive income and income of corporate consolidated subsidiaries of EBS Master, affected our book basis in EBS Master without similarly affecting our tax basis in EBS Master. In the case of our corporate consolidated subsidiaries, the Company recognized income tax expense both at the subsidiary and the parent company level for the same income (once as it was earned at the subsidiary level and once as a result of the tax effect of the difference in tax and book basis of the limited liability company which controlled those corporate subsidiaries). As a result, in periods prior to the 2011 Transactions, our effective income tax rates were impacted by these matters. In connection with the 2011 Transactions, our organizational structure was simplified and, as a result, we expect the impact of these factors to be less than prior to the 2011 Transactions.

Noncontrolling interest Prior to the 2011 Transactions, a portion of the interests of EBS Master were held by entities not under our control. Accordingly, we historically recognized income tax expense only for the portion of the income generated by EBS Master that was attributable to us. In connection with the 2011 Transactions, EBS Master became a wholly owned subsidiary of the Company.

Change in valuation allowance We record valuation allowances or reverse existing valuation allowances related to assumed future income tax benefits depending on circumstances and factors related to our business. During 2010, we recognized a capital loss for tax purposes. Because we do not anticipate being able to recognize the benefit of this capital loss in the foreseeable future, we increased our valuation allowance by approximately $3.2 million related to this matter.

State Income Taxes Our effective tax rate for state income tax was impacted by changes in our uncertain tax positions, valuation allowances, regulatory environment and apportionment. During the period from January 1, 2011 to November 1, 2011, we recognized an income tax benefit of approximately $8.0 million related to an interpretive change by regulatory authorities in the state of Tennessee.

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Stock-Based and Equity Compensation Expense

In connection with the 2011 Transactions, the Company s then outstanding stock options, EBS Units and restricted stock units under various equity compensation programs, including the 2009 Equity Incentive Plan (the 2009 Plan), became fully vested immediately prior to the closing of the Merger and were settled in cash, canceled or, for certain members of senior management, exchanged for new options of Parent common stock (the Rollover Options). Except for the Rollover Options, each option holder received an amount in cash, without interest and less applicable withholding taxes, equal to $19.00 less the exercise price of each option. Additionally, each EBS Unit and restricted stock unit holder received $19.00 in cash, without interest and less applicable withholding taxes.

Parent assumed the 2009 Plan in connection with the 2011 Transactions by adopting the Beagle Parent Corp. Amended and Restated 2009 Equity Incentive Plan (the Parent Equity Plan). Pursuant to the Parent Equity Plan, 125,718 shares of Parent common stock have been reserved for the issuance of equity awards to employees, directors and consultants of Parent and its affiliates.

During 2012, Parent granted 113,595 options to certain employees and directors to purchase shares of Parent common stock under the Parent Equity Plan. Grants under the Parent Equity Plan consist of one, or a combination, of time-vested options and/or performance-based options. In each case, the options are subject to certain call rights by Parent in the event of termination of service by the option holder and put rights by the option holder or his/her beneficiaries in the event of death or disability.

Related to the equity arrangements described above, we incurred equity compensation expense of $6.8 million, $0.0 million, $54.8 million (including $35.3 associated with the acceleration of vesting of equity based awards) and $17.6 million for the year ended December 31, 2012, for the periods from November 2, 2011 to December 31, 2011 and January 1, 2011 to November 1, 2011 and for the year ended Decembers 31, 2010, respectively.

Interest Rate Swaps

We manage economic risks, including interest rate, liquidity and credit risk, primarily by managing the amount, sources and duration of our debt funding and the use of derivative financial instruments. Specifically, we enter into interest rate swap agreements to manage exposures that arise from business activities which result in the receipt or payment of future known and uncertain cash amounts, the value of which are determined by interest rates. Our interest rate swap agreements are used to manage differences in the amount, timing and duration of our known or expected cash receipts and our known or expected cash payments principally related to our borrowings.

