Emdeon Inc.
Form 10-K
March 10, 2011

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2010

or

o **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 001-34435
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)

Title of Each Class	**Name of Each Exchange on Which Registered**
Class A common stock, $0.00001 par value	New York Stock Exchange

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 o No þ

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 o No þ

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 þ No o

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 o No o

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. þ

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 o	Accelerated filer þ	Non-accelerated filer o (Do not check if a smaller reporting company)	Smaller reporting company o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No þ

The aggregate market value of the voting stock held by non-affiliates of the registrant was $380,115,806. Market value is determined by reference to the closing price on June 30, 2010 of the registrant s Common Stock as reported by the New York Stock Exchange. Class B common stock is not publicly listed for trade on any exchange or market system; however, Class B common stock can be exchanged for Class A common stock on a one-for-one basis. Accordingly, the market value was calculated based on the market price of Class A common stock. For purposes of the foregoing calculation only, the registrant has assumed that all officers and directors of the registrant are affiliates.

Class	**Outstanding as of March 4, 2011**
Class A common stock, $0.00001 par value	**91,064,486**
Class B common stock, $0.00001 par value	**24,689,142**

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s Definitive Proxy Statement for its 2011 Annual Meeting of Stockholders to be filed subsequently with the Securities and Exchange Commission are incorporated by reference into Part III hereof.

Emdeon Inc.

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FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K (Annual Report) contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. You should not place undue reliance on those statements because they 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. Forward-looking statements include information concerning our possible or assumed future results of operations, including descriptions of our business strategy. These statements often include words such as may, will, should, believe, expect, anticipate, intend estimate or similar expressions. These statements are based upon assumptions that we have made in light of our experience in the industry, as well as our perceptions of historical trends, current conditions, expected future developments and other factors that we believe are appropriate under the circumstances. As you read this Annual Report, you should understand that these statements are not guarantees of performance or results. They involve known and unknown risks, uncertainties and assumptions, including those described under the heading Risk Factors in Part I, Item 1A. and elsewhere in this Annual Report. Although we believe that these forward-looking statements are based upon reasonable assumptions, you should be aware that many factors, including those described under the heading Risk Factors in Part I, Item 1A. and elsewhere in this Annual Report, 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.

Our forward-looking statements made herein speak only as of the date on which made. We 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. All subsequent written and oral forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the cautionary statements contained in this Annual Report.

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.

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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 U.S. healthcare system. Our product and service offerings 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 capabilities, 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 products and services, 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. Our services are delivered primarily through recurring, transaction-based processes that leverage our health information network, the single largest financial and administrative information exchange in the U.S. 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 150 labs.

We deliver our solutions and operate our business in three business segments: (i) payer services, which provides services to commercial insurance companies, third party administrators and governmental payers; (ii) provider services, which provides services to hospitals, physicians, dentists and other healthcare providers, such as labs and home healthcare providers; and (iii) pharmacy services, which provides services to pharmacies, pharmacy benefit management companies and other payers. Through our payer services segment, we provide payment cycle solutions, both directly and through our network of companies, or channel partners, with which we have contracted to market and sell certain of our products and services, including healthcare information system vendors, such as physician and dental practice management system, hospital information system and electronic medical record vendors, that help simplify the administration of healthcare related to insurance eligibility and benefit verification, claims filing, 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 services and other electronic solutions to pharmacies, pharmacy benefit management companies and government agencies related to prescription benefit claim filing, adjudication and management.

In 2010, we processed a total of approximately 5.8 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 25 years and connect to virtually all private and government payers, claim-submitting providers and pharmacies. Our network and related products and services 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. Our predecessors have been in the healthcare information solutions business for over 25 years. We have grown both organically and through targeted acquisitions in order to offer the full range of

products and services required to automate the patient encounter process.

A brief history of our organizational structure is as follows:

Prior to November 2006, the group of companies that comprised Emdeon Business Services, or EBS, was owned by HLTH Corporation, currently known as WebMD Health Corp. , or WebMD. EBS

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Master LLC, or EBS Master, was formed by WebMD to act as a holding company for EBS. EBS Master, through its 100% owned subsidiary, Emdeon Business Services LLC, or EBS LLC, owns EBS.

