Change Healthcare Holdings, Inc.
Form 10-K
March 14, 2016
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2015

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

CHANGE HEALTHCARE HOLDINGS, 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, 2015, there were issued and outstanding 100 shares of common stock, par value $.01 per share. The registrant is a wholly owned subsidiary of Change Healthcare Intermediate Holdings, Inc., which is a wholly owned subsidiary of Change Healthcare, Inc.

* 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.

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CHANGE HEALTHCARE HOLDINGS, INC.

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CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K (the Annual Report) of Change Healthcare Holdings, Inc. (Change Healthcare 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, similar expressions. Forward-looking statements also may include information concerning our possible or assumed future results of operations, including descriptions of our revenues, profitability and outlook and our overall business strategy. These statements are subject to numerous uncertainties and factors relating to our operations and business environment, all of which are difficult to predict and many of which are beyond our control. Although we believe that these forward-looking statements are based on reasonable assumptions, readers should be aware that many factors could affect our actual financial results or results of operations and could cause actual results to differ materially from those in the forward-looking statements.

Other factors that may cause actual results to differ materially include those set forth in the risks discussed in Part I, Item 1A, Risk Factors, and Part II, Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations 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, Change Healthcare and the Company refer to Change Healthcare Holdings, Inc. and its subsidiaries.

PART I

ITEM 1. *BUSINESS*

Overview

We are a leading provider of software and analytics, network solutions and technology-enabled services that optimize communications, payments and actionable insights designed to enable smarter healthcare. Our integrated capabilities enable our customers to exchange mission-critical information, optimize revenue opportunities, control costs, increase cash flow and efficiently manage complex healthcare workflows. The foundation of our solutions is embedded in our Change Healthcare Intelligent Healthcare Network™, which facilitates the capture and standardization of healthcare data seamlessly in our customers workflow. Our intelligent healthcare platform underpins the United States healthcare system, benefiting all major healthcare stakeholders: commercial and governmental payers, employers, hospitals, physician practices, dentists, laboratories, pharmacies and consumers.

Over the past decade, the digitization of healthcare information has been robust, accelerated in part by regulatory and government incentives that have enabled providers to embed technology directly into their clinical and administrative workflow. At the same time, policy makers, payers, employers and individuals are increasingly focused on improving value in healthcare and constraining cost growth. This backdrop has driven the need to not only collect the data, but

also to establish a deepened understanding on how to achieve improved quality and value outcomes across the continuum of care.

Change Healthcare s Intelligent Healthcare Network, the single largest financial and administrative healthcare network in the United States, reaches approximately 750,000 physicians, 105,000 dentists, 60,000 pharmacies, 5,000 hospitals, 600 channel partners, 450 laboratories and 1,200 government and commercial payers, allowing us to bring actionable data, analytics and insights to the healthcare ecosystem. By leveraging our Intelligent Healthcare Network, customers are able to more efficiently manage the complex revenue and payment cycle and clinical information exchange processes.

In 2015, our network processed approximately 8.8 billion healthcare-related transactions, covering $1.7 trillion in claims. 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 in a hybrid cloud-based, user-centric and secure infrastructure environment. Our solutions are designed to interface with our customers existing technology infrastructures, utilize actionable data from our Intelligent Healthcare Network and automate key processes in the healthcare workflow. We believe our customers recognize incremental value and enhanced benefits as they utilize more of our diverse suite of products and technology-enabled services.

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Our Organizational Structure and Corporate History

The Company is a Delaware corporation that was initially formed as a Delaware limited liability company in September 2006 and converted into a Delaware corporation in September 2008. On November 2, 2011, pursuant to an Agreement and Plan of Merger among the Company (formerly known as Emdeon Inc.), Change Healthcare, Inc. (formerly known as Beagle Parent Corp.) (Parent) and Beagle Acquisition Corp. (Merger Sub), Merger Sub merged with and into the Company, with the Company surviving the merger (the 2011 Merger). Subsequent to the 2011 Merger, we became an indirect wholly owned subsidiary of Parent, which is controlled by The Blackstone Group L.P. (Blackstone), Hellman & Friedman LLC (Hellman & Friedman) and certain investment funds affiliated with Blackstone and Hellman & Friedman (collectively, the Investor Group). In the fourth quarter of 2015, we initiated a rebranding to align under the Change Healthcare brand.

Our Solutions

Through our broad portfolio of solutions, we are able to serve the needs of multiple stakeholders in the healthcare system across payers, providers and pharmacies, including commercial insurance companies, third-party administrators, governmental payers, self-insured employers, hospitals, physician practices, dentists, laboratories, pharmacies, pharmacy benefit management companies and government agencies. During 2015, we delivered our solutions and operated our business in three reportable segments: (i) software and analytics, (ii) network solutions and (iii) technology-enabled services. The selected financial information for each segment is provided in Note 18 in the accompanying Notes to Consolidated Financial Statements contained in Part IV, Item 15, beginning on Page F-1 of this Annual Report.

Software and Analytics: Through the software and analytics segment, our powerful platform allows us to provide payment and reimbursement optimization and decision support solutions for our customers. Our software and analytics offerings include revenue cycle technology, revenue optimization, payment integrity, electronic payment, risk adjustment, quality reporting, data and analytics and engagement solutions.

Network Solutions: Through our network solutions segment, we leverage our Intelligent Healthcare Network, the single largest financial and administrative healthcare network in the United States, to optimize information exchange and workflows among healthcare system participants. Our network solutions offerings include financial and administrative information exchange solutions for medical, pharmacy and dental claims management and other standardized healthcare transactions, including clinical information exchange capabilities.

Technology-Enabled Services: Through our technology-enabled services segment, we provide payment and communication, workflow, advisory and other administrative solutions to optimize payment and reimbursement processes. Our technology-enabled services offerings include payment and communication, eligibility and enrollment, healthcare consulting, payment automation and pharmacy benefits administration solutions.

Software and Analytics

Revenue Cycle Technology:

Our applications are delivered as software-as-a-service (SaaS), and provide complete end-to-end revenue cycle management (RCM) workflow for hospitals, physician offices, laboratories and other ancillary care providers. Our software applications allow providers to bill for services rendered, track claims, manage denials, discover and correct errors in real-time and manage payments received from payers and consumers. Our RCM solutions integrate with all

major institutional electronic health record (EHR) systems and give customers the flexibility to optimize their processes.

Revenue Optimization:

Our revenue optimization solutions help ensure that providers are reimbursed rapidly and accurately from the right payer, per the applicable contract terms. Identification and management of denials and underpayments is a significant challenge for many providers. Our revenue optimization solutions include: (i) proprietary contract management software, which enables us to identify additional revenue previously overlooked by our clients; (ii) a solution that queries commercial and government payers such as Medicare, Medicaid and Tri-Care to identify valid insurance coverage for those accounts that would otherwise go uncollected; (iii) third-party liability analytics solutions, which manages the process of identifying, validating and verifying coordination of benefit opportunities; and (iv) coding and auditing solutions, which optimize and improve revenue cycle processes for hospitals, health systems and medical groups. We also offer outsourced support for appropriate coding practices and assistance with third-party reimbursement audits.

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Payment Integrity:

Our payment integrity solutions help payers detect and prevent fraud, waste and abuse at every step of the reimbursement process. Our advanced analytics technology, investigation experience, fraud, waste and abuse detection and cost management solutions, along with a comprehensive portfolio of audit and recovery solutions, make us a leading integrated solution provider to address improper claim payments. Our solutions integrate within a payer s existing claims workflow and provide multi-layered protection that offers both prospective and retrospective claims review, as well as in- and out-of-network claims management.

Electronic Payment:

Our electronic payment solutions support both business-to-business (B2B) and consumer-to-business (C2B) payments. We believe we are well positioned to further drive the healthcare industry s adoption of automated, cost-saving payment processes through our comprehensive network of payers and providers.

Our B2B payment solutions offer payers and providers the ability to distribute and receive payments in the most efficient manner via electronic funds transfer (EFT), direct payment, virtual card or checks. We also assist our customers in automating these processes by: (i) converting paper-based payer remittances and payments to electronic form, (ii) expanding their remittance and payment distribution network, (iii) simplifying administrative and financial processes associated with the distribution and settlement of funds and (iv) improving workflow automation for provider payment posting.

Our C2B payment solutions help providers and payers efficiently bill consumers and offer consumer-friendly options to make payments via credit card or eCheck, online portal, phone/interactive voice response system or mail.

Risk Adjustment:

Our risk adjustment solutions consist of applications that analyze patient data and quantify the inherent health risk across a population of covered members based on prior health history and other factors. We provide an end-to-end risk solution, including identifying gaps in acuity documentation, chart retrieval and coding for documentation of member acuity and providing workflow tools for assembling and analyzing data to prepare reports for regulatory bodies.

Quality Reporting:

Our quality reporting solutions are applications that report quality metrics for services provided to a health plan s covered members. These quality measures are ultimately translated into Star Ratings (Centers for Medicare & Medicaid Services) or Healthcare Effectiveness Data and Information Sets (HEDIS) metrics. Star Ratings form the basis for payers to receive either bonuses or penalties based upon the quality of their respective health plan. HEDIS scores form an objective, third-party rating system upon which prospective purchasers can compare different health plans and are a component of the Star Ratings. Our solutions obtain information on healthcare claims through clinical chart abstraction and coding, data analytics to identify gaps in quality and providing workflow tools for reporting quality metrics to regulatory bodies.

Data and Analytics:

Our Intelligent Healthcare Network, workflow software and large ecosystem of channel partners combines the reach of a national network with the power of software analytics to deliver targeted and actionable insights to payers, providers, pharmacies and consumers within their normal workflow. The ongoing transformation of the healthcare industry requires all stakeholders to be better informed and make better decisions. Payers need to engage with their plan members in a personalized manner and help them navigate complex clinical and financial decisions. Providers must understand the needs of their patients and be more resourceful in demonstrating value to them. With consumers paying more out of pocket, the experience consumers have with payers and providers will increasingly impact their decisions as to with whom they develop long-term relationships. Our data and analytics solutions are able to use one of the largest and most timely sources of healthcare transactional data available, including 8.8 billion transactions, covering $1.7 trillion in claims in 2015. Payers leverage our data to identify and manage risk, stop fraud, waste and abuse and provide members with better decision-making tools around their healthcare choices. Healthcare systems can benefit from our data and analytics solutions by identifying revenue lost to non-health system providers and inefficient referral patterns that can result in lost revenue for providers.

Engagement:

Our cost and quality transparency and engagement solutions serve large employers and health plans to provide cost and quality transparency, decision support and educational tools to patients. These transparency solutions enable consumers to better understand

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and utilize their healthcare benefits, make informed purchasing decisions based on quality, cost and convenience and realize savings opportunities. The transformation of the healthcare industry is making it more consumer-oriented. However, most consumers still lack the tools they need to make informed decisions relating to their healthcare choices.

We also provide engagement solutions to health plans, including government-sponsored health plans, and risk-bearing providers that help address gaps in care by engaging with plan members to facilitate the scheduling of new and follow-up appointments with providers, provide automated communication programs and coordinate in-home clinical care visits. In addition, our solutions assist health plan members, primarily in Medicare Advantage, with the eligibility and enrollment process for community-based assistance programs and Medicaid dual-eligibility. These solutions leverage our proprietary analytics and algorithms to help payers identify members who may qualify for these programs from a larger population set, providing increased reimbursement for the health plan from regulatory agencies.

Network Solutions

Medical Network:

Our medical network reaches nearly all payers in the United States (approximately 1,200) and over 750,000 physicians. Additionally, approximately 480 of our payer customers have entered into management services agreements with us to utilize Change Healthcare as their sole source or primary gateway for routing electronic data interchange (EDI) transactions. Our medical network is interoperable with other networks and supports real-time, near real-time and batch transactions. Our medical network provides comprehensive support for healthcare financial and administrative transactions including eligibility, claims, electronic remittance advice, claim status, pre-authorization and medical attachments. Our medical network also integrates with our payments network, which allows payers and providers to reconcile out-of-pocket cash, EFT and credit card payments to settle bills and claims.

Pharmacy Network:

Our pharmacy network supports prescription routing, prescription refill requests, eligibility, medication history, formulary look-up and pharmacy claims to over 60,000 pharmacies. Our pharmacy network also sends patient- and drug-specific messages and alerts to pharmacies allowing them to better evaluate and address patient needs. In addition, our ability to connect to pharmacy benefit managers and payers allows us to meet the growing need for pharmacies to connect to medical payers as they implement and bill for new clinical services, such as flu shots and urgent care, that are covered as medical (not pharmacy) benefits.

Dental Network:

Our dental network reaches over 105,000 dentists, over 500 payers and over 125 dental EHRs and other channel partners. We provide eligibility, claims, electronic remittance advice and payment solutions to dental practices primarily through software channel partners.

Clinical Network:

Our clinical network connects to over 450 reference laboratories to deliver laboratory orders efficiently from physician EHRs to laboratories and return clinical results back to the EHR. This connectivity provides an efficient mechanism for EHRs and laboratories to connect with each other without the cost of expensive and redundant direct connections.

Technology-Enabled Services

Payment and Communication:

We provide payment and communication solutions for payers, providers, channel partners and other stakeholders in the healthcare system. We offer our payer clients explanation of benefits (EOBs), explanation of payments, checks, claims and correspondence. We offer our provider and channel partner clients patient statements and related correspondence. Because of the breadth and scale of our connectivity to both payers and providers, customers can realize significant print and operational cost savings through the use of our high-volume co-operative print and mail solutions to reduce postage and material costs.

Eligibility and Enrollment:

We provide technology-enabled eligibility and enrollment services to providers primarily for self-pay patients, in an inpatient hospital setting. Our provider solutions use a combination of technology and on-site consultants to educate patients about programs and payer sources, including Medicaid, disability and health insurance exchanges, that may help cover costs of their healthcare and help patients advocate for benefits, coverage solutions or financial assistance for which they may be eligible. By analyzing government assistance programs available to self-pay patients and facilitating patient use of applicable programs, Change Healthcare has been able to help hospitals significantly increase reimbursements and decrease written off payments.