The financial statement effects of our interest rate swap agreements vary based on whether the agreements are designated as a hedge of future cash flows. Beginning in the fourth quarter of 2010, our prior interest rate swap agreement was not designated as a hedge, and as such, interest expense for the period from January 1, 2011 to November 1, 2011 and for the year ended December 31, 2010 was reduced by $8.0 million and $3.9 million, respectively, due to changes in the fair value of this interest rate swap agreement. In connection with the 2011 Transactions, we terminated this interest rate swap agreement and no interest rate swap agreement was in place for the period from November 2, 2011 to December 31, 2011.

In January 2012, we executed three new interest rate swap agreements to reduce the variability of interest payments associated with the Term Loan Facility. For the year ended December 31, 2012, our interest rate swap agreements were designated as cash flow hedges so that changes in the fair value of the interest rate swap agreements were included within other comprehensive income.

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Amendments of the Senior Credit Agreement

In April 2012, we amended the Senior Credit Agreement to reprice the Senior Credit Facilities and borrow $80.0 million of additional term loans for general corporate purposes, including acquisitions. The amendments to the Senior Credit Agreement resulted in a loss on extinguishment of debt of $21.9 million and other expenses related to fees paid to third parties of $3.6 million during the year ended December 31, 2012. As a result of these amendments, the LIBOR-based interest rate applicable to the Senior Credit Facilities paid by the Company was generally reduced by 175 basis points.

Critical Accounting Estimates

The preparation of financial statements in accordance with U.S. generally accepted accounting principles requires us to make estimates and assumptions that affect reported amounts and related disclosures. We consider an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on our consolidated results of operations and financial condition.

The following discussion of critical accounting estimates is not intended to be a comprehensive list of all of our accounting policies that require estimates and highlights only those policies that involve estimates that we believe entail a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and financial condition.

The discussion that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate:

Revenue Recognition

We generate most of our revenue by using technology solutions to provide services to our customers that automate and simplify business and administrative functions for payers, providers and pharmacies, generally on either a per transaction, per document, per communication, per member per month, monthly flat-fee, contingent fee or hourly basis.

Revenue for transaction services, payment services, patient statements and consulting services are recognized as the services are provided. Postage fees related to our payment services and patient statement volumes are recorded on a gross basis. Revenue for our government eligibility and enrollment services and accounts receivable management services generally are recognized at the time that our provider customer receives notice from the payer of a pending payment.

Cash receipts or billings in advance of revenue recognition are recorded as deferred revenues in our consolidated balance sheets.

We exclude sales and use tax from revenue in our consolidated statements of operations.

Business Combinations

We recognize the consideration transferred (i.e. purchase price) in a business combination, as well as the acquired business identifiable assets, liabilities and noncontrolling interests at their acquisition date fair value. The excess of the consideration transferred over the fair value of the identifiable assets, liabilities and noncontrolling interest, if any, is recorded as goodwill. Any excess of the fair value of the identifiable assets acquired and liabilities assumed over the consideration transferred, if any, is generally recognized within earnings as of the acquisition date. To the extent that our initial accounting for a business combination is incomplete at the end of a reporting period, provisional amounts are reported for those items which are incomplete. We retroactively adjust such provisional amounts as of the acquisition date once new information is received about facts and circumstances that existed as of the acquisition date.

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The fair value of the consideration transferred, assets, liabilities and noncontrolling interests is estimated based on one or a combination of income, cost or market approaches as determined based on the nature of the asset or liability and the level of inputs available to us (i.e., quoted prices in an active market, other observable inputs or unobservable inputs). With respect to assets, liabilities and noncontrolling interest, the determination of fair value requires management to make subjective judgments as to projections of future operating performance, the appropriate discount rate to apply, long-term growth rates, etc. The effect of these judgments then impacts the amount of the goodwill that is recorded and the amount of depreciation and amortization expense to be recognized in future periods related to tangible and intangible assets acquired.

