Emdeon Inc.
Form 10-K
March 16, 2015
Table of Contents

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, 2014

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 1-34435

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 ¨ No x*

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, 2014, 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 of Beagle Parent Corp.

* The registrant is a voluntary filer of certain reports required to be filed by companies under Section 13 or 15(d) of the Securities and Exchange Act of 1934 and has filed all reports that would have been required to have been filed by the registrant during the preceding 12 months had it been subject to such filing requirements during the entirety of such period.

DOCUMENTS INCORPORATED BY REFERENCE

None.

Table of Contents

EMDEON INC.

INDEX

Table of Contents

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K (the Annual Report) of Emdeon Inc. (Emdeon or 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, estimate or similar express 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 in 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 the Company refer to Emdeon Inc. and its subsidiaries.

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, pharmacies and patients in the United States healthcare system. Our solutions integrate and automate key business and administrative functions of our payer, provider and pharmacy customers throughout the patient encounter. These solutions include pre-care patient eligibility and benefits verification and enrollment, clinical information exchange, consumer engagement, claims management and adjudication, payment integrity, payment distribution, payment posting and 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, 700,000 providers, 5,000 hospitals, 105,000 dentists, 60,000 pharmacies and 450 labs.

In 2014, we processed a total of approximately 8.1 billion healthcare-related transactions. 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

Table of Contents

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 senior secured term loan credit facility (as amended, the Term Loan Facility) and a 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).

In 2012, the outstanding unregistered Senior Notes were exchanged in a registered offering with the Securities and Exchange Commission (the SEC) for substantially identical Senior Notes that are freely tradable.

Our Solutions

During 2014, we delivered our solutions and operated our business in three reportable segments: (i) payer services, which provides solutions primarily to commercial insurance companies, third party administrators and governmental payers; (ii) provider services, which provides solutions primarily to hospitals, physician practices, laboratories and other healthcare providers; and (iii) pharmacy services, which provides solutions to pharmacies, pharmacy benefit management companies, government agencies and other payers. The selected financial information for each segment is provided in Note 19 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 that help simplify the administration of healthcare. Our payer services offerings include insurance eligibility and benefits verification, claims management, payment integrity and payment distribution. Additionally, we provide patient billing and payment services and consulting services through the payer services segment.

Through the provider services segment, we provide revenue cycle management solutions, both directly and through our channel partners, that help simplify providers revenue cycle and workflow, reduce related costs and improve cash flow. Our provider services offerings include revenue cycle management solutions, government program eligibility and enrollment services and revenue optimization solutions.

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 also have three other operating segments, one of which provides revenue cycle management solutions through channel partners; one of which provides revenue cycle solutions, either directly or through channel partners, to dental practices; and one of which provides consumer engagement and transparency solutions that enable consumers to make informed healthcare purchasing decisions based on quality, cost and convenience and, in turn, helps payers control their healthcare costs.

We have reorganized our reportable segments to align with our solution and service offerings effective January 1, 2015.

Table of Contents

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.

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 electronic updates to patients and online bill presentment and payment functionalities. We believe our solutions are more timely, cost-effective and consistent than in-house print and mail operations and improve patient collections. In addition, we offer providers digital delivery, which enables providers to securely send communications electronically to a patient. 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.

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 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.

Table of Contents

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

Claims Management

Our claims management solutions are delivered to providers 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 automate the entire payment process. On behalf of our provider customers, we accept paper payments from both third party payers and patients and convert them into automated workflows which are 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 revenue optimization 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.

Pharmacy Services Solutions

Prescription Benefits Administration (Payers)

Our prescription solutions provide claims processing and other administrative services for pharmacy payers and state Medicaid programs 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.

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.

All Other

All Other consists of three operating segments, one of which provides revenue cycle management solutions through channel partners; one of which provides revenue cycle solutions, either directly or through channel partners, to dental practices; and one of which provides consumer engagement and transparency solutions that enable consumers to make informed healthcare purchasing decisions based on quality, cost and convenience and, in turn, helps payers control their healthcare costs.

Table of Contents

Customers

We generally provide solutions to our payer, provider and pharmacy customers on either a per transaction, per document, per communication, 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 management services agreements with more than 480 of our payer customers under which we provide 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, patient billing and payment services and consulting services solutions. For the year ended December 31, 2014, our top ten payer customers represented approximately 15% of our total revenues and no payer customer accounted for more than 4% of our total revenues.

Provider Services

The provider market is comprised of hospitals, physician practices, laboratories and other healthcare providers. We currently have contractual or submitter relationships, directly or through channel partners, with approximately 700,000 physicians, 2,700 hospitals, 105,000 dentists and 450 labs. For the year ended December 31, 2014, our top ten provider customers represented approximately 9% of our total revenues and no provider customer accounted for more than 2% 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, 2014, no pharmacy services customer accounted for more than 2% of our total revenues.

Marketing and Sales

Marketing activities for our 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.

Our Technology

Our technology platforms employ a standard enterprise services bus in a service-oriented architecture, configured for 24/7 operations. We operate 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 utilize several satellite data centers including cloud platforms and plan to further consolidate our data centers over time. 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.