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Healthcare Consulting:

Our healthcare consulting solutions help healthcare clients analyze, develop and implement business and technology strategies that are designed to align with healthcare trends and overall business goals. Our consultants combine extensive healthcare industry knowledge with practical experience that can help solve many industry challenges such as revenue cycle management, compliance and auditing issues and updating disparate and out-of-date technology systems and antiquated processes. We assist clients with improving clinical documentation, optimizing billing management, assessing enterprise risk and internal controls, deploying healthcare information technology solutions quickly and cost-effectively and valuation support.

Payment Automation:

Through a blend of technology and services, we offer comprehensive payment automation solutions that facilitate, expedite and automate payment processing and posting activities. On behalf of our provider customers, we accept paper payments from both third-party payers and patients and convert them into automated workflows that are reconciled and posted. Our technology-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 allow providers to identify underpayments, efficiently appeal denials and resubmit claims in a timely manner, provide insight into patterns of denials and 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.

Pharmacy Benefits Administration:

Our Pharmacy Benefits Administration (PBA) solutions provide healthcare management and other administrative services for pharmacy payers and state Medicaid programs. Our clients have the option of a fully-outsourced PBA solution, a state-administered SaaS solution or select PBA services. Our solutions provide claims processing and other administrative services 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 and rebate management, as well as implementation, training and account management.

Customers

We generally provide solutions to our payer, provider and pharmacy customers on a per transaction, per document, per communication, per member per month, per provider 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.

Payers:

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. For the year ended December 31, 2015, our top ten payer customers represented approximately 15% of our total revenue and no payer customer

accounted for more than approximately 3.5% of our total revenue. We have entered into management services agreements with approximately 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.

Providers:

The provider market is comprised of hospitals, physician practices, dentists, skilled nursing facilities, home health agencies, senior care facilities, laboratories and other healthcare providers. We currently have contractual or submitter relationships, directly or through channel partners, with approximately 750,000 physicians, 5,000 hospitals, 105,000 dentists and 450 laboratories. For the year ended December 31, 2015, our top ten provider customers represented approximately 9% of our total revenue and no provider customer accounted for more than approximately 2% of our total revenue.

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Pharmacies:

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 to virtually all pharmacies utilizing electronic transaction connectivity services. For the year ended December 31, 2015, no pharmacy services customer accounted for more than approximately 1% of our total revenue.

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 the payer, provider and pharmacy markets. We also deliver certain of our solutions through over 600 channel partner relationships, which further extends the reach of our network. 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 platform is a hybrid cloud-based, user-centric, partner-friendly network and analytics platform that collects, synthesizes and analyzes our extensive set of real-time, near real-time and batch transactions for medical, pharmacy, dental, laboratory and other financial and administrative data to generate timely and relevant insights in an effort to enable our customers to achieve their financial and operational goals.

We believe that we benefit from decades of experience developing, implementing and optimizing interfaces which are embedded in the core workflows of healthcare stakeholders and are used by our customers to optimize their operations and services end-to-end. We have extensive expertise working with constantly evolving customer interfaces, which often include diverse legacy applications and technologies.

We believe the timeliness, depth and breadth of our data allows us to generate one of the broadest sets of analytics in the healthcare industry, supporting applications and services for consumer engagement, eligibility and enrollment, payment integrity, revenue cycle management, revenue optimization, risk adjustment, quality measurement and payments. We store vast data sets in scalable, secure and accessible transaction data stores in the cloud with industry-leading data warehousing capabilities. This data feeds our analytics engine for data product and analytics creation. The analytics data environments enable online analytics processing with data persisted in a scalable, open standards-based infrastructure, incorporating performance with high availability.

Our technology architecture is based on open source standards and leverages agility and cost-effectiveness to provide scalability and reliability. Our technology platform is implemented with a comprehensive set of enterprise standards and governing principles resulting in a consistent architecture for client-side user interfaces, middleware, database and storage, which provide advanced orchestration, interoperability and process control. Our platform is deployed over hybrid public and private cloud infrastructures, including two secure, interconnected, environmentally controlled data centers, one in Nashville, Tennessee and one in Memphis, Tennessee, each with emergency power generation capabilities. Our technology platform is architected and developed to help the healthcare industry improve the technology gap that exists today and be responsive to our customers and partners future needs relating to capabilities, performance and scalability.

Our Industry

We are a leader in the healthcare information technology sector, addressing healthcare constituents across the continuum of care. This sector is large and growing with nearly $50 billion spent across the provider and payer sectors on information technology software and related solutions in 2015. We believe that our products and services provide tools and solutions that enhance revenue, reduce costs and simplify healthcare for patients, providers and payers. The sector is expected to continue to grow rapidly over the next several years driven in part by the evolution in new healthcare focused technologies, but also due to underlying industry trends that are affecting the healthcare sector as a whole.

Recent Industry Trends and Developments

Ongoing Rise in Healthcare Costs:

Healthcare spending in the U.S. is a significant component of the economy, representing approximately $3.1 trillion in 2015, or 18% of GDP, and is expected to grow to $5.4 trillion, or approximately 19.6% of GDP, in 2024. As of June 2012, it was estimated that the cost of healthcare administration in the U.S. is approximately $360 billion per year, or 14% of total healthcare expenditures, and approximately one half of these costs were spent by payers and providers on billing and insurance-related activities. Over the past

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several years, healthcare spending has decelerated, but it is unclear to what degree that slowdown will continue in the future, and in any case policy makers, employers and individuals remain concerned about the implications of rising costs. We believe that the growing need to slow the increase in healthcare expenditures, expanded financial pressures on payers and providers and public policy initiatives to reduce healthcare administrative inefficiencies should accelerate demand for solutions that simplify and improve value in the business of healthcare.

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. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (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.

Fraud, Waste and Abuse:

The focus by commercial and government payers on better managing costs has driven increased attention to the significant amount of healthcare costs attributable to fraud, waste and abuse each year, which based on industry estimates are between $70 billion and $272 billion each year. Government agencies have implemented programs, such as the Medicare RAC (Recovery Audit Contractor) program, while other payers have looked to outsource portions of their claims review process in an effort to reduce these costs. This cost, however, is not limited to payers. The federal False Claims Act (FCA) and state false claims laws have shifted the burden to providers. The applications of these laws are broad and carry significant civil and criminal penalties. We believe our historical claims data, combined with our healthcare payment integrity services, position us to benefit from government proposals to promote cost effective healthcare and reduce fraud, waste and abuse, as well as from our customers initiatives designed to promote the detection and prevention of improper or fraudulent healthcare payments.

Shift to Value-Based Healthcare:

The traditional fee-for-service reimbursement model in healthcare has played a major role in elevating both the level and growth rate of healthcare spending. In response, both the public and private sectors are shifting away from the historical fee-for-service models toward value-based, capitated payment models that are designed to incentivize value and quality at the patient level. The Department of Health and Human Services (HHS) has set quality and value targets for certain Medicare alternative payment models, including Accountable Care Organizations (ACOs) and bundled payment arrangements, with 50% of payments tied to such value targets by the end of 2018. Private payers are also shifting their focus with certain payers to mirror or exceed HHS targets for 2018. These payment models

require a high level of documentation and systems that quickly adapt to new rules and goals in order to comply with value-based healthcare targets. Many payers and providers lack the administrative processes to manage these changes, and are increasingly partnering with third parties, such as us, to streamline administrative and financial tasks.

Growth in High-Deductible Health Plans (HDHP) and Out-of-Pockets Costs:

Faced with significant increases in out-of-pocket costs, patients are increasingly focused on healthcare costs and seeking high value (high quality-low price) providers. The increased adoption of HDHP, which has grown 14.5% annually since 2010 to be utilized by 19.7 million people as of 2015, is also shifting many employer and payer costs to the patient. As a result, patients are progressively becoming more interested in the costs tied to their care. These new cost-conscience patients are demanding tools and solutions that provide price transparency and decision support, while also simplifying the payment process.

Increasing Complexity:

We believe that the increasing complexity of healthcare promotes the outsourcing of administrative functions. For example, 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 post-payment review programs, 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 and Medicaid reimbursement. Because of such increased government requirements and the continued proliferation of private-payer benefit plan design changes, providers face increasingly complex and frequently changing reimbursement mechanisms involving multiple parties and greater administrative

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burdens. Many payers and providers are not equipped to handle this increased complexity and the associated administrative challenges and rely on inefficient and labor intensive processes. As a result, payers and providers continue to seek solutions that automate and simplify administrative and financial processes.

Significant Digitization of Healthcare Information:
The proliferation of EHR and other healthcare digitization systems have created unprecedented amounts of healthcare data. These large amounts of data, however, are contained within various pools of unstandardized data. The data is generally difficult to convert to meaningful insights for payers, providers and patients on a real-time or near real-time basis. This backdrop has created demand for tools and solutions that standardize the transfer and collection of this data and mine and analyze the data for actionable solutions, and for services that empower providers and payers to change patient behavior. As the amount of data in healthcare continues to grow, our integrated platform and solutions can help connect the various market constituents and provide software and analytics for payers, providers and pharmacies to better understand the relative quality and cost of healthcare across the U.S.

Payer and Provider Landscape

Healthcare is generally provided through a fragmented industry of payers and providers that have, in many cases, historically underinvested in administrative and clinical information systems. Based on industry reports, within the universe of providers, we estimate that there are currently over 5,700 hospitals and over 589,000 office-based doctors, of which approximately 73% are in small physician practices consisting of five 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.

Increasing Administrative Burden: 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.

Increasing Complexity: 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 in the shift to ICD-10 and 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.

Increasing Patient Financial Responsibility: 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 HDHPs and consumer-oriented plans (which grew to 19.7 million people as of 2015, 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 ACA, 35 million remained uninsured in 2015, according to Congressional Budget Office estimates released in March 2015.

Increasing Regulatory Environment: The healthcare industry is highly regulated and subject to frequently changing complex regulatory and other requirements. For example, the ACA significantly affects the healthcare regulatory environment 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. 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 the ACA 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.

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Need for Increased Administrative Efficiency: 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 payment reductions in 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 (HIPAA) format and data content standards and value-based capitated payment models, 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, financial and administrative systems often have not been sufficiently integrated, resulting in persistently high costs associated with administering these plans.

The Revenue and Payment Cycle

The healthcare revenue and payment cycle consists of all the processes and efforts that providers undertake to ensure they are properly compensated 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 patients. 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 the patients 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 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.

The rapid growth in healthcare spending combined with the impact of regulations has increased the complexity of healthcare payments. Unlike payments in many other industries, a majority of healthcare payments still involve paper. There are several reasons why adoption of electronic payments in healthcare has trailed other industries. Healthcare payments from payers are reimbursements against a claim, not payment of an invoice. The amount of the reimbursement payment is determined by the adjudication of the claim against a contract or government guidelines, which usually results in a smaller payment than the claim amount. This payment process often takes an extended period of time, which typically results in high levels of bad debt in patient collections. In addition, many payers and providers have not developed the capabilities to engage effectively with and collect payments from an increasingly important payer in healthcare the consumer. Until recently, most health insurance coverage was negotiated between payers and employers, and most provider payments were from payers with only a modest component coming from consumers. With the rapid growth in consumer-driven health plans, providers now have to develop new capabilities to bill and collect from consumers for out-of-pocket payments.

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Regulatory Landscape

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 that can affect 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, Risk Factors in this Annual Report.

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 the solutions we offer 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;

Healthcare payment and communication solutions providers, including financial institutions and payment processors that have invested in healthcare data management assets, and print and mail vendors;

Eligibility and enrollment services companies;

Payment integrity companies;

Engagement and transparency companies; and

Providers of healthcare risk adjustment, quality reporting and other data and analytics solutions.

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.

Our Intellectual Property

We rely upon a combination of trade secrets, 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.

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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, 2016, we had approximately 7,000 employees, of which approximately 2,000 are seasonal. 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 and electronic medical record system vendors; (iii) large information technology and healthcare consulting service providers; (iv) health insurance companies, pharmacy benefit management companies, hospital management companies and pharmacies that provide or are developing electronic transaction and payment distribution services for use by providers and/or by their members and customers; (v) healthcare payments and communication solutions providers, including financial institutions and payment processors that have invested in healthcare data management assets, and print and mail vendors; (vi) eligibility and enrollment services companies; (vii) payment integrity companies; (viii) engagement and transparency companies; and (ix) providers of healthcare risk adjustment, quality and other data and analytics solutions. In addition, major software, hardware, information systems and business process outsourcing companies, both with and without healthcare companies as their partners, offer or have announced their intention to offer products or services that are competitive with solutions that we offer.

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

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

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

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

Our success depends substantially upon the retention of our customers, particularly due to our 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 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 may be made either directly or through a clearinghouse. We may not be able to maintain our links with a large number of payers on terms satisfactory to us and we may not be able to develop new connections, either directly or through other clearinghouses, on satisfactory terms. The failure to maintain these connections could cause our solutions to be less attractive to our provider customers. In addition, our payer customers view our connections to a large number of providers as essential in allowing them to receive a high volume of transactions and realize the resulting cost efficiencies through the use of our solutions. Our failure to maintain existing connections with payers, providers and other clearinghouses or to develop new connections as circumstances warrant, or an increase in the utilization of direct links between payers and providers, could cause our electronic transaction processing systems to be less desirable to healthcare constituents, which would reduce the number of transactions that we process and for which we are paid, resulting in a decrease in revenues and an adverse effect on our financial condition and results of operations.