In September 2006, we were formed by General Atlantic LLC, or General Atlantic, as a Delaware limited liability company for the purpose of making an investment in EBS Master. In November 2006, we acquired a 52% interest in EBS Master from WebMD (the 2006 Transaction). WebMD retained a 48% interest in EBS Master upon closing of the 2006 Transaction.

In February 2008, WebMD sold its remaining 48% interest in EBS Master (the 2008 Transaction) to affiliates of General Atlantic and Hellman & Friedman LLC, or H&F. As a result, following the 2008 Transaction, EBS Master was owned by affiliates of General Atlantic, who we sometimes refer to herein as the General Atlantic Equityholders, and by affiliates of H&F, who we sometimes refer to herein as the H&F Equityholders. The General Atlantic Equityholders and H&F Equityholders are sometimes collectively referred to herein as the Principal Equityholders. Together, our Principal Equityholders currently control approximately 72% of the combined voting power of our Class A common stock and Class B common stock.

In anticipation of our initial public offering, or IPO, we converted into a Delaware corporation, changed our name to Emdeon Inc. and completed a corporate restructuring (collectively, the reorganization transactions).

In August 2009, we completed the IPO of our Class A common stock and began trading on the New York Stock Exchange, or NYSE, under the symbol EM.

A brief description of businesses we have acquired since January 1, 2010 is as follows:

In January 2010, we acquired FutureVision Investment Group, L.L.C., or FVTech, a provider of outsourced services specializing in electronic data conversion and information management solutions. This acquisition allowed us to electronically process virtually all patient and third party healthcare payments regardless of the format in which payments are submitted by combining FVTech s document conversion technology with our broad connectivity network and revenue cycle management solutions.

In March 2010, we acquired Healthcare Technology Management Services, Inc., or HTMS, a management consulting company focused primarily on the healthcare payer market. This acquisition allowed us to assist payers in evaluating their existing technology strategies and systems in order to help our customers implement effective solutions by combining HTMS consulting services with our infrastructure, payer relationships and distribution network.

In June 2010, we acquired Chapin Revenue Cycle Management, LLC, or Chapin, a technology-enabled provider of accounts receivable denial and recovery services. By leveraging Chapin s contract management systems, this acquisition enhanced our ability to assist providers identify and prevent underpayments, appeal denials and resubmit claims in a timely manner to help ensure that providers collect appropriate payments for services rendered.

In October 2010, we acquired Chamberlin Edmonds & Associates, Inc., or CEA, a technology-enabled provider of 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.

Our Industry

Payer and Provider Landscape

Healthcare expenditures are a significant component of the U.S. economy, representing $2.5 trillion in 2009, or 17.6% of gross domestic product, or GDP, and are expected to grow at 6.1% per year to $4.4 trillion, or 20% of GDP, in 2018. We believe the cost of healthcare administration in the U.S. was approximately $360 billion in 2008, or 17% of total healthcare expenditures, and that $150 billion of these costs were spent by payers and providers on billing and insurance administration-related activities. We believe the increased

need to slow the rise in healthcare expenditures, particularly during the recent period of U.S. economic weakness, increased financial pressures on payers and providers and public policy initiatives to reduce healthcare administrative inefficiencies should accelerate adoption of our solutions.

Healthcare is generally provided through a fragmented industry of providers that have, in many cases, historically under-invested 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 can 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 burden 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, we believe payers and providers will continue to seek solutions that automate and simplify the administrative and clinical processes of healthcare. We benefit from this trend given our suite of administrative and clinical information exchange product and service offerings.

Payers 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 the Health Insurance Portability and Accountability Act of 1996, or HIPAA, format and data content standards continues to increase the complexity of the reimbursement process. For example, preferred provider organizations, or PPOs, health maintenance organizations, point of service plans and high-deductible health plans, or 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. In addition, industry estimates indicate that between $68 billion and $226 billion in healthcare costs are attributable to fraud, waste and abuse each year. Despite significant consolidation among private payers in recent years, claims systems have often not been sufficiently integrated, resulting in persistently high costs associated with administering these plans.