With respect to the consideration transferred, certain of our acquisitions include contingent consideration, the fair value of which is generally required to be measured each quarter until resolution of the contingency. In addition to the judgments applicable to valuing intangible and intangible assets, the determination of the fair value of the attainment of certain specified financial performance measures requires management to make subjective judgments as to the probability and timing of the attainment of certain specified financial performance measures. The determination of the fair value of the contingent consideration is particularly sensitive to judgments relative to the probability of achieving the specified financial performance measures.

Goodwill and Intangible Assets

Goodwill and intangible assets from our acquisitions are accounted for using the acquisition method of accounting. Intangible assets with definite lives are amortized on a straight-line basis over the estimated useful lives of the related assets generally as follows:

Customer relationships	10 to 20 years
Trade names	3 to 20 years
Data sublicense agreement	6 years
Non-compete agreements	3 to 5 years
Backlog	1 to 2 years

With respect to intangible assets (excluding goodwill), we review for impairment whenever events or changes in circumstances indicate that carrying amounts may not be recoverable. For those assets that are held and used, we recognize an impairment loss only if its carrying amount is not recoverable through its undiscounted cash flows and measure the impairment loss based on the difference between the carrying amount and fair value. Assets held for sale are reported at the lower of cost or fair value less costs to sell.

We assess our goodwill for impairment annually (as of October 1 of each year) or whenever significant indicators of impairment are present. We first assess whether we can reach a more likely than not conclusion that goodwill is not impaired via qualitative analysis alone. To the extent, such a conclusion cannot be reached based on a qualitative assessment alone, we (using the assistance of a valuation specialist as appropriate) compare the fair value of each reporting unit to its associated carrying value. If the fair value of the reporting unit is less than the carrying value, then a hypothetical acquisition method allocation is performed to determine the amount of the goodwill impairment to recognize.

We have historically identified our payer, provider, and pharmacy operating segments as our reporting units. We estimate the fair value of our reporting units using a methodology that considers both income and market approaches. Specifically, for 2012, we estimated fair value of our reporting units based on the weighted average of fair value measures estimated under the income and market approaches.

Each approach requires the use of certain assumptions. The income approach requires management to exercise judgment in making assumptions regarding the reporting unit s future income stream, a discount rate and a constant rate of growth after

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the initial five year forecast period utilized. These assumptions are subject to change based on business and economic conditions and could materially affect the indicated values of our reporting units. For example, a 100 basis point increase in our selected discount rate would result in a decrease in the indicated value of our payer, provider and pharmacy reporting units of approximately $87.0 million, $120.0 million and $32.0 million, respectively. However, as the indicated fair value of each reporting unit exceeded their respective carrying values in the most recent annual impairment test by approximately $149.0 million, $348.0 million and $70.0 million, respectively, we do not believe that any of our reporting units are at risk of failing step one of our annual impairment test.

The market approach requires management to exercise judgment in its selection of guideline companies, as well in its selection of the most relevant transaction multiple. Guideline companies selected are comparable to us in terms of product or service offerings, markets and/or customers, among other characteristics.

Income Taxes

We record deferred income taxes for the tax effect of differences between book and tax bases of our assets and liabilities, as well as differences related to the timing of recognition of income and expenses.

Deferred income taxes reflect the available net operating losses and the net tax effect of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Realization of the future tax benefits related to deferred tax assets is dependent on many factors, including our past earnings history, expected future earnings, the character and jurisdiction of such earnings, reversing taxable temporary differences, unsettled circumstances that, if unfavorably resolved would adversely affect utilization of our deferred tax assets, carryback and carryforward periods and tax strategies that could potentially enhance the likelihood of realization of a deferred tax asset.

We recognize tax benefits for uncertain tax positions at the time that we conclude the tax position, based solely on its technical merits, is more likely than not to be sustained upon examination. The benefit, if any, is measured as the largest amount of benefit, determined on a cumulative probability basis that is more likely than not to be realized upon ultimate settlement. Tax positions failing to qualify for initial recognition are recognized in the first subsequent interim period that they meet the more likely than not standard, upon resolution through negotiation or litigation with the taxing authority or on expiration of the statute of limitations.