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

We have entered into contracts with our channel partners to market and sell some of our solutions. Most of these contracts are on a non-exclusive basis. However, under contracts with some of our channel partners, we may be bound by provisions that restrict our ability to market and sell our solutions to potential customers. Our arrangements with some of these channel partners involve negotiated payments to them based on percentages of revenues they generate. If the payments prove to be too high, we may be unable to realize acceptable margins, but if the payments prove to be too low, the channel partners may not be motivated to produce a sufficient volume of revenues. The success of these contractual arrangements will depend in part upon the channel partners own competitive, marketing and strategic considerations, including the relative advantages of using alternative products being developed and marketed by them or our competitors. If any of these channel partners are unsuccessful in marketing our solutions or seek to amend the financial or other terms of the contracts we have with them, we will need to broaden our marketing efforts to increase focus on the solutions they sell and alter our distribution strategy, which may divert our planned efforts and resources from other projects. In addition, as part of the packages these channel partners sell, they may offer a choice to their

customers between solutions that we supply and similar solutions offered by our competitors or by the channel partners directly. If our solutions are not chosen for inclusion in these packages, the revenues we earn from our channel partner relationships will decrease. Lastly, we could be subject to claims and liability, as a result of the activities, products or services of these channel partners or other resellers of our solutions. Even if these claims do not result in liability to us, investigating and defending these claims could be expensive, time-consuming and result in adverse publicity that could harm our business.

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 pressure, 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.

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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 tried in the past, and may try in the future, 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.

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.

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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 payment and communication 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, providers and patients;
- eligibility and enrollment services for payers and providers;
- accounts receivable management, denial management, appeals and collection improvement services for providers;
- healthcare and information technology consulting services for payers and providers;
- decision support, clinical information exchange or other business intelligence and data analytics solutions;
- consumer engagement and transparency services; and
- healthcare risk adjustment and quality solutions.

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

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 than anticipated, 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.

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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 also highly dependent on our payment and communication 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 cloud-based data hosting, 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 solutions and fulfill contractual demands, could require us to devote significant financial and other resources to mitigate such problems and could increase our future security costs, including through organizational changes, deploying additional personnel and protection technologies, further training of employees and engaging third party experts and consultants. Moreover, unauthorized access, use or disclosure of certain confidential information in our possession could result in civil or criminal liability or regulatory action, including potential fines and penalties, as well as costs relating to required notifications, credit monitoring services and other necessary expenses. In addition, any actual or perceived breach of our security measures may cause existing customers to terminate their relationship with us or deter customers from using or purchasing our solutions in the future. The occurrence of any of these events could disrupt our business and operations or harm our brand and reputation, either of which could adversely affect our financial condition and operating results.

Recently, there have been a number of high profile security breaches involving the improper dissemination of personal information of individuals both within and outside of the healthcare industry. Lawsuits resulting from these security breaches have sought significant monetary damages. While we maintain liability insurance coverage, claims could exceed the amount of our applicable insurance coverage, if any, or this coverage may not continue to be available on acceptable terms or in sufficient amounts.

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

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

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

Our activities and the activities of our third party contractors involve the storage, use and transmission of financial and personal health information. Accordingly, security breaches of our or their computer systems or at our operation centers could expose us to a risk of loss or litigation, government enforcement actions and contractual liabilities. We cannot be certain that contractual provisions attempting to limit our liability in these areas will be successful or enforceable, or that other parties will accept such contractual provisions as part of our agreements. Any security breaches also could impact our ability to provide our solutions, as well as impact the confidence of our customers in our solutions, either of which could have an adverse effect on our business, financial condition and results of operations.

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

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

Almost all of our revenue is either derived from the healthcare industry or could be affected by changes in healthcare spending. The healthcare industry is highly regulated and subject to changing political, legislative, regulatory and other influences. For example, the ACA changes how healthcare services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced Medicare program spending and insurance market reforms. ACA seeks to increase health insurance coverage through the expansion of Medicaid (of which states may opt out), establishment of health insurance exchanges to facilitate the purchase of health insurance by individuals and small employers, imposing penalties on individuals who do not obtain health insurance and imposing fines on employers with 50 or more full-time employees that do not offer employees health insurance. ACA insurance market reforms include increased dependent coverage, prohibitions on excluding individuals based on pre-existing conditions and mandated minimum medical loss ratios for health plans. In addition, ACA provides for significant new taxes, including an industry user tax paid by health insurance companies, as well as an excise tax on health insurers and employers offering high cost health coverage plans. ACA also imposes significant Medicare Advantage funding cuts and material reductions to Medicare and Medicaid program spending. ACA further provides for additional resources to combat healthcare fraud, waste and abuse and also requires the HHS to adopt additional standards for electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized

electronic transaction.

While many of the provisions of ACA are not directly applicable to us, ACA affects the businesses of our payer, provider and pharmacy customers and the Medicaid programs of the states with which we have contracts. The provisions of ACA that are designed to expand health coverage potentially could result in an overall increase in transactions for our business and demand for our solutions; however, our customers may attempt to reduce spending to offset the increased costs associated with meeting the various ACA insurance market reforms. Likewise, as the Medicare payment reductions and other reimbursement changes impact our customers, our customers may attempt to seek price concessions from us or reduce their use of our solutions. Thus, ACA may result in a reduction of expenditures by customers or potential customers in the healthcare industry, which could have an adverse effect on our business, financial condition and results of operations. Further, we may experience increased costs from responding to new standardized transaction and implementation rules and our customers needs. 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 or limited interpretive guidance, remaining or new court challenges, implementation issues and the possibility of further delays, amendments or repeal.

Moreover, there are currently numerous federal, state and private initiatives and studies seeking ways to increase the use of information technology in healthcare as a means of improving care and reducing costs. For example, 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 EHR technology, and through December 2015 approximately $32 billion in payments have been distributed. These initiatives may

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result in additional or costly legal or regulatory requirements that are applicable to us and our customers, may encourage more companies to enter our markets, may provide advantages to our competitors and may result in the development of technology solutions that compete with ours. Any such initiatives also may result in a reduction of expenditures by customers or potential customers in the healthcare industry, which could have an adverse effect on our business.

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

- government regulation or private initiatives that affect the manner in which providers interact with patients, payers or other healthcare industry constituents, including changes in pricing or means of delivery of healthcare solutions;
- reductions in governmental funding for healthcare, in addition to reductions required by ACA, such as reductions resulting from the BCA, which requires automatic spending reductions of $1.2 trillion for federal fiscal years 2013 through 2021, minus any deficit reductions enacted by Congress and debt service costs, and laws that extend these cuts through federal fiscal year 2025; and
- adverse changes in business or economic conditions affecting payers, providers, pharmaceutical companies, medical device manufacturers or other healthcare industry constituents.

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

- changes in the billing patterns of providers;
- changes in the design of health insurance plans;
- changes in the contracting methods payers use in their relationships with providers;
- decreases in marketing expenditures by pharmaceutical companies or medical device manufacturers, as a result of governmental regulation or private initiatives that discourage or prohibit promotional activities by pharmaceutical or medical device companies; and

implementation of government programs that streamline and standardize eligibility enrollment processes that could result in decreased pricing or demand for our eligibility and enrollment solutions.

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

Government regulation, industry standards and other requirements create risks and challenges with respect to our compliance efforts and our business strategies.

The healthcare industry is highly regulated and subject to frequently changing regulatory and other requirements. Many healthcare laws and regulations are complex, and their application to specific services and relationships may not be clear. Because our customers are subject to various requirements, we may be impacted as a result of our contractual obligations even when we are not directly subject to such requirements. For many of these requirements, there is little history of regulatory or judicial interpretation upon which to rely. In particular, many existing healthcare laws and regulations, when enacted, did not anticipate the healthcare information solutions that we provide, and these laws and regulations may be applied to our solutions in ways that we do not anticipate. ACA and other federal and state efforts to reform or revise aspects of the healthcare industry or to revise or create additional statutory and regulatory requirements could impact our operations, the use of our solutions and our ability to market new solutions, or could create unexpected liabilities for us. We also may be impacted by non-healthcare laws, industry standards and other requirements 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 payment and remittance services we offer directly or through third-party vendors. Additionally, laws and regulations governing how we communicate with our customer s patients, such as the Telephone Consumer Protection Act (TCPA), place certain restrictions on companies that place telephone calls to consumers and may impact our operations.

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We are unable to predict what changes to laws, regulations and other requirements might be made in the future or how those changes could affect our business or the costs of compliance.

We have attempted to structure our operations to comply with legal and other requirements applicable to us directly and to our customers and third-party contractors, but there can be no assurance that our operations will not be challenged or impacted by enforcement initiatives. We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Certain of our businesses have been reviewed or are currently under review, including for compliance with coding and other requirements under the Medicare risk-adjustment model. Any determination by a court or agency that our solutions violate, or cause our customers to violate, applicable laws, regulations or other requirements could subject us or our customers to civil or criminal penalties. Such a determination also could require us to change or terminate portions of our business, disqualify us from serving customers who are or do business with government entities or cause us to refund some or all of our service fees or otherwise compensate our customers. In addition, failure to satisfy laws, regulations or other requirements could adversely affect demand for our solutions and could force us to expend significant capital, research and development and other resources to address the failure. Even an unsuccessful challenge by regulatory and other authorities or private whistleblowers could be expensive and time consuming, could result in loss of business, exposure to adverse publicity and injury to our reputation and could adversely affect our ability to retain and attract customers. Laws, regulations and other requirements impacting our operations include the following:

HIPAA Privacy and Security Requirements. There are numerous federal and state laws and regulations related to the privacy and security of personal health information. In particular, regulations promulgated pursuant to HIPAA establish privacy and security standards that limit the use and disclosure of individually identifiable health information (known as protected health information) and require the implementation of administrative, physical and technological safeguards to protect the privacy of protected health information and ensure the confidentiality, integrity and availability of electronic protected health information. We are directly subject to certain provisions of the regulations as a Business Associate through our relationships with customers. We are also directly subject to the HIPAA privacy and security regulations as a Covered Entity with respect to our operations as a healthcare clearinghouse and with respect to our clinical care visit services. The privacy regulations established under HIPAA also provide patients with rights related to understanding and controlling how their health information is used and disclosed. To the extent permitted by applicable privacy regulations and our contracts with our customers, we may use and disclose protected health information to perform our services and for other limited purposes, such as creating de-identified information, but other uses and disclosures, such as marketing communications, require written authorization from the individual or must meet an exception specified under the privacy regulations. Determining whether data has been sufficiently de-identified to comply with the HIPAA privacy standards and our contractual obligations may require complex factual and statistical analyses and may be subject to interpretation.

If we are unable to properly protect the privacy and security of protected health information entrusted to us, we could be found to have breached our contracts with our customers. Further, if we fail to comply with applicable HIPAA privacy and security standards, we could face civil and criminal penalties. HHS is required to perform compliance audits and has announced its intent to perform audits in 2016. In addition to enforcement by HHS, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations that threaten the privacy of state residents. HHS has the discretion to impose penalties without being required to attempt to resolve violations through informal means, such as implementing a corrective action plan. Although we have implemented and maintain policies and processes to assist us in complying with these regulations and our contractual obligations, we cannot provide assurance regarding how these standards will be interpreted, enforced or applied to our

operations.

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

Data Protection and Breaches. In recent years, there have been a number of well-publicized data breaches involving the improper dissemination of personal information of individuals both within and outside of the healthcare industry. Most states require holders of personal information to maintain safeguards and take certain actions in response to a data breach, such as providing prompt notification of the breach to affected individuals. In many cases, these laws are limited to electronic data, but states are increasingly enacting or considering stricter and broader requirements. Under HIPAA, Covered Entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days following discovery of the breach by a Covered Entity or its agents. Notification also must be made to HHS and, in certain circumstances involving large breaches, to the media. Business Associates must report breaches of unsecured protected health information to Covered Entities within 60 days of discovery of the breach by the Business Associate or its agents. A non-permitted use or disclosure is presumed to be a breach unless the Covered Entity or Business Associate establishes that there is a low probability the protected health information has been compromised.

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

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

HIPAA Transaction and Identifier Standards. HIPAA and its implementing regulations mandate format and data content standards and provider identifier standards (known as the National Provider Identifier) that must be used in certain electronic transactions, such as claims, payment advice and eligibility inquiries. As required by ACA, HHS has established standards that health plans must use for electronic fund transfers with providers, has established operating rules for certain transactions and is in the process of establishing operating rules to promote uniformity in the implementation of the remaining types of covered transactions. ACA also requires HHS to establish standards for health claims attachment transactions. Further, HHS adopted updated standard code sets for diagnoses and procedures known as the ICD-10 code sets. The use of the ICD-10 code sets became required on October 1, 2015.

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

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

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

identifier standards or how CMS will view our practice of accommodating requests to process transactions that include legacy formats or identifiers for non-Medicare claims. Any regulatory change, clarification or enforcement action by CMS that prohibited the processing by healthcare clearinghouses or private payers of transactions containing legacy formats or identifiers could have an adverse effect on our business.

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

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

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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 similar anti-kickback laws that are not necessarily limited to items or services for which payment is made by a federal healthcare program. The laws in this area are both broad and vague and generally are not subject to frequent regulatory or judicial interpretation. We review our practices with regulatory experts in an effort to comply with all applicable laws and regulatory requirements.

However, we are unable to predict how these laws will be interpreted or the full extent of their application, particularly to services that are not directly reimbursed by federal healthcare programs, such as transaction processing services. Any determination by a state or federal regulatory agency that any of our activities or those of our customers or vendors violate any of these laws could subject us to civil or criminal penalties, could require us to change or terminate some portions of our business, could require us to refund a portion of our service fees, could disqualify us from providing services to customers who are or do business with government programs and could have an adverse effect on our business. Even an unsuccessful challenge by regulatory authorities of our activities could result in adverse publicity and could require a costly response from us.

False or Fraudulent Claim Laws. We provide claims processing and other solutions to providers that relate to, or directly involve, the reimbursement of health services covered by Medicare, Medicaid, other federal healthcare programs and private payers. In addition, as part of our data transmission and claims submission services, we may employ certain edits, using logic, mapping and defaults, when submitting claims to third-party payers. Such edits are utilized when the information received from providers is insufficient to complete individual data elements requested by payers. We also provide services including risk analytics services, chart reviews, clinical care visits, payment integrity services, audit functions and enrollment and eligibility services, to Medicaid and Medicare managed care plans, commercial plans and other entities. These services, which include identifying diagnosis codes with respect to hierarchical condition categories, impact the amounts paid by Medicare and Medicaid to managed care plans.