Table of Contents

Our Industry

Healthcare expenditures are a significant component of the United States economy, representing approximately $2.9 trillion in 2013, or 17.4% of GDP, and are expected to grow at 6.2% per year to $4.7 trillion, or approximately 19.9% of GDP, in 2021. 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, 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 such as ICD-10 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.

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 17.4 million in January 2014, up from 6.1 million in January 2008), higher deductibles and co-payments for privately insured individuals and the continued ranks of the uninsured. Although the number of uninsured is decreasing in part due to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (ACA), 42 million remained uninsured in 2014, according to Congressional Budget Office estimates released in April 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. 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.

Table of Contents

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.

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 solutions 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 exchange 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;

Print and mail vendors;

Table of Contents

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

Government program eligibility and enrollment services companies;

Payment integrity companies; and

Consumer engagement and transparency companies.

We also compete in some cases with certain of our customers that provide internally some of the same solutions we offer, as well as 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 solutions include McKesson (RelayHealth) and UnitedHealth Group (Optum), 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 requirements 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, requirements and industry standards 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 and other requirements, see Part I, Item 1A, Risk Factors of this Annual Report.

ACA

ACA significantly affects 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, ACA expands coverage through changes in Medicaid and private sector health insurance and other reforms, including the individual mandate, under which individuals generally must obtain insurance coverage or pay a penalty. The ACA employer mandate imposes fines on employers with 50 or more full-time employees that do not offer employees health insurance. However, implementation of the employer mandate was delayed for most employers until January 1, 2015 and will not be fully implemented for all employers until January 1, 2016. In addition, states may choose not to implement the ACA Medicaid expansion and the number of states that will ultimately participate and under what terms is not clear. The full impact of ACA, including its impact on our government eligibility and enrollment services offerings, is difficult to predict due to uncertainty regarding how many states will ultimately implement the Medicaid expansion, as well as the law s complexity, lack of implementing regulations for all of the law s provisions, limited interpretive guidance, remaining or new court challenges, implementation issues and the possibility of further delays, amendment or repeal. For example, during the

2015 session the U.S. Supreme Court will decide a case known as *King v. Burwell*, which challenges the extension of federal subsidies to premiums for health insurance policies purchased through health insurance exchanges operated by the federal government. If the plaintiffs prevail, the ruling could significantly affect implementation of ACA, including making it more difficult for residents of states not operating an exchange to purchase or maintain insurance coverage.

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 federal subsidies that began in 2011 for eligible hospitals and eligible professionals that adopt and meaningfully use certified electronic health record (EHR) technology, and through December 2014, approximately $26 billion in payments have been distributed. 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.

Table of Contents

Moreover, 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 half 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 provider and plan identifier standards and format and data content for certain electronic healthcare transactions, including claims, enrollment, payment and eligibility inquiries. In addition, ACA 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 ACA, payers and service contractors of payers, including, in some cases, us, are required to certify compliance with these transaction standards to the United States Department of Health and Human Services (HHS). The compliance date for the certification requirement depends on the type of transaction, beginning with the earliest certification date of December 31, 2015. 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, other federally funded plans or programs 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.

9

Table of Contents

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. ACA 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 ACA, 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. The reductions have been extended through 2024. 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 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, patents, 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 trade secrets, copyrights, trademarks, service marks, patents 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, 2015, we had approximately 4,100 employees. None of our employees are represented by a labor union. We consider our relationship with our employees to be good.

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

Table of Contents

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) 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; (viii) payment integrity companies; and (ix) consumer engagement and transparency 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.

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.

Table of Contents

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.

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 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 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 may become more intense and the importance of establishing and maintaining relationships with key healthcare industry constituents could 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. In addition, our customers sometimes request that our solutions be customized to satisfy particular security protocols, modifications and other contractual terms in excess of industry norms and our standard configurations. These customer imposed requirements may impact the profitability of particular solutions and customer engagements. We may not be successful in responding to technological and regulatory developments or 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, as well as evolving industry standards and customer demands, 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.

Table of Contents

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;
- 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 and other 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, providers and patients 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;

Table of Contents

- healthcare and information technology consulting services for payers;
- decision support, clinical information exchange or other business intelligence and data analytics solutions; and
- consumer engagement and transparency services.

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.

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 a 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 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 risk 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 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 and plan to continue such consolidation. Our business and results of operations are

Table of Contents

also highly dependent on our print and mail operations, which 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.

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.

If the security measures protecting our information technology systems are breached or fail, we could be subject to liability, and customers may curtail or stop using our solutions.

Our business relies to a significant degree upon the secure electronic transmission, use and storage of sensitive information, including personal health information, financial information and other confidential data. Despite the implementation of security measures, our infrastructure, data centers and systems that we interface with, including the internet and related systems and our vendors, 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. We cannot predict whether our security measures will be adequate to prevent all possible security threats. Any of these events, including the unauthorized access, misappropriation, disclosure or loss of sensitive information, including financial or personal health information, or a significant disruption of our network, could adversely affect our ability to provide our solutio