Government payers continue to introduce more complex rules 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 program, both of which have increased administrative burdens on providers by requiring more detailed classification of patients and care provided in order to receive and retain associated Medicare reimbursement. Further, because we believe there is an increasing number of drug prescriptions authorized by providers and an industry-wide shortage of pharmacists, we believe pharmacists must increasingly be able to efficiently process transactions in order to maximize their productivity and better control prescription drug costs. Most payers, providers and many independent pharmacies are not equipped to handle this increased complexity and the associated administrative challenges alone.

Increases in patient financial responsibility for healthcare expenses have put additional pressure on providers to collect payments at the patient 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 HDHP and consumer-oriented plans (which grew to 10.0 million in January 2010, up from 8.0 million in January 2009,

6.1 million in January 2008, 4.5 million in January 2007 and 3.2 million in January 2006), higher deductibles and co-payments for privately insured individuals and the increasing ranks of the uninsured (50.7 million or 16.7% of the U.S. population in 2009). We believe the breadth of our network, coupled with our solutions, positions us to help providers estimate financial liability and significantly improve collection at the point of care.

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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.

We believe payers and providers spend approximately $150 billion annually on these revenue and payment cycle activities. 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 enroll 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.

Claim Management/Adjudication: The provider prepares and submits paper or electronic claims to a payer for services rendered directly or through a clearinghouse, such as ours. 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 explanation of benefits, or 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.

Recent Industry Trends

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 electronic transactions. For example, in July 2008, Congress passed legislation providing financial incentives to Medicare providers using electronic prescribing. In addition, the American Recovery and Reinvestment Act of 2009, or ARRA, included at least $20 billion in federal subsidies to incentivize the implementation and meaningful use of electronic health records. Meaningful Use criterion under the Health Information Technology for Economic and Clinical Health, or HITECH, provisions of ARRA requires providers to successfully capture and exchange electronic clinical healthcare information, such as electronic prescriptions and lab orders, to receive incentive payments from Medicare

and Medicaid. 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 electronic health records with computerized physician order entry applications, such as electronic prescribing, may also promote greater utilization of

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electronic transactions. We believe that increasing provider adoption of electronic prescribing has contributed to making it one of the fastest growing transaction types in our business. Currently, we believe only approximately 18% of all prescriptions are transmitted electronically. Moreover, we believe our historical claims data, combined with our healthcare fraud, waste and abuse management 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.

Reducing administrative costs continues to garner significant public policy attention. A key component of recent healthcare reform initiatives includes a focus on reducing inefficiency and increasing quality of care. For example, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, 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. PPACA also contains a number of provisions intended to further link Medicare and Medicaid program payments to quality and efficiency. In late 2008, we launched the U.S. Healthcare Efficiency Index™, or the Index, an industry-wide transparency and efficiency initiative that identifies and tracks the transition of specific transactions from manual-to-electronic-based formats in order to raise awareness of cost saving opportunities and the immediate benefits of adopting standard electronic transactions. Based on the Index, we estimate that the transition to electronic medical claims and payment-related transactions could produce over $30 billion annually in administrative cost savings.

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Our Market Opportunity and Solutions

Opportunities exist to increase efficiencies and cash flow throughout many steps of the healthcare revenue and payment cycle. The breadth of our revenue and payment cycle network and solutions is illustrated in the chart below:

Products and Services

Our business operations are organized into three reportable segments: payer services, provider services and pharmacy services. The selected financial information for each operating segment is provided in Note 23

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in the accompanying Notes to Consolidated Financial Statements contained in Part II, Item 8 of this Annual Report. A description of our payer, provider and pharmacy solutions follows:

Payer Products and Services

Pre-Care and Claim Management

Our pre-care solutions interface directly with the payer s own 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 claim submission solutions include electronic data interchange, or EDI, and 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 our other business partners. We also perform payer-specific edits of claims for proper format, including standards in accordance with HIPAA, before submission to minimize manual processes associated with pending claims. Our healthcare 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 and prevent payment of fraudulent and improper claims, creating efficiencies and cost savings for payers and providers.