Tax Receivable Agreement Obligations

We are a party to tax receivable agreements which obligate us to make payments to certain current and former owners of the Company, including affiliates of Blackstone, Hellman & Friedman and certain members of management, equal to 85% of the applicable cash savings that the Company realizes as a result of tax attributes arising from certain previous transactions, including the 2011 Transactions.

Prior to the Merger, the Company s balance sheet reflected these obligations at the amount that was both probable and reasonably estimable. In connection with the Merger, the tax receivable agreement obligations were adjusted to their fair value. The determination of the fair value required management to make assumptions as to the timing of the realization of net operating losses, the timing of payments to the TRA Members and the tax rates in effect during the life of the agreements. Changes in any of these or other factors are expected to result in increases or decreases to the gross payments due under the tax receivable agreements. For example, if our corporate tax rate were to increase by 100 basis points, the gross obligation under the tax receivable agreements would increase by approximately $12.4 million.

The fair value of these obligations at the time of the Merger is being accreted to the amount of the gross expected obligation using the interest method. Changes in the amount of these obligations resulting from changes to either the timing or amount of cash flows are recognized in the period of change and measured using the discount rate inherent in the initial fair value of the obligations. The accretion of these obligations is classified as a separate caption in our consolidated statements of operations.

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Results of Operations

The following table summarizes our consolidated results of operations for the year ended December 31, 2012, the periods from November 2, 2011 to December 31, 2011 and January 1, 2011 to November 1, 2011 and the year ended December 31, 2010, respectively.

	Successor				Predecessor			
	Fiscal Year Ended December 31, 2012		November 2 through December 31, 2011		January 1 through November 1, 2011		Fiscal Year Ended December 31, 2010	
	Amount	% of Revenue [1]	Amount	% of Revenue [1]	Amount	% of Revenue [1]	Amount	% of Revenue [1]
Revenues [2]								
Payer Services	$ 502,847	42.7%	$ 77,725	40.8%	$ 380,961	41.0%	$ 430,062	42.9%
Provider Services	585,237	49.7	98,324	51.6	480,822	51.7	494,199	49.3
Pharmacy Services	95,651	8.1	15,018	7.9	70,776	7.6	81,794	8.2
Eliminations	(5,464)	(0.5)	(683)	(0.4)	(3,295)	(0.4)	(3,903)	(0.4)
Total revenues	1,178,271	100.0	190,384	100.0	929,264	100.0	1,002,152	100.0
Costs of operations								
Payer Services	332,025	66.0	51,102	65.7	255,437	67.1	281,853	65.5
Provider Services	365,220	62.4	60,710	61.7	291,055	60.5	304,245	61.6
Pharmacy Services	39,484	41.3	6,252	41.6	29,134	41.2	30,044	36.7
Eliminations	(5,204)		(643)		(3,085)		(3,775)	
Total costs of operations	731,525	62.1	117,421	61.7	572,541	61.6	612,367	61.1
Development and engineering								
Payer Services	10,927	2.2	1,940	2.5	8,700	2.3	9,475	2.2
Provider Services	14,371	2.5	2,234	2.3	11,693	2.4	13,993	2.8
Pharmacy Services	6,496	6.8	979	6.5	5,697	8.0	7,170	8.8
Total development and engineering	31,794	2.7	5,153	2.7	26,090	2.8	30,638	3.1
Sales, marketing, general and admin								
Payer Services	35,705	7.1	5,870	7.6	26,905	7.1	28,914	6.7
Provider Services	39,937	6.8	4,518	4.6	38,385	8.0	33,982	6.9
Pharmacy Services	5,810	6.1	830	5.5	5,078	7.2	6,133	7.5
Eliminations	(260)		(40)		(210)		(128)	
Total sales, marketing, general and admin excluding corporate	81,192	6.9	11,178	5.9	70,158	7.5	68,901	6.9
Income from segment operations	333,760	28.3	56,632	29.7	260,475	28.0		