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

In addition, the federal False Claims Act (FCA) and some state false claims laws provide significant civil and criminal penalties for noncompliance and can be enforced by private individuals through whistleblower or qui tam actions on behalf of the government alleging that the defendant has defrauded the government. For example, the federal Civil Monetary Penalty Law provides for penalties ranging from $10,000 to $50,000 per prohibited act and assessments of up to three times the amount claimed or received. Further, violations of the FCA are punishable by treble damages and penalties of up to $11,000 per false claim, and whistleblowers may receive a share of amounts recovered. The

Bipartisan Budget Act of 2015 requires civil monetary penalties, including those imposed under the federal Anti-Kickback Law and the FCA, to increase by up to 150% by August 1, 2016 and annually thereafter. Civil penalties also may be imposed for the failure to report and return an overpayment made by the federal government within 60 days of identifying the overpayment and also may result in liability under the FCA. ACA provides that submission of a claim for an item or service generated in violation of the Anti-Kickback Law constitutes a false or fraudulent claim under the FCA. Whistleblowers and the federal government have taken the position and some courts have held, that providers who allegedly have violated other statutes, such as the Stark Law, have thereby submitted false claims under the FCA. We rely on our customers to provide us with accurate and complete information and to appropriately use analytics, codes, reports and other information in connection with the services we provide.

From time to time, constituents in the healthcare industry, including us, may be subject to actions under the FCA or other fraud, waste and abuse provisions, such as the federal Civil Monetary Penalty Law. Errors and the unintended consequences of data manipulations by us or our systems with respect to entry, formatting, preparation or transmission of claims, coding, audit, eligibility and other information may be determined or alleged to be in violation of these laws and regulations or could adversely impact the compliance of our customers. Although we believe our editing and other processes are consistent with applicable reimbursement rules and industry practice, a court, enforcement agency or whistleblower could challenge these practices. In addition, we cannot guarantee that state and federal agencies will regard any billing errors we process or make as inadvertent or will not hold us responsible for any compliance issues related to claims, reports and other information we

handle on behalf of providers and payers. We cannot predict the impact of any enforcement actions under the various false claims and fraud, waste and abuse laws applicable to our operations. Even an unsuccessful challenge of our practices could cause adverse publicity and cause us to incur significant legal and related costs.

Financial Services Related Laws and Rules. Financial services and electronic payment processing services are subject to numerous laws, regulations and industry standards. These laws may subject us, our vendors and our customers to liability as a result of our payment and communication solutions. Although we do not act as a bank, we offer solutions that involve banks, or vendors who contract with banks and other regulated providers of financial services. The various payment modalities that we offer our customers directly and through third party providers may be deemed regulated activity at the federal or state level, and, as a result, we may be affected by banking and financial services industry laws, regulations and standards, such as licensing requirements, solvency standards, reporting and disclosure obligations and requirements to maintain the privacy and security of nonpublic personal financial information. In addition, our payment and communication solutions may be affected by payment card industry operating rules and security standards, certification requirements, state prompt payment laws and other rules governing electronic funds transfers. If we fail to comply with any applicable payment and communication rules or requirements, we may be subject to fines and changes in transaction fees and may lose our ability to process payment transactions or facilitate other types of billing and payment solutions. Moreover, in addition to regulatory requirements related to electronic funds transfers, payment transactions processed using the Automated Clearing House Network are subject to network operating rules promulgated by the National Automated Clearing House Association, and these rules may affect our payment practices. Further, our payment and communication solutions may impact the ability of our payer customers to comply with state prompt payment laws. These laws require payers to pay healthcare claims meeting the statutory or regulatory definition of a clean claim within a specified time frame. Finally, as we expand our financial services offerings we may be subject to additional laws and regulations, including certain consumer protection laws such as the Fair Debt Collections Practices Act (FDCPA), the Fair Credit Reporting Act (FCRA) and various other state laws implicated by such financial services.

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

Other State Laws. Most states have a variety of laws that may potentially impact our operations and business practices. For instance, many states in which we provide clinical care in-home assessment services prohibit corporations and other non-licensed entities from practicing medicine by employing physicians and certain non-physician practitioners. These prohibitions on the corporate practice of medicine impact how we structure our relationships with physicians and other affected non-physician practitioners. If our arrangements with physicians or other practitioners were found to violate a corporate practice of medicine prohibition, our contractual arrangements with practitioners in such states could be adversely affected, which, in turn, may adversely affect both our operations and profitability. Further, we could face sanctions for aiding and abetting the violation of the state s professional licensure statutes. We continually monitor legislative, regulatory and judicial developments related to licensure and engagement arrangements with professionals; however, new agency interpretations, federal or state legislation or regulations, or judicial decisions could require us to change how we operate, may increase our costs of services and could have a material adverse effect on our results of operations.

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

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

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

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

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

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

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

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

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

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

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

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

broad audit rights; and

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

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

The protection of our intellectual property requires substantial resources.

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

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

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

A write-off or acceleration of amortization of all or a part of our long-lived assets (including identifiable intangible assets and goodwill) would adversely affect our operating results and reduce our net worth.

We have significant long-lived assets which include property and equipment, identifiable intangible assets and goodwill. As of December 31, 2015, we had $244.1 million of property and equipment, $1,707.9 million of identifiable intangible assets and $2,230.1 million of goodwill on our balance sheet, which collectively represented in excess of 91% of our total assets. We amortize property and equipment and identifiable intangible assets over their estimated useful lives which generally range from 3 to 20 years. Though we are not permitted to amortize goodwill under United States generally accepted accounting principles, we evaluate our goodwill for impairment at least annually. In the event of anticipated obsolescence or impairment of our long-lived assets, we may write-off all or part of the affected assets or accelerate the related amortization of these assets. For example, in connection with our plan to rebrand as Change Healthcare in the fourth quarter of 2015, we revised the useful life of our previous tradename asset, resulting in accelerated amortization of $126.1 million for our previous tradename asset during the second half of fiscal 2015. Similar write-offs or acceleration of amortization in the future would result in an immediate one-time charge to earnings in the event of an impairment of assets and, in the event of anticipated obsolescence of assets that do not reach the level of an impairment, regular reductions to earnings over the remaining lives of the affected assets. Although it would not affect our cash flow, a write-off or acceleration of amortization in future periods of all or a part

of these long-lived assets would adversely affect our financial condition and operating results. See Management s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Estimates Goodwill and Intangible Assets of this Annual Report.

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

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

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

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

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

From time to time, we have been, and may in the future be, a party to legal and regulatory proceedings and investigations, including matters involving governmental agencies and entities with whom we do business and other proceedings and investigations arising in the ordinary course of business. In addition, there are an increasing number of, and we may be subject to, investigations and proceedings in the healthcare industry generally that seek recovery under HIPAA, the federal Anti-Kickback Law, the FCA and other statutes and regulations applicable to our business. We also may be subject to legal proceedings under non-healthcare laws affecting our business, such as the TCPA, FDCPA, FCRA, employment, banking and financial services and USPS laws and regulations. Governmental Investigations, audits and other reviews could result in the assessment of damages, civil or criminal penalties or other sanctions, including restrictions or changes in the way we conduct business or exclusion from participation in government programs. We evaluate our exposure to these legal and regulatory proceedings and establish reserves for the estimated liabilities in accordance with United States generally accepted accounting principles. Assessing and predicting the outcome of these matters involves substantial uncertainties. Unexpected outcomes in these legal proceedings, or changes in management s evaluations or predictions and accompanying changes in established reserves, could have an adverse impact on our financial results.

Risks Related to Our Organization and Structure

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

We are a holding company and our principal asset is our ownership of equity interests in our subsidiaries. We have no independent means of generating revenue. We intend to cause our subsidiaries to make distributions to us as the direct or indirect holder of 100% of the equity interests of such subsidiaries in amounts sufficient to make payments in respect of our outstanding indebtedness, including a senior secured term loan credit facility (as amended, the Term Loan Facility), a senior secured revolving credit facility (the Revolving Facility ; and collectively with the Term Loan Facility, the Senior Credit Facilities), the 11% senior notes due 2019 (the 2019 Notes), the 11.25% senior notes due 2020 (the 2020 Notes) and the 6% senior notes due 2021 (the 2021 Notes , and collectively with the 2019 Notes and 2020 Notes, the Senior Notes), as well as payments required under our tax receivable agreements (as discussed below). To the extent that we need funds and our subsidiaries are unable or otherwise restricted from making such distributions under applicable law or regulation, as a result of the terms in our credit agreements or are otherwise unable to provide such funds, our liquidity and financial condition could be adversely affected.

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

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

The payments we are required to make under the tax receivable agreements could be substantial. The amount and timing of any payments under the tax receivable agreements will vary depending upon a number of factors, including the amount and timing of the taxable income we generate in the future and the tax rate then applicable. We expect that, assuming no material changes in tax law and that we earn sufficient taxable income to realize the full potential tax benefit, future payments will range from $1.0 million to $89.7 million per year over the next 14 years. As of December 31, 2015, we expected total remaining payments under the tax receivable agreements of approximately $355.7 million. $174.5 million of this amount, which included the initial fair value of the tax receivable agreement obligations at the time of the 2011 Merger plus accretion to date, was reflected as an obligation on the balance sheet at December 31, 2015.

There may be circumstances in which the payments under the tax receivable agreements may differ significantly (in both timing and amount) from the underlying tax benefits we actually realize. Pursuant to the tax receivable agreements, upon a covered change of control, we could be required to make payments that significantly exceed our actual cash tax savings from the tax benefits giving rise to such payments. Moreover, upon a covered change of control or initial public offering, we will have the option to terminate the tax

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

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

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

Risks Related to Our Indebtedness and the Senior Notes

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

As of December 31, 2015, our total debt was $2,821.8 million (before the deduction of unamortized debt discount of $47.8 million), comprised of $1,803.5 million of senior secured indebtedness under our Term Loan Facility, $375.0 million of indebtedness under the 2019 Notes, $375.0 million of indebtedness under the 2020 Notes, $250.0 million under the 2021 Notes and $18.2 million of indebtedness under our data sublicense agreement and other financing arrangements. Additionally, we had $118.3 million of unutilized capacity under our Revolving Facility. If we cannot generate sufficient cash flow from operations to service our debt, we may need to refinance our debt, dispose of assets or issue equity to obtain necessary funds. We do not know whether we will be able to take any of such actions on a timely basis or on terms satisfactory to us or at all.

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

making it more difficult for us to make payments on the Senior Credit Facilities and the Senior Notes;

increasing our vulnerability to general economic and industry conditions;

requiring a substantial portion of cash flow from operations to be dedicated to the payment of principal and interest on our indebtedness, thereby reducing our ability to use our cash flow to fund our operations, capital expenditures and future business opportunities;

exposing us to the risk of increased interest rates as our borrowings under our Senior Credit Facilities are at variable rates of interest;

restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;

limiting our ability to obtain additional financing for working capital, capital expenditures, debt service requirements, acquisitions and general corporate or other purposes;

limiting our ability to adjust to changing market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged; and

increasing our cost of borrowing.

Borrowings under our Senior Credit Facilities are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness may increase even though the amount borrowed remains the same, and our net income and cash flows, including cash available for servicing our indebtedness, will correspondingly decrease. Due to a floor on the floating rate index of 1.25% under the Term Loan Facility, a 0.125% increase in the floating rates on the funded amounts under our Senior Credit Facilities would have had only a minimal impact on our annual cash interest expense. Assuming all

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revolving loans are drawn under the Revolving Facility, a 0.125% change in the floating rate would result in an additional $0.2 million increase in our annual cash interest expense. In January 2012, we entered into interest rate swaps that involve the exchange of floating for fixed rate interest payments that partially reduced our exposure to interest rate volatility. However, we may not maintain these interest rate swaps as currently structured with respect to our variable rate indebtedness, and any future additional swaps we enter into may not fully mitigate our interest rate risk.

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

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

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

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

The Senior Credit Agreement requires us to comply with a quarterly maximum consolidated first lien net leverage ratio test. In addition, our Senior Credit Facilities include negative covenants that, among other things and subject to certain significant exceptions, limit our ability and the ability of our restricted subsidiaries to:

- incur additional indebtedness or guarantees;
- incur liens;
- make investments, loans and acquisitions;

consolidate or merge;

sell assets, including capital stock of our subsidiaries;

pay dividends on capital stock or redeem, repurchase or retire capital stock of the Company or any restricted subsidiary;

alter the business we conduct;

amend, prepay, redeem or purchase subordinated debt;

engage in transactions with our affiliates; and

enter into agreements limiting subsidiary dividends and distributions.

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

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

pay dividends on our capital stock or redeem, repurchase or retire our capital stock, subject to customary exceptions, including compliance with a fixed charge coverage ratio and subject to limitation based on net income generated during the term of the Indentures;

incur additional indebtedness or issue certain capital stock;

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incur certain liens;

make investments, loans, advances and acquisitions;

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

prepay subordinated debt;

engage in certain transactions with our affiliates; and

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

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

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

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

ITEM 1B.*UNRESOLVED STAFF COMMENTS*

None.

ITEM 2. ***PROPERTIES***

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

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

We also lease approximately 93,000 square feet of office space at a facility in Toledo, Ohio, which is subject to a lease agreement due to expire in February 2022, and approximately 116,000 square feet at a facility in Bridgeton, Missouri, a suburb of St. Louis, which is subject to a lease agreement due to expire in November 2023, for our payment and communication solutions operations.

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

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ITEM 3. ***LEGAL PROCEEDINGS***

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

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

Not applicable.

PART II

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

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

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

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

The following table sets forth our selected historical consolidated financial data at the dates and for the periods indicated. The selected historical consolidated financial data as of December 31, 2015 and 2014, and for the years ended December 31, 2015, 2014 and 2013 presented in this table, have been derived from the historical audited consolidated financial statements included in this Annual Report. The selected historical consolidated financial data as of December 31, 2013, 2012 and 2011, for the year ended December 31, 2012 and for the periods from November 2, 2011 to December 31, 2011 and January 1, 2011 to November 1, 2011 presented in this table have been derived from our historical audited consolidated financial statements not included in this Annual Report.

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

		Successor			Predecessor
Fiscal Year Ended December 31, 2015	Fiscal Year Ended December 31, 2014	Fiscal Year Ended December 31, 2013	Fiscal Year Ended December 31, 2012	November 2, 2011 through December 31, 2011	January 1, 2011 through November 1, 2011

	(In thousands)					
Statement of Operations Data:[1]						
Revenue:						
Solutions revenue	$ 1,124,188	$ 1,006,949	$ 930,713	$ 843,394	$ 136,291	$ 658,226
Postage revenue	352,895	343,464	311,854	308,919	50,825	255,553
Total revenue	1,477,083	1,350,413	1,242,567	1,152,313	187,116	913,779
Costs and expenses:						
Cost of operations	507,358	462,332	447,324	388,480	61,080	288,854
Development and engineering	45,489	32,956	31,426	33,271	5,268	26,828
Sales, marketing, general and administrative	217,716	198,379	170,051	147,012	23,910	123,361
Customer postage	352,895	343,464	311,854	308,919	50,825	255,553
Depreciation and amortization	342,303	189,218	183,839	187,225	29,094	128,761
Accretion	10,496	14,446	26,470	8,666	2,459	
Impairment of long-lived assets	8,552	83,169	10,619	1,865		
Transaction related costs					17,857	66,625
Total costs and expenses	1,484,809	1,323,964	1,181,583	1,075,438	190,493	889,982
Operating income (loss)	(7,726)	26,449	60,984	76,875	(3,377)	23,797
Interest expense, net	168,252	146,829	153,169	172,253	29,343	43,202
Loss on extinguishment of debt			23,160	21,853		
Contingent consideration	(4,825)	1,307	(69)		(5,843)	(8,036)
Other	(741)	(3,968)	(4,133)	1,250		13
Income (loss) before income taxes	(170,412)	(117,719)	(111,143)	(118,481)	(26,877)	(11,382)
Income tax provision	(74,343)	(41,865)	(36,685)	(40,146)	(10,185)	8,201
Net income (loss)	(96,069)	(75,854)	(74,458)	(78,335)	(16,692)	(19,583)
Net income attributable to noncontrolling interest						5,109
Net income (loss) attributable to Change Healthcare	$ (96,069)	$ (75,854)	$ (74,458)	$ (78,335)	$ (16,692)	$ (24,692)

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	As of December 31,				
	2015	2014	2013	2012	2011
	(In thousands)				
Balance Sheet Data:[1]					
Cash and cash equivalents	$ 66,655	$ 82,306	$ 76,538	$ 31,763	$ 37,925
Total assets	4,573,534	3,840,642	3,730,526	3,744,499	3,795,698
Total debt[2]	2,773,953	2,162,776	2,019,317	1,996,575	1,930,353
Tax receivable obligations to related parties	173,493	163,983	150,496	125,003	117,810
Total equity	$ 975,689	$ 902,065	$ 968,546	$ 1,032,151	$ 1,103,789

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

(2) Our debt at December 31, 2015, 2014, 2013, 2012 and 2011 is reflected net of unamortized debt discount of approximately $47.8 million, $41.6 million, $44.1 million, $71.8 million and $89.9 million, respectively, related to original loan fees and purchase accounting adjustments to discount the debt to fair value. Total debt as of December 31, 2015, 2014, 2013, 2012 and 2011 includes an obligation of approximately $18.2 million, $29.4 million, $35.1 million, $27.2 million and $31.3 million, respectively, related to our data sublicense agreement and other financing arrangements.

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

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

Overview

We are a leading provider of software and analytics, network solutions and technology-enabled services that optimize communications, payments and actionable insights designed to enable smarter healthcare. Our integrated capabilities enable our customers to exchange mission-critical information, optimize revenue opportunities, control costs, increase cash flow and efficiently manage complex healthcare workflows. The foundation of our solutions is embedded in our Change Healthcare Intelligent Healthcare Network™, which facilitates the capture and standardization of healthcare data seamlessly in our customers workflow. Our intelligent healthcare platform underpins the United States healthcare system, benefiting all major healthcare stakeholders: commercial and governmental payers, employers, hospitals, physician practices, dentists, laboratories, pharmacies and consumers.

We deliver our solutions and operate our business in three reportable segments: (i) software and analytics, which provides payment and reimbursement optimization and decision support solution for our customers; (ii) network solutions, which leverages our healthcare information network to optimize information exchange and workflows among healthcare system participants; and (iii) technology-enabled services, which provides payment and communication, workflow, advisory and other administrative solutions to optimize payment and reimbursement efficiencies. Through our software and analytics segment, we provide revenue cycle technology, revenue optimization, payment integrity, electronic payment, risk adjustment, quality reporting, data and analytics and engagement solutions. Through our network solutions segment, we provide financial and administrative information

exchange solutions for medical, pharmacy and dental claims management and other standardized healthcare transactions, including clinical information exchange capabilities. Through our technology-enabled services segment, we provide payment and communication, eligibility and enrollment, healthcare consulting, payment automation and pharmacy benefits administration solutions. We generally provide our solutions to payer, provider and pharmacy customers, including commercial insurance companies, third party administrators, governmental payers, self-insured employers, hospitals, physician practices, dentists, laboratories, pharmacies, pharmacy benefit management companies and government agencies.

There are a number of company-specific initiatives and industry trends that may affect our business volumes, revenues, cost of operations and margins. As part of our strategy, we encourage our customers to migrate from paper-based claim, communication, payment and other transaction processing to electronic, automated processing in order to improve efficiency. Our business is aligned with our customers to support this transition, and as they migrate from paper-based processing to electronic processing, even though our revenues for an applicable customer generally will decline, our margins and profitability will typically increase.

Part of our strategy also includes the development and introduction of new and updated solutions. Our new and updated solutions are likely to require us to incur development and engineering expenditures, both operating and capital, and related sales and marketing costs at increased levels in order to successfully develop and achieve market acceptance of such solutions. We also may acquire, or enter into agreements with third parties to assist us in providing, new solutions. For example, we offer our electronic payment solutions through banks or vendors who contract with banks and other financial service firms. The costs of these initiatives or the failure to achieve broad penetration in target markets with respect to new or updated solutions may negatively affect our results of operations, margins and cash flow. Because newly introduced solutions generally will have lower margins initially as compared to our existing and more mature solutions, our margins and margin growth may be adversely affected on a percentage basis until these new solutions achieve scale and maturity. In addition, we continue to improve the scalability and performance of our network and platform. Any improvements in our current network or platform, the development of new networks or platforms, including those leveraging cloud-based environments, may result in more operating costs and less capital expenditures as compared to prior periods.

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

We also expect to continue to be affected by general economic, regulatory and demographic factors affecting the healthcare industry. Significant changes in regulatory schemes, such as the updated HIPAA, ARRA, ACA and other federal healthcare policy initiatives, impact our customers healthcare activities. In particular, we believe the ACA has significantly affected 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.

While we believe the ACA, through an increased number of people with health insurance coverage, has contributed increasing transaction volumes in our network solutions segment, we believe ACA has negatively impacted our eligibility and enrollment solutions within our technology-enabled services segment as a result of expanded coverage of uninsured individuals, particularly in opt-in states, and changes in federal and state reimbursement patterns and rates. We are seeking to mitigate the impact of ACA on the market for eligibility and enrollment services by offering additional value-added solutions to our customers. In addition, we are unable to predict how providers, payers, pharmacies and other healthcare market participants will continue to respond to the various other reform provisions of the ACA, and we cannot be sure that the markets for our solutions will continue to exist at current levels or that we will have adequate technical, financial and marketing resources to react to changes in those markets.

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

Recent Developments

In January 2015, we reorganized our reportable segments as software and analytics, network solutions and technology-enabled services. This discussion and analysis related to prior periods has been restated to reflect our current organizational structure.

In January 2015, in order to clarify the nature of customer related postage activities, we created separate captions on the statement of operations within revenue and costs and expenses, respectively. This discussion and analysis related to prior periods has been restated to reflect our current presentation.

In August 2015, we acquired Altegra Health, Inc. (Altegra Health), a technology-enabled provider that assists payers and risk bearing providers with analytics and reporting capabilities for risk adjustment, member engagement and quality analysis to achieve actionable insights and improved management for value-based healthcare, for initial cash consideration and the assumption of certain liabilities.

In September 2015, we announced our plan to rebrand as Change Healthcare effective in the fourth quarter of 2015. As a result of this plan, we revised the remaining useful life of our existing tradename asset. During the year ended December 31, 2015, we accelerated amortization expense of approximately $126.1 million related to our previous tradename asset.

Our Revenues and Expenses

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

Cost of operations consists primarily of costs related to services we provide to customers and costs associated with the operation and maintenance of our networks. These costs primarily include materials costs related to our payment and communication solutions, rebates paid to our channel partners (net of rebates to certain customers that offset revenue) and data communications costs, all of which generally vary with our revenues and/or volumes. Cost of operations also includes personnel costs associated with production, network operations, customer support and other personnel, facilities expenses and equipment maintenance, all of which vary less directly with our revenue and/or volumes due to the fixed or semi-fixed nature of these expenses.

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Rebates are paid to channel partners for electronic and other volumes delivered through our network to certain payers and can be impacted by the number of comprehensive management services agreements we execute with payers, the associated rate structure with our payer customers, the success of our direct sales efforts to providers and the extent to which direct connections to payers are developed by our channel partners. While these rebates are generally a component of our cost of operations, in cases where the channel partners are also our customers, these rebates generally are recognized as an offset to revenue.

Our data communication expense consists of telecommunication and transaction processing charges.

Our material costs relate primarily to our payment and communication solutions volumes, and consist primarily of paper and printing costs.

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

Sales, marketing, general and administrative expense consists primarily of personnel costs associated with our sales, account management and marketing functions, as well as management, administrative and other shared corporate services related to the operations of our operating segments and overall business operations.

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

Postage, which is generally billed as a pass-through cost to our customers, is the most significant cost incurred in the delivery of our payment and communication solutions. Our postage costs and related revenues increase as our payment and communication solutions volumes increase and also when the USPS increases postage rates. Although the USPS historically has increased postage rates annually in most recent years, including in January 2014 and May 2015, the frequency and nature of such annual increases may not occur as regularly in the future.

Our depreciation and amortization expense is related to depreciation of our property and equipment, including technology assets, and amortization of intangible assets. The amount of depreciation and amortization expense is affected by the level of our recent investment in property and equipment, acquisition activity and asset impairments or certain changes in estimates.

Our interest expense consists principally of cash interest associated with our long-term debt obligations and non-cash interest associated with the amortization of borrowing costs and discounts related to debt issuance. If market interest rates on the variable portion of our long-term debt increase in the future, our interest expense may increase.

Our income taxes consist of federal and state income taxes. These amounts include current income taxes payable, as well as income taxes for which the payment is deferred to future periods and dependent on the occurrence of future events. Our income taxes are affected by the recognition of valuation allowances, our tax status and other items. For additional information, see the discussion of income taxes in the section Significant Items Affecting Comparability-Income Taxes .

Significant Items Affecting Comparability

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

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Acquisitions and Divestitures

We actively evaluate opportunities to improve and expand our business through targeted acquisitions that are consistent with our strategy. On occasion, we also may dispose of certain components of our business that no longer fit within our overall strategy. Because of our acquisition and divestiture activity as well as the shifting revenue mix of our business due to this activity, our results of operations may not be directly comparable among periods. The following summarizes our significant acquisition transactions since January 1, 2013 and affected segments:

Date	Business	Description	Affected Segment
June 2013	Goold Health Systems (Goold)	Technology-enabled provider of pharmacy benefit and related services primarily to state Medicaid agencies	Technology-enabled Services
July 2014	Capario Corp. (Capario)	Technology-enabled provider of revenue cycle management solutions	Software and Analytics; Network Solutions
November 2014	Change Healthcare Corporation (Engagement Solutions)	Technology-enabled provider of healthcare consumer engagement solutions	Software and Analytics
December 2014	Adminisource Communications, Inc. (Adminisource)	Technology-enabled provider of payment and communication solutions	Technology-enabled Services
August 2015	Altegra Health	Technology-enabled provider of analytical and reporting solutions for risk adjustment, member engagement and quality analysis	Software and Analytics; Technology-enabled Services

For certain of our acquisitions, we agreed to transfer additional consideration to the sellers of the acquired businesses in the event that specified performance measures are achieved, including Goold and Engagement Solutions. United States generally accepted accounting principles generally require us to recognize the initial fair value of the expected amount to be paid under such contingent consideration arrangements as a component of the total consideration transferred. Subsequent changes in the fair value of the amounts expected to be paid, however, are generally required to be recognized as a component of net income. Such changes in fair value may occur based on changes in the expected timing or amount of payments or the effect of discounting the liability for the time value of money.

Efficiency Measures

We evaluate and implement efficiency measures and other cost savings initiatives on an ongoing basis to improve our financial and operating performance through reorganization, cost savings, productivity improvements, product development and other process improvements. For instance, we continue to evaluate measures to consolidate our data centers, operations and networks, to outsource certain information technology and operations functions and to streamline product development. The implementation of these measures often involves upfront cash costs related to severance, professional fees, contractor costs and/or capital expenditures, with the cost savings or other improvements not realized until the measures are successfully completed. Additionally, we may recognize impairment charges as a result of such initiatives.

Income Taxes

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

	Year Ended December 31,		
	2015	**2014**	**2013**
Statutory U.S. federal tax rate	35.00%	35.00%	35.00%
State income taxes (net of federal benefit)	7.45	1.00	(1.89)
Other	1.18	0.79	(0.10)
Change in tax status		(1.23)	
Effective income tax rate	43.63%	35.56%	33.01%

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State Income Taxes Our effective tax rate for state income taxes is generally impacted by changes in our apportionment. In addition, our effective rate for state income taxes was affected by the following discrete matters:

In January 2014, we effected a change in the tax status of one of our subsidiaries from a partnership to a corporation.

In May 2015, the state of Tennessee enacted the Tennessee Revenue Modernization Act, which changed the manner in which our Tennessee apportionment is determined. This change in our Tennessee apportionment, along with routine changes in apportionment that arose following the filing of the Company s annual tax returns during 2015, resulted in an increase in our effective state income tax rate.

In December 2015, we simplified our legal organizational structure for which the primary economic effect was to enable us to realize deferred tax assets for state income tax purposes that we previously had concluded were not likely to be realized. This legal organizational simplification resulted in a decrease to the Company s effective state income tax rate.

Change in Tax Status Prior to the change in the tax status of one of our subsidiaries from a partnership to a corporation, we recognized a deferred tax liability for the difference between the book and tax basis of our investment in this subsidiary (i.e. outside basis). The outside tax basis of the investment in this subsidiary excluded consideration of goodwill within that subsidiary that otherwise would have no tax basis. Following the tax status change, our deferred tax balances reflect only the difference in the book and tax bases of the individual assets and liabilities included in the corporation.

Amendments of the Senior Credit Agreement and New Senior Notes

Our interest expense primarily is affected by the amount of debt funding and the applicable variable interest rates, including a fixed spread, under our Senior Credit Agreement. In April 2012, we amended the Senior Credit Agreement to reprice the Senior Credit Facilities and borrow $80.0 million of additional term loans for general corporate purposes, including acquisitions. As a result of these amendments, the LIBOR-based interest rate applicable to our Senior Credit Facilities was generally reduced by 175 basis points. The Senior Credit Agreement was also amended in April 2013 to further reduce the LIBOR-based interest rate by an additional 125 basis points, and to modify certain financial covenants. In December 2014 and August 2015, we borrowed an additional $160.0 million and $395.0 million, respectively, under incremental term loan facilities through amendments to our Senior Credit Agreement.

In August 2015, we borrowed $250.0 million by issuing the 2021 Notes.

Impairment of Long-lived Assets

During the year ended December 31, 2015, we determined, as a result of technology challenges, slower than expected customer adoption, and management attrition, that one of our recently developed products in the network solutions segment was impaired. We recognized a $5.0 million impairment charge to adjust the carrying value of the asset group to its fair value. In addition, throughout 2015, the Company abandoned certain hardware and software in connection with the continued migration of software development to a cloud-based environment. Among this abandoned hardware and software was a complete redevelopment of an existing software and analytics solution in this cloud-based environment. We recognized impairment charges of $3.6 million related to this migration.

During the year ended December 31, 2014, our technology-enabled services segment received notice that its existing contract with a customer would not be renewed in full upon its expiration. As a result, we abandoned a customer

related project that was under development and assessed the recoverability of the net assets included in the relevant asset group. We recognized a $73.2 million impairment charge to write off the abandoned project and to adjust the carrying value of the asset group to its fair value. Additionally, we abandoned certain network solutions and technology-enabled services segment development projects in connection with execution of certain strategic initiatives. We recognized impairment charges of $10.0 million during the year ended December 31, 2014 related to these abandoned projects.

Critical Accounting Estimates

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

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

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

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

Revenue Recognition

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

Revenue for financial and administrative information exchange, payment and communication, risk adjustment, quality reporting and healthcare consulting solutions are recognized as the services are provided. Postage fees related to our payment and communication solutions volumes are recorded on a gross basis. Revenue for our eligibility and enrollment and revenue optimization solutions generally are recognized at the time that our provider customer receives notice from the payer of a pending payment. Revenue for payment integrity solutions are recognized at the time that notice of customer acceptance is received.

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

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

Business Combinations

We recognize the consideration transferred (i.e. purchase price) in a business combination as well as the acquired business identifiable assets, liabilities and noncontrolling interests at their acquisition date fair value. The excess of the consideration transferred over the fair value of the identifiable assets, liabilities and noncontrolling interest, if any, is recorded as goodwill. Any excess of the fair value of the identifiable assets acquired and liabilities assumed over the consideration transferred, if any, is generally recognized within earnings as of the acquisition date. To the extent that our initial accounting for a business combination is incomplete at the end of a reporting period, provisional amounts are reported for those items which are incomplete. Following the adoption of Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) No. 2015-16, we adjust such provisional amounts in the reporting period in which the adjustment amounts are determined.

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

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

fair value of the contingent consideration is particularly sensitive to judgments relative to the probability of achieving the specified financial performance measures.

Goodwill and Intangible Assets

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

Customer relationships	5-20 years
Tradenames	3-20 years
Data sublicense agreement	6 years
Non-compete agreements	2-5 years
Premise-based software	1-3 years

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

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

During 2015, we identified software and analytics, network solutions and technology-enabled services as our operating segments. Our reporting units are comprised of the network solutions and technology-enabled services, each of which are operating segments, as well as the components of the software and analytics operating segment (Engagement Solutions and the aggregate of all other components (All Other) of this operating segment).

We estimated the fair value of our reporting units using a methodology that considers both income and market approaches. Specifically, for 2015, we estimated fair value of our reporting units based on the weighted average of fair value measures estimated under the income and market approaches.

Each approach requires the use of certain assumptions. The income approach requires management to exercise judgment in making assumptions regarding the reporting unit s future income stream, a discount rate and a constant rate of growth after the initial forecast period utilized. These assumptions are subject to change based on business and economic conditions and could materially affect the indicated values of our reporting units. For example, a 100 basis point increase in our selected discount rate would have resulted in a decrease in the indicated value of our network solutions, technology-enabled services, Engagement Solutions and All Other reporting units of approximately $137.6 million, $121.5 million, $20.2 million and $128.8 million, respectively. The indicated fair value of each reporting unit exceeded their respective carrying values in the most recent annual impairment test by approximately $1,019.4 million, $682.6 million, $8.6 million and $134.8 million, respectively. Because the Engagement Solutions reporting unit was recently acquired and represents a stand-alone reporting unit, it is inherently more susceptible to potential impairment than the other reporting units. A significant downturn in operating performance or market conditions may result in a future impairment of this reporting unit. Goodwill of the Engagement Solutions reporting unit totaled $110.0 million as of December 31, 2015.

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

Income Taxes

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

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

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

Tax Receivable Agreement Obligations

The Company is a party to tax receivable agreements which obligate us to make payments to the TRA Members, equal to 85% of the applicable cash savings that the Company realizes as a result of tax attributes arising from certain previous transactions, including the 2011 Merger.

Prior to the 2011 Merger, the Company s balance sheet reflected these obligations at the amount that was both probable and reasonably estimable. In connection with the 2011Merger, the tax receivable agreement obligations were adjusted to their fair value. The determination of the fair value required management to make assumptions as to the timing of the realization of net operating losses, the timing of payments to the TRA Members and the tax rates in effect during the life of the agreements. Changes in any of these or other factors are expected to impact the timing and amount of gross payments.

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The fair value of these obligations at the time of the 2011 Merger is being accreted to the amount of the gross expected obligation using the interest method. Changes in the amount of these obligations resulting from changes to either the timing or amount of cash flows are recognized in the period of change and measured using the discount rate inherent in the initial fair value of the obligations. The accretion of these obligations is classified as a separate caption in our consolidated statements of operations.

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Results of Operations

The following table summarizes our consolidated results of operations for the years ended December 31, 2015, 2014 and 2013, respectively (amounts in thousands).

	Year Ended December 31, 2015		Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Revenue	Amount	% of Revenue	Amount	% of Revenue
Revenue:						
Solutions revenue	$ 1,124,188	76.1%	$ 1,006,949	74.6%	$ 930,713	74.9%
Postage revenue	352,895	23.9	343,464	25.4	311,854	25.1
Total revenue	1,477,083	100.0	1,350,413	100.0	1,242,567	100.0
Cost and expenses:						
Cost of operations (exclusive of depreciation and amortization below)	507,358	45.1	462,332	45.9	447,324	48.1
Development and engineering	45,489	4.0	32,956	3.3	31,426	3.4
Sales, marketing, general and administrative	217,716	19.4	198,379	19.7	170,051	18.3
Customer postage	352,895	23.9	343,464	25.4	311,854	25.1
Depreciation and amortization	342,303	23.2	189,218	14.0	183,839	14.8
Accretion	10,496	0.7	14,446	1.1	26,470	2.1
Impairment of long-lived assets	8,552	0.6	83,169	6.2	10,619	0.9
Operating income	(7,726)	(0.5)	26,449	2.0	60,984	4.9
Interest expense, net	168,252	11.4	146,829	10.9	153,169	12.3
Loss on extinguishment of debt					23,160	1.9
Contingent consideration	(4,825)		1,307		(69)	
Other	(741)	(0.1)	(3,968)	(0.3)	(4,133)	(0.3)
Income (loss) before income tax provision (benefit)	(170,412)	(11.5)	(117,719)	(8.7)	(111,143)	(8.9)
Income tax provision (benefit)	(74,343)	(5.0)	(41,865)	(3.1)	(36,685)	(3.0)
Net income (loss)	$ (96,069)	(6.5)%	$ (75,854)	(5.6)%	$ (74,458)	(6.0)%

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Year Ended December 31, 2015 Compared to Year Ended December 31, 2014

Solutions Revenues

Our solutions revenues were $1,124.2 million for the year ended December 31, 2015 as compared to $1,006.9 million for the year ended December 31, 2014, an increase of $117.2 million, or 11.6%. Factors affecting our solutions revenues are described in the various segment discussions below.

Cost of Operations

Our total cost of operations was $507.4 million for the year ended December 31, 2015 as compared to $462.3 million for the year ended December 31, 2014, an increase of $45.0 million, or 9.7%. The increase in our cost of operations is primarily due to business growth, the impact of acquired businesses and increased labor and strategic growth initiative costs. As a percentage of solutions revenue, our cost of operations was 45.1% for the year ended December 31, 2015 as compared to 45.9% for the year ended December 31, 2014. The decrease in our cost of operations as a percentage of revenue is primarily due to changes in revenue mix, the impact of acquired businesses and increased productivity.

Development and Engineering Expense

Our total development and engineering expense was $45.5 million for the year ended December 31, 2015 as compared to $33.0 million for the year ended December 31, 2014, an increase of $12.5 million, or 38.0%. The increase in our development and engineering expense is primarily due to increased research and development and the impact of acquired businesses.

Sales, Marketing, General and Administrative Expense

Our total sales, marketing, general and administrative expense was $217.7 million for the year ended December 31, 2015 as compared to $198.4 million for the year ended December 31, 2014, an increase of $19.3 million, or 9.7%. The increase in our sales, marketing, general and administrative expense was primarily due to business growth, including the impact of acquired businesses and increased strategic initiatives, partially offset by productivity improvements and efficiency measures.

Postage

Our postage revenue and customer postage expense was $352.9 million for the year ended December 31, 2015 as compared to $343.5 million for the year ended December 31, 2014, an increase of $9.4 million, or 2.7%. This increase in postage revenue and corresponding expense was due to the impact of acquired businesses and the United States postage rate increase effective in May 2015, partially offset by customer attrition.

Depreciation and Amortization Expense

Our depreciation and amortization expense was $342.3 million for the year ended December 31, 2015 as compared to $189.2 million for the year ended December 31, 2014, an increase of $153.1 million, or 80.9%. This increase was primarily due to the acceleration of amortization of our previous tradename as a result of our rebranding to Change Healthcare and the impact of acquired businesses.

Accretion Expense

Our accretion expense was $10.5 million for the year ended December 31, 2015 as compared to $14.4 million for the year ended December 31, 2014. The amount recognized as accretion expense can vary significantly from period to period due to changes in estimates related to the amount or timing of our tax receivable agreement obligation payments. Such changes can result from a variety of factors, including changes in tax rates and the expected timing of prior net operating loss utilization, which can be affected by business combinations, changes in leverage, operations or other factors.

Interest Expense

Our interest expense was $168.3 million for the year ended December 31, 2015 as compared to $146.8 million for the year ended December 31, 2014, an increase of $21.4 million, or 14.6%. This increase was primarily due to the impact of the December 2014 and August 2015 incremental term loans and the 2021 Notes, partially offset by scheduled principal payments of term loans under the Senior Credit Facilities.

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Income Taxes

Our income tax benefit was $74.3 million for the year ended December 31, 2015 as compared to $41.9 million for the year ended December 31, 2014. Our effective tax rate was 43.6% for the year ended December 31, 2015 as compared to 35.6% for the year ended December 31, 2014. The effective tax rate for the year ended December 31, 2015 was primarily affected by changes in state tax apportionment resulting from the Tennessee Revenue Modernization Act and changes in state income tax valuation allowances resulting from the simplification of our legal organizational structure.

Segment Revenues and Adjusted EBITDA

We operate our business in three reportable segments: software and analytics, network solutions and technology-enabled services. We also maintain a corporate function which includes pass-through postage costs, management, administrative and certain other shared corporate services functions such as legal, finance, human resources and marketing, as well as eliminations to remove inter-segment revenue and expenses.

The segment profit measure primarily utilized by management is adjusted EBITDA which is defined as EBITDA (defined as net income (loss) before net interest expense, income tax provision (benefit) and depreciation and amortization), plus certain other non-cash or non-operating items. The non-cash or other non-operating items affecting the segment profit measure generally include equity compensation; acquisition accounting adjustments; acquisition-related costs; strategic initiatives, duplicative and transition costs; impairment of long lived assets; and contingent consideration adjustments. Adjusted EBITDA for the respective segments excludes all costs and adjustments associated with the above-referenced corporate functions. Financial information, including details of our adjustments to EBITDA, for each of our segments is set forth in Note 18 to the consolidated financial statements included in Item 15 of this Annual Report.