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 EOBs to patients. Because of the breadth and scale of our connectivity to both payers and providers, our payer customers can realize significant print and operational cost savings through the use of either electronic payment and remittance products or our 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 drive 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 our healthcare clients analyze, develop and implement technology strategies designed to ensure alignment with healthcare trends and overall business goals. Our consultants bring 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 our clients with analysis, selection, procurement and implementation services in deploying information technology solutions quickly and cost-effectively.

Provider Products and Services

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 and also integrating 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 to 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 help providers save time and money by offering 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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Claim 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 claim 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, (ii) tools to edit claims prior to submission and identify errors that delay reimbursement and (iii) robust reporting to providers in order to track claims throughout their life cycle and to 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 identify root cause, but also help 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 Products and Services

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. Our 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 products and services improve

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pharmacy workflow and customer service, increase operational efficiency and patient safety, and 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 denial claims, which we believe allows our pharmacy customers to improve their collections.

Customers

We generally provide our products and services to our payer, provider and pharmacy customers on either a per transaction, per document, per communication or per member per month or, in some cases, on a 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 terms unless terminated. We have also entered into exclusive or other comprehensive management services agreements with more than 400 of our payer customers under which we provide exclusive or other comprehensive services for certain eligibility and benefit verification and/or claims management services. These comprehensive management services agreements generally have terms of three years and renew automatically for successive terms unless terminated.

Payer Services

The payer market is comprised of more than 1,200 payers across four main segments: 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 services and with intelligent claim capture and routing services. For the year ended December 31, 2010, our top 10 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 composed 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 our channel partners, with approximately 340,000 physicians, 2,700 hospitals, 81,000 dentists and 150 labs. For the year ended December 31, 2010, our top 10 provider customers represented approximately 10% of our total revenues and no provider customer accounted for more than 4% of our total revenues.

Pharmacy Services

The pharmacy market is composed 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, 2010, no pharmacy services customer accounted for more than 2% of our total revenues.

Marketing and Sales

Marketing activities for our payer, provider and pharmacy solutions include direct sales, targeted direct marketing, advertising, tradeshow exhibits, provider 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 segments.

As of December 31, 2010, we also had 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

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providers. We integrate our products and services into these channel partners software solutions for distribution to their provider customers.

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.

Competition

We compete on the basis of the size and reach of our network, the ability to offer a single-vendor solution, the breadth and functionality of products and services we offer and are able to develop, and our pricing models. While we do not believe any single competitor offers a similarly expansive suite of products and services, 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 their revenue and payment cycle management and clinical information exchanges processes, including physician and dental practice management system, hospital information system 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; and
- financial institutions that have invested in healthcare data management assets.

We also compete, in some cases, with alliances formed by the above competitors. 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 competitive products or services. Major competitors for our products and/or services include McKesson (RelayHealth) and UnitedHealth Group (Ingenix and OptumHealth), as well as other smaller competitors that typically compete with us in one or more of our product and/or service categories.

Some of our existing payer and provider customers compete with us or plan to do so. In general, these customers offer services that compete with some of our solutions but do not offer the full range of products and services we offer. For example, some payers currently offer, through affiliated clearinghouses, internet portals and other means, electronic

data transmission services to providers that allow the provider to have a direct connection to the payer, bypassing third party EDI service providers such as us. In addition, the solutions offered by healthcare information system vendors, including our channel partners, may include products and services that we supply directly or similar products and services offered by our competitors.

Certain of our current and potential competitors have greater financial and marketing resources than we have. Furthermore, we believe that the increasing acceptance of automated solutions in the healthcare marketplace, the adoption of more sophisticated technology, legislative and regulatory reform and consolidation within the payer, provider and pharmacy industries will result in increased competition. There can be no

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assurance that we will continue to maintain our existing customer base or that we will be successful with any new products or services that we have introduced or will introduce. See Risk Factors We face significant competition for our products and services in Part I, Item 1A. of this Annual Report.

Regulation and Legislation

Introduction

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 into law the PPACA. As enacted, 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. By January 2014, PPACA requires states to expand Medicaid coverage significantly and establish health insurance exchanges to facilitate the purchase of health insurance by individuals and small employers and provides subsidies to states to create non-Medicaid plans for certain low-income residents. Effective in 2014, PPACA imposes penalties on individuals who do not obtain health insurance and employers that do not provide health insurance to their employees. PPACA also sets forth several health insurance market reforms, including increased dependent coverage, prohibitions on excluding individuals based on pre-existing conditions and mandated minimum medical loss ratios for health plans. In addition, PPACA further 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 provides for additional resources to combat healthcare fraud, waste and abuse and also requires the U.S. Department of Health & Human Services (HHS) to adopt standards for electronic transactions in addition to those required under HIPAA, including standards for electronic payments, 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, as enacted, will affect the business of our payer, provider and pharmacy customers and will also affect the Medicaid programs of the states. Because of the many variables involved, including PPACA s complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, pending court challenges and possible amendment or repeal, we are unable to predict all of the ways in which PPACA could impact us or the business of our customers. Implementation of PPACA, particularly those provisions expanding health insurance coverage, could be delayed, revised or even blocked due to court challenges and congressional efforts to repeal or amend the law. Further, it is unclear how federal lawsuits challenging the constitutionality of PPACA will be resolved or what the impact will be of any resulting changes to all or portions of PPACA.

In addition to PPACA, the healthcare industry is required to comply with extensive and complex laws and regulations at the federal and state levels. Although many regulatory and governmental requirements do not directly apply to our operations, our customers are required to comply with a variety of laws, and we may be impacted by these laws 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. We may also be impacted by banking and financial services industry laws, regulations and industry standards as a result of payment and remittance services and products we offer directly and through our third party vendors. We have attempted to structure our operations to comply with applicable legal requirements, but there can be no assurance that our operations will not be challenged or impacted by enforcement initiatives.

HIPAA Administrative Simplification and ARRA Electronic Health Records Requirements

General. HIPAA mandated a package of interlocking administrative simplification rules to establish standards and requirements for the electronic transmission of certain healthcare claims and payment transactions. These regulations are intended to encourage electronic commerce in the healthcare industry and apply directly to health plans, most providers and healthcare clearinghouses (Covered Entities). Some of our

businesses, including our healthcare clearinghouse operations, are considered Covered Entities under HIPAA and its implementing regulations. Other aspects of our operations are considered business associates under HIPAA and are impacted by the HIPAA regulations as a result of our contractual obligations to our customers and interactions with other constituents in the healthcare industry that are Covered Entities (Business Associates).

Transaction Standards. The standard transaction regulations established under HIPAA, or Transaction Standards, mandate certain format and data content standards for the most common electronic healthcare transactions, using technical standards promulgated by recognized standards publishing organizations. These transactions include healthcare claims, enrollment, payment and eligibility. In addition, PPACA requires HHS to establish standards for additional electronic healthcare transactions including electronic funds transfer and health claims attachment transactions. The Transaction Standards are applicable to that portion of our business involving the processing of healthcare transactions among payers, providers, patients and other healthcare industry constituents. Failure to comply with the Transaction Standards may subject us to civil and potentially criminal penalties and breach of contract claims. The Centers for Medicare & Medicaid Services, or CMS, is responsible for enforcing the Transaction Standards.