Software and Analytics

Our software and analytics solutions segment revenue and adjusted EBITDA is summarized in the following table (in thousands):

	December 31, 2015	December 31, 2014	$ Change
Solutions Revenue	$ 353,526	$ 249,489	$ 104,037
Adjusted EBITDA	$ 121,860	$ 89,528	$ 32,332

Software and analytics revenue for the year ended December 31, 2015 increased by $104.0 million, or 41.7%, as compared to the prior year period. This increase was primarily driven by $94.2 million related to the impact of acquired businesses, including the August 2015 acquisition of Altegra Health, and new sales and implementations, partially offset by customer attrition.

Software and analytics adjusted EBITDA for the year ended December 31, 2015 increased by $32.3 million, or 36.1% as compared to the prior year period. As a percentage of solutions revenue, software and analytics adjusted EBITDA was 34.5% for the year ended December 31, 2015 as compared to 35.9% for the year ended December 31, 2014. The increase in our software and analytics adjusted EBITDA was primarily due to the impact of the revenue items described above and increased productivity. The decrease in our software and analytics adjusted EBITDA as a

percentage of revenue is primarily due to changes in revenue mix, partially offset by increased productivity.

Network Solutions

Our network solutions segment revenue and adjusted EBITDA is summarized in the following table (in thousands):

	December 31, 2015	December 31, 2014	$ Change
Solutions Revenue	$ 375,582	$ 349,061	$ 26,521
Adjusted EBITDA	$ 203,737	$ 179,539	$ 24,198

Network solutions revenue for the year ended December 31, 2015 increased by $26.5 million, or 7.6%, as compared to the prior year period primarily due to increased volumes, new sales and implementations and $10.9 million related to the impact of acquired businesses, partially offset by customer attrition.

Network solutions adjusted EBITDA for the year ended December 31, 2015 increased by $24.2 million, or 13.5%, as compared to the prior year period. As a percentage of solutions revenue, network solutions adjusted EBITDA was 54.2% for the year ended December 31, 2015 as compared to 51.4% for the year ended December 31, 2014. The increase in network solutions adjusted EBITDA and as a percentage of solutions revenue was primarily due to the impact of the revenue items described above, pricing initiatives and other efficiency measures.

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Technology-enabled Services

Our technology-enabled services segment revenue and adjusted EBITDA is summarized in the following table (in thousands):

	December 31, 2015	December 31, 2014	$ Change
Solutions Revenue	$ 421,455	$ 431,674	$ (10,219)
Adjusted EBITDA	$ 152,770	$ 161,497	$ (8,727)

Technology-enabled services revenue for the year ended December 31, 2015 decreased by $10.2 million, or 2.4%, as compared to the prior year period. This decrease was primarily due to the effects of changing reimbursement patterns and rates of federal and state payers related to our government program eligibility and enrollment services, the previously disclosed partial loss of a customer contract which occurred in June 2015 and decreased volumes in our payment and communication solutions, partially offset by $16.2 million related to the impact of acquired businesses and new sales and implementations.

Technology-enabled services adjusted EBITDA for the year ended December 31, 2015 decreased by $8.7 million, or 5.4%, as compared to the prior year period. As a percentage of revenue, technology-enabled services adjusted EBITDA was 36.2% for the year ended December 31, 2015 as compared to 37.4% for the year ended December 31, 2014. The decrease in technology-enabled services adjusted EBITDA and as a percentage of revenue was primarily due to the impact of the revenue items described above and changes in revenue mix, partially offset by productivity improvements and other efficiency measures.

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Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Solutions Revenues

Our solutions revenues were $1,006.9 million for the year ended December 31, 2014 as compared to $930.7 million for the year ended December 31, 2013, an increase of $76.2 million, or 8.2%. Factors affecting our solutions revenues are described in the various segment discussions below.

Cost of Operations

Our total cost of operations was $462.3 million for the year ended December 31, 2014 as compared to $447.3 million for the year ended December 31, 2013, an increase of $15.0 million, or 3.4%. The increase in our cost of operations is primarily due to business growth, including the impact of acquired businesses and increased labor and strategic growth initiative costs. As a percentage of solutions revenue, our cost of operations was 45.9% for the year ended December 31, 2014 as compared to 48.1% for the year ended December 31, 2013. The decrease in our cost of operations as a percentage of revenue is primarily due to changes in revenue mix and increased productivity.

Development and Engineering Expense

Our total development and engineering expense was $33.0 million for the year ended December 31, 2014 as compared to $31.4 million for the year ended December 31, 2013, an increase of $1.5 million, or 4.9%. The increase in our development and engineering expense is primarily due to business growth, including the impact of acquired businesses, partially offset by cost reductions resulting from efficiency measures.

Sales, Marketing, General and Administrative Expense

Our total sales, marketing, general and administrative expense was $198.4 million for the year ended December 31, 2014 as compared to $170.1 million for the year ended December 31, 2013, an increase of $28.3 million, or 16.7%. The increase in our sales, marketing, general and administrative expense was primarily due to business growth, including the impact of acquired businesses and increased strategic growth initiatives and acquisition-related costs, partially offset by productivity improvements.

Postage

Our postage revenue and customer postage expense was $343.5 million for the year ended December 31, 2014 as compared to $311.9 million for the year ended December 31, 2013, an increase of $31.6 million, or 10.1%. This increase in postage revenue and corresponding expense was due to increased volumes in our payment and communication solutions business and approximately $9.5 million related to the impact of the United States postage rate increase effective January 2014.

Depreciation and Amortization Expense

Our depreciation and amortization expense was $189.2 million for the year ended December 31, 2014 as compared to $183.8 million for the year ended December 31, 2013, an increase of $5.4 million, or 2.9%. This increase was primarily due to capital expenditures and acquisition activity, partially offset by the effects of the impairment charge related to the pending partial loss of a customer contract.

Accretion Expense

Our accretion expense was $14.4 million for the year ended December 31, 2014 as compared to $26.5 million for the year ended December 31, 2013. The amount recognized as accretion expense can vary significantly from period to period due to changes in estimates related to the amount or timing of our tax receivable agreement obligation payments. Such changes can result from a variety of factors, including changes in tax rates and the expected timing of prior net operating loss utilization, which can be affected by business combinations, changes in leverage, operations or other factors.

Interest Expense

Our interest expense was $146.8 million for the year ended December 31, 2014 as compared to $153.2 million for the year ended December 31, 2013, a decrease of $6.3 million, or 4.1%. This decrease was primarily due to the effect of lower interest rates on the Senior Credit Facilities as a result of the April 2013 repricing transaction and continued principal amortization, partially offset by the impact of the December 2014 incremental term loan.

Income Taxes

Our income tax benefit was $41.9 million for the year ended December 31, 2014 as compared to $36.7 million for the year ended December 31, 2013. Our effective tax rate was 35.6% for the year ended December 31, 2014 as compared to 33.0% for the year

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ended December 31, 2013. Differences between the federal statutory rate and the effective income tax rates for these periods principally relate to the change in tax status of a subsidiary from a partnership to a corporation in January 2014, a decrease in state income tax rates and return to provision adjustments related to the 2013 tax year that we recognized in 2014.

Segment Revenues and Adjusted EBITDA

Software and Analytics

Our software and analytics segment revenue and adjusted EBITDA is summarized in the following table (in thousands):

	December 31, 2014	December 31, 2013	$ Change
Solutions Revenue	$ 249,489	$ 206,974	$ 42,515
Adjusted EBITDA	$ 89,528	$ 65,739	$ 23,789

Software and analytics revenue for the year ended December 31, 2014 increased by $42.5 million, or 20.5%, as compared to the prior year period. This increase was primarily driven by new sales and implementations, particularly within our electronic payment and revenue cycle technology solutions, and $6.4 million related to the impact of acquired businesses.

Software and analytics adjusted EBITDA for the year ended December 31, 2014 increased by $23.8 million, or 36.2% as compared to the prior year period. As a percentage of solutions revenue, software and analytics adjusted EBITDA was 35.9% for the year ended December 31, 2014 as compared to 31.8% for the year ended December 31, 2013. The increase in our software and analytics adjusted EBITDA and as a percentage of solutions revenue was primarily due to the impact of the revenue items described above, as well as revenue mix and increased productivity.

Network Solutions

Our network solutions segment revenue and adjusted EBITDA is summarized in the following table (in thousands):

	December 31, 2014	December 31, 2013	$ Change
Solutions Revenue	$ 349,061	$ 331,479	$ 17,582
Adjusted EBITDA	$ 179,539	$ 164,700	$ 14,839

Network solutions revenue for the year ended December 31, 2014 increased by $17.5 million, or 5.3%, as compared to the prior year period primarily due to increased volumes, new sales and implementations and $9.1 million related to the impact of acquired businesses, partially offset by customer attrition.

Network solutions adjusted EBITDA for the year ended December 31, 2014 increased by $14.8 million, or 9.0%, as compared to the prior year period. As a percentage of solutions revenue, network solutions adjusted EBITDA was 51.4% for the year ended December 31, 2014 as compared to 49.7% for the year ended December 31, 2013. The

increase in network solutions adjusted EBITDA and as a percentage of solutions revenue was primarily due to the impact of the revenue items described above, as well as productivity improvements and other efficiency measures.

Technology-enabled Services

Our technology-enabled services revenue and adjusted EBITDA is summarized in the following table (in thousands):

	December 31, 2014	December 31, 2013	$ Change
Solutions Revenue	$ 431,674	$ 417,262	$ 14,412
Adjusted EBITDA	$ 161,497	$ 153,729	$ 7,768

Technology-enabled services revenue for the year ended December 31, 2014 increased by $14.4 million, or 3.5%, as compared to the prior year period. This increase was primarily due to the impact of acquired businesses, improved reimbursement patterns of federal and state payers related to our government eligibility and enrollment services and new sales and implementations, partially offset by customer attrition.

Technology-enabled services adjusted EBITDA for the year ended December 31, 2014 increased by $7.8 million, or 5.1%, as compared to the prior year period. As a percentage of revenue, technology-enabled services adjusted EBITDA was 37.4% for the year ended December 31, 2014 as compared to 36.8% for the year ended December 31, 2013. The increase in technology-enabled services adjusted EBITDA and as a percentage of revenue was primarily due to the impact of the revenue items described above, as well as productivity improvements and other efficiency measures.

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Liquidity and Capital Resources

General

We are a holding company with no material business operations. Our principal assets are the equity interests we own in our subsidiaries. We conduct all of our business operations through our direct and indirect subsidiaries. Accordingly, our only material sources of cash are borrowings under our Senior Credit Facilities and dividends or other distributions or payments that are derived from earnings and cash flow generated by our subsidiaries.

We anticipate cash generated by operations, the funds available under our Senior Credit Facilities, including the Revolving Facility (which currently expires in November 2016), and existing cash and equivalents will be sufficient to meet working capital requirements, service our debt and finance capital expenditures. There can be no assurance, however, that our business will generate sufficient cash flow from operations or that future borrowings will be available to us under our Senior Credit Facilities in amounts sufficient to enable us to repay our indebtedness, or to fund other liquidity needs.

We and our subsidiaries, affiliates or significant stockholders may from time to time seek to retire or purchase our outstanding debt (including our Senior Notes) through cash purchases and/or exchanges for equity securities, in open market purchases, privately negotiated transactions or otherwise. Such repurchases or exchanges, if any, will depend on prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. The amounts involved may be material.

Cash Flows

Operating Activities

Cash provided by operating activities was $166.8 million for the year ended December 31, 2015 as compared to $205.7 million for the year ended December 31, 2014, a decrease of $38.9 million. The decrease in cash provided by operating activities was primarily due to liabilities of Altegra Health that were assumed in connection with the acquisition and paid at closing, the transition of recently acquired payments solutions to our payments platform and higher interest expense related to the Altegra Health financing, partially offset by business growth.

Cash provided by operating activities was $205.7 million for the year ended December 31, 2014 as compared to $150.4 million for the year ended December 31, 2013, an increase of $55.3 million. The increase in cash provided by operating activities was primarily due to business growth, the timing and reduction of interest payments under our Senior Credit Facilities and the timing of collections and disbursements.

Cash provided by operating activities can be significantly impacted by our non-cash working capital assets and liabilities, which may vary based on the timing of cash receipts that fluctuate by day of week and/or month and also may be impacted by cash management decisions.

Investing Activities

Cash used in investing activities was $780.0 million, $308.2 million and $83.6 million for the years ended December 31, 2015, 2014 and 2013, respectively. Cash used in investing activities for all such periods primarily consisted of cash consideration paid for acquisitions and capital expenditures for property and equipment and certain intangible assets.

Financing Activities

Cash provided by financing activities was $597.5 million for the year ended December 31, 2015. Cash provided by financing activities for the year ended December 31, 2015 primarily consisted of borrowings under our Senior Credit Facilities and 2021 Notes and capital contributions to partially finance the Altegra Health acquisition, partially offset by the payment at closing of debt assumed in connection with the Altegra Health acquisition and principal payments under our Senior Credit Facilities and deferred financing arrangements.

Cash provided by financing activities was $108.3 million for the year ended December 31, 2014. Cash provided by financing activities for the year ended December 31, 2014 primarily consisted of borrowings under our Senior Credit Facilities to partially fund acquired businesses, partially offset by principal payments under our Senior Credit Facilities, debt assumed from acquired businesses and deferred financing arrangements.

Cash used in financing activities was $22.1 million for the year ended December 31, 2013. Cash used in financing activities for the year ended December 31, 2013 primarily consisted of principal payments under our Senior Credit Facilities and deferred financing arrangements.

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Long-term Debt

Our long-term indebtedness is comprised primarily of the Term Loan Facility, the Revolving Facility and the Senior Notes.

Long-term debt as of December 31, 2015 and 2014 consisted of the following (amounts in thousands):

	December 31, 2015	December 31, 2014
Senior Credit Facilities		
$1,696 million Senior Secured Term Loan facility, due November 2, 2018, net of unamortized discount of $23,511 and $20,016 at December 31, 2015 and December 31, 2014, respectively (effective interest rate of 4.29%)	$ 1,621,981	$ 1,245,376
$160 million Senior Secured Term Loan facility, due November 2, 2018, net of unamortized discount of $3,334 and $4,438 at December 31, 2015 and December 31, 2014, respectively (effective interest rate of 4.54%)	154,666	155,162
$125 million Senior Secured Revolving Credit facility, expiring on November 2, 2016 and bearing interest at a variable base rate plus a spread rate		
Senior Notes		
$375 million 11% Senior Notes due December 31, 2019, net of unamortized discount of $6,299 and $7,477 at December 31, 2015 and December 31, 2014, respectively (effective interest rate of 11.53%)	368,701	367,523
$375 million 11.25% Senior Notes due December 31, 2020, net of unamortized discount of $8,471 and $9,651 at December 31, 2015 and December 31, 2014, respectively (effective interest rate of 11.85%)	366,529	365,349
$250 million 6% Senior Notes due February 15, 2021, net of unamortized discount of $6,161 and $0 at December 31, 2015 and December 31, 2014, respectively (effective interest rate of 6.57%)	243,839	
Obligation under data sublicense agreement	10,810	17,237
Other	7,427	12,129
Less current portion	(32,775)	(27,308)
Long-term debt	$ 2,741,178	$ 2,135,468

Senior Credit Facilities

The Senior Credit Agreement provides that, subject to certain conditions, we may request additional tranches of term loans, increase commitments under the Revolving Facility or the Term Loan Facility or add one or more incremental revolving credit facility tranches (provided that the revolving credit commitments outstanding at any time have no more than three different maturity dates) in an aggregate amount not to exceed (a) $300.0 million plus (b) an unlimited amount at any time, subject to compliance on a pro forma basis with a first lien net leverage ratio of no greater than 4.00 to 1.00. Availability of such additional tranches of term loans or revolving credit facilities and/or increased commitments is subject to, among other conditions, the absence of any default under the Senior Credit Agreement and the receipt of commitments by existing or additional financial institutions. Proceeds of the Revolving Facility, including up to $30.0 million in the form of borrowings on same-day notice, referred to as swingline loans, and up to $50.0 million in the form of letters of credit ($6.7 million outstanding as of December 31, 2015), are available to provide financing for working capital and general corporate purposes.

Borrowings under the Senior Credit Facilities bear interest at an annual rate equal to an applicable margin plus, at our option, either (a) a base rate determined by reference to the highest of (i) the applicable prime rate, (ii) the federal funds rate plus 0.50% and (iii) a LIBOR rate determined by reference to the costs of funds for United States dollar deposits for an interest period of one month, adjusted for certain additional costs, plus 1.00%, which base rate, in the case of the Term Loan Facility only, shall be no less than 2.25%, or (b) a LIBOR rate determined by reference to the costs of funds for United States dollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs, which, in the case of the Term Loan Facility only, shall be no less than 1.25%.

In April 2012, we amended the Senior Credit Agreement to reprice the Senior Credit Facilities and borrow $80.0 million of additional term loans. In April 2013, we again amended the Senior Credit Agreement to further reprice, and also to modify certain financial covenants under, the Senior Credit Facilities. Following the April 2013 amendment, the interest rate on both the Term Loan Facility and Revolving Facility is LIBOR plus 2.50%. The Term Loan Facility remains subject to a LIBOR floor of 1.25%, and there continues to be no LIBOR floor on the Revolving Facility. In connection with the April 2013 repricing, the Senior Credit Agreement also was amended to, among other things, eliminate the financial covenant related to the consolidated cash interest coverage ratio and modify the financial covenant related to the net leverage test by maintaining the required first lien net leverage ratio at 5.35 to 1.00 for the remaining term of the Senior Credit Facilities.

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In December 2014 and August 2015, through further amendments to the Senior Credit Agreement, we borrowed an additional $160.0 million and $395.0 million, respectively, under incremental term loan facilities on identical terms and having the same rights and obligations as the existing term loans under the Senior Credit Agreement.

In addition to paying interest on outstanding principal under the Senior Credit Facilities, we are required to pay customary agency fees, letter of credit fees and a 0.50% commitment fee in respect of the unutilized commitments under the Revolving Facility.

The Senior Credit Agreement requires that we prepay outstanding loans under the Term Loan Facility, subject to certain exceptions, with (a) 100% of the net cash proceeds of any incurrence of debt other than debt permitted under the Senior Credit Agreement, (b) 50% (which percentage will be reduced to 25% and 0% based on our first lien net leverage ratio) of our annual excess cash flow and (c) 100% of the net cash proceeds of certain asset sales and casualty and condemnation events, subject to reinvestment rights and certain other exceptions.

We generally may voluntarily prepay outstanding loans under the Senior Credit Facilities at any time without premium or penalty other than breakage costs with respect to LIBOR loans.

We are required to make quarterly payments equal to 0.25% of the aggregate principal amount of the loans under the Term Loan Facility, with the balance due and payable on November 2, 2018. Any principal amount outstanding under the Revolving Facility is due and payable on November 2, 2016.

Certain of our United States wholly-owned restricted subsidiaries, together with the Company, are co-borrowers and jointly and severally liable for all obligations under the Senior Credit Facilities. Such obligations of the co-borrowers are unconditionally guaranteed by Change Healthcare Intermediate Holdings, Inc., a direct wholly-owned subsidiary of Change Healthcare, Inc., the Company and each of our existing and future United States wholly-owned restricted subsidiaries (with certain exceptions including immaterial subsidiaries). These obligations are secured by a perfected security interest in substantially all of the assets of the co-borrowers and guarantors now owned or later acquired, including a pledge of all of the capital stock of the Company and our United States wholly-owned restricted subsidiaries and 65% of the capital stock of our foreign restricted subsidiaries, subject in each case to the exclusion of certain assets and additional exceptions.

The Senior Credit Agreement requires us to comply with a maximum first lien net leverage ratio financial maintenance covenant, to be tested on the last day of each fiscal quarter. A breach of the first lien net leverage ratio covenant is subject to certain equity cure rights. In addition, the Senior Credit Facilities contain a number of negative covenants that, among other things and subject to certain exceptions, restrict our ability and the ability of our subsidiaries to:

- incur additional indebtedness or guarantees;
- incur liens;
- make investments, loans and acquisitions;

consolidate or merge;

sell assets, including capital stock of subsidiaries;

pay dividends on capital stock or redeem, repurchase or retire capital stock of the Company or any restricted subsidiary;

alter the business of the Company;

amend, prepay, redeem or purchase subordinated debt;

engage in transactions with affiliates; and

enter into agreements limiting dividends and distributions of certain subsidiaries.

The Senior Credit Agreement also contains certain customary representations and warranties, affirmative covenants and provisions relating to events of default (including upon change of control).

As of December 31, 2015, we believe we were in compliance with all of the applicable debt covenants under the Senior Credit Agreement.

Senior Notes

The 2019 Notes bear interest at an annual rate of 11.00% with interest payable semi-annually on June 30 and December 31 of each year. The 2019 Notes mature on December 31, 2019. The 2020 Notes bear interest at an annual rate of 11.25% with interest

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payable quarterly on March 31, June 30, September 30 and December 31 of each year. The 2020 Notes mature on December 31, 2020. The 2021 Notes bear interest at an annual rate of 6.00% with interest payable semi-annually on April 15 and October 15 of each year, commencing on April 15, 2016. The 2021 Notes mature on February 15, 2021.

We may redeem the 2019 Notes, the 2020 Notes or both, in whole or in part, at any time on or after December 31, 2015 at the applicable redemption price, plus accrued and unpaid interest.

We may redeem the 2021 Notes, in whole or in part, at any time on or after August 15, 2017 at the applicable redemption price, plus accrued and unpaid interest. At any time prior to August 15, 2017, we may, at our option and on one or more occasions, redeem up to 40% of the aggregate principal amount of the 2021 Notes at a redemption price equal to 100% of the aggregate principal amount, plus a premium and accrued and unpaid interest with the net cash proceeds of certain equity offerings. At any time prior to August 15, 2017, we may redeem the 2021 Notes, in whole or in part, at its option and on one or more occasions, at a redemption price equal to 100% of the principal amount, plus a make-whole premium and accrued and unpaid interest.

If we experience specific kinds of changes in control, we must offer to purchase the Senior Notes at a purchase price equal to 101% of the principal amount, plus accrued and unpaid interest.

The Senior Notes are senior unsecured obligations and rank equally in right of payment with all of our existing and future indebtedness and senior in right of payment to all of our existing and future subordinated indebtedness. Our obligations under the Senior Notes are guaranteed on a senior basis by all of our existing and subsequently acquired or organized wholly-owned United States restricted subsidiaries that guarantee our Senior Credit Facilities or our other indebtedness or indebtedness of any affiliate guarantor. The Senior Notes and the related guarantees are effectively subordinated to our existing and future secured obligations and that of our affiliate guarantors to the extent of the value of the collateral securing such obligations, and are structurally subordinated to all existing and future indebtedness and other liabilities of any of our subsidiaries that do not guarantee the Senior Notes.

The Indentures contain customary covenants that restrict our ability and the ability of our restricted subsidiaries to:

- pay dividends on our capital stock or redeem, repurchase or retire our capital stock, subject to customary exceptions, including compliance with a fixed charge coverage ratio and subject to limitation based on net income generated during the term of the Indentures;
- incur additional indebtedness or issue certain capital stock;
- incur certain liens;
- make investments, loans, advances and acquisitions;
- consolidate, merge or transfer all or substantially all of our assets and the assets of our subsidiaries;

prepay subordinated debt;

engage in certain transactions with our affiliates; and

enter into agreements restricting our subsidiaries ability to pay dividends.

The Indentures also contain certain affirmative covenants and events of default.

As of December 31, 2015, we believe we were in compliance with all of the applicable debt covenants under the Senior Notes.

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Summary Disclosures about Contractual Obligations and Commercial Commitments

Contractual Obligations

The following table presents certain minimum payments due under contractual obligations with minimum firm commitments as of December 31, 2015:

		Payments by Period				
		Total	Less than 1 year	1-3 years	3-5 years	After 5 years
				(in thousands)		
Senior Credit Facilities and other long-term obligations	(1)	$ 1,821,729	$ 32,775	$ 1,788,954	$	$
2019 Notes	(2)	375,000			375,000	
2020 Notes	(3)	375,000			375,000	
2021 Notes	(4)	250,000				250,000
Expected interest	(5)	646,453	168,427	320,526	155,625	1,875
Tax receivable agreement obligations to related parties	(6)	355,742	986	63,920	131,573	159,263
Operating lease obligations	(7)	70,233	14,748	24,413	12,053	19,019
Contingent consideration obligation	(8)	4,650	4,650			
Purchase obligations and other	(9)	102,920	54,772	19,148	12,000	17,000
Interest rate swap agreements	(10)	3,117	2,547	570		
Total contractual obligations	(11)	$ 4,004,844	$ 278,905	$ 2,271,531	$ 1,061,251	$ 447,157

(1) Represents the principal amount of indebtedness under the Senior Credit Facilities, deferred financing obligations and our data sublicense agreement.
(2) Represents the principal amount of indebtedness under the 2019 Notes without reduction for any original issue discount.
(3) Represents the principal amount of indebtedness under the 2020 Notes without reduction for any original issue discount.
(4) Represents the principal amount of indebtedness under the 2021 Notes without reduction for any original issue discount.
(5) Consists of interest payable under the Senior Credit Facilities, Senior Notes and imputed interest payable under our data sublicense and other financing obligation agreements. Interest related to the Senior Credit Facilities is based on our interest rates in effect as of December 31, 2015 and assumes that we make no optional or mandatory prepayments of principal prior to their maturity. Because the interest rates under the Senior Credit Facilities are variable, actual payments may differ.
(6) Represents amount due based on facts and circumstances existing as of December 31, 2015 (without reduction for any fair value adjustment recognized in acquisition method accounting). The timing and/or amount of the aggregate payments due may vary based on a number of factors, including the amount and timing of the taxable income the Company generates in the future and the tax rate then applicable, the use of loss carryovers and the

portion of payments under the tax receivable agreements constituting imputed interest or amortizable basis.

(7) Represents amounts due under existing operating leases related to our offices and other facilities.

(8) Contingent consideration transferred in connection with acquisitions includes a contingent obligation to make additional payments based on the achievement of certain future performance objectives. Because the ultimate timing and amount of payments are dependent on the outcome of future events, the timing and/or amount of these additional payments may vary from this estimate.

(9) Represents contractual commitments under the transaction and advisory fee agreement we entered into with affiliates of the Investor Group in connection with the 2011 Merger, certain telecommunication and other supply contracts and certain other obligations. Where our purchase commitments are cumulative over a period of time (i.e. no specified annual commitment), the table above assumes such commitments will be fulfilled on a ratable basis over the commitment period. Under the transaction and advisory fee agreement, in connection with or in anticipation of a change in control, sale of all or substantially all of our assets or an initial public offering of our equity, the affiliates of the Investor Group have the option to receive a single lump sum cash payment equal to the then-present value of all the then-current and future annual advisory fees payable, assuming a remaining 12-year payment period from the date of the election.

(10) Under our interest rate swap agreements, we receive a three-month LIBOR rate and pay a fixed rate of 1.6485% on a $640.0 million notional amount. The amounts in the above table represent the net amounts we expect to pay (including interest) in the respective periods based upon the three-month LIBOR yield curve in effect as of December 31, 2015.

(11) Total contractual obligations exclude liabilities for uncertain tax positions of $0.1 million and commitments of a maximum of $7.0 million potentially due under the Company s long term incentive plans from the above table due to the high degree of uncertainty regarding the ultimate amount, if any, and timing of future cash payments.

See the notes to our consolidated financial statements included elsewhere in this Annual Report for additional information related to our operating leases and other commitments and contingencies.

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Off-Balance Sheet Arrangements