Payers and providers who are unable to exchange data in the required standard formats can achieve Transaction Standards compliance by contracting with a clearinghouse to translate between standard and non-standard formats. As a result, use of a clearinghouse has allowed numerous payers and providers to establish compliance with the Transaction Standards independently and at different times, reducing transition costs and risks. In addition, the standardization of formats and data standards envisioned by the Transaction Standards has only partially occurred. Multiple versions of a HIPAA standard claim have emerged as each payer defines for itself what constitutes a HIPAA-compliant claim. To date, payers have published more than 600 different companion documents setting forth their individual interpretations and implementation of the government guidelines. However, PPACA requires HHS to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction. The operating rules for eligibility for a health plan and health claim status transactions must be adopted by July 1, 2011 and will be effective no later than January 1, 2013. PPACA sets forth a schedule with staggered deadlines for the development of and compliance with operating rules for the other standardized electronic transactions, with all operating rules finalized and requiring compliance by December 31, 2015. Under PPACA, payers and service contractors of payers, including, in some cases, us, will be required to certify compliance with these 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.

In order to help prevent disruptions in the healthcare payment system, CMS has permitted the use of contingency plans under which claims and other covered transactions can be processed, in some circumstances, in either HIPAA standard or legacy formats. CMS terminated the Medicare contingency plan for incoming claims in 2005. The Medicare contingency plan for HIPAA transactions, other than claims, remains in effect. Our contingency plan, pursuant to which we process HIPAA-compliant standard transactions and legacy transactions, as appropriate, based on the needs of our customers, remains in effect. We cannot provide assurance regarding how CMS will enforce the Transaction Standards or how long CMS will permit constituents in the healthcare industry to utilize contingency plans. We continue to work with payers and providers, healthcare information system vendors and other healthcare constituents to implement fully the Transaction Standards.

In January 2009, CMS published a final rule adopting updated standard code sets for diagnoses and procedures known as the ICD-10 code sets. A separate final rule also published by CMS in January 2009 resulted in changes to the formats to be used for electronic transactions subject to the ICD-10 code sets, known as Version 5010. While use of the ICD-10 code sets is not mandatory until October 1, 2013 and the use of Version 5010 is not mandatory until January 1, 2012, we have begun to modify our systems and processes to prepare for their implementation. These changes may result in errors and otherwise negatively impact our service levels, and we may experience complications

related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Also, the compliance date

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for ICD-10 code sets and the use of Version 5010 may overlap with the adoption of the operating rules as mandated by PPACA, which may further burden our resources.

NPI Standard. The national provider identifier, or NPI, regulations established under HIPAA, or NPI Standard, require providers that transmit any health information in electronic form in connection with a HIPAA-standard transaction to obtain a single, ten position all-numeric NPI and to use the NPI in standard transactions for which a provider identifier is required. Health plans and healthcare clearinghouses must use a provider s NPI to identify the provider on all standard transactions requiring a provider identifier.

All of our clearinghouse systems are fully capable of transmitting transactions that include the NPI. 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. We cannot provide assurance regarding how CMS will enforce the NPI Standard or how CMS will view our practice of including legacy identifiers for non-Medicare claims. We continue to work with payers, providers, practice management system vendors and other healthcare industry constituents to implement the NPI Standard. Any CMS regulatory change or clarification or enforcement action that prohibited the processing by healthcare clearinghouses or private payers of transactions containing legacy identifiers could have an adverse effect on our business.

Health Plan Identifier. PPACA requires HHS to promulgate regulations implementing the establishment of a unique health plan identifier, or HPI, by October 12, 2012. Similar to a provider s NPI, the HPI will provide an identification system for health plans to use for electronic transactions. How the HPI requirement will be applied, what process will be involved to obtain a HPI and how the HPI process will impact us is unclear at this time.

Electronic Health Records. ARRA provides for Medicare and Medicaid incentive payments beginning in 2011 for eligible hospitals and eligible professionals that adopt and meaningfully use certified electronic health records, or EHR, technology. At least $20 billion in incentives is being made available through the Medicare and Medicaid incentive programs to providers who successfully demonstrate meaningful use of EHR technology. Beginning in 2015, eligible hospitals and eligible professionals who fail to demonstrate meaningful use of EHR technology will face reductions in Medicare payments.

Regulation of Healthcare Relationships and Payments

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 or orders for services or items covered by a federal healthcare program, such as Medicare, Medicaid or TriCare. 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 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 have laws and regulations that are similar to the federal Anti-Kickback Law. In many cases, these state requirements are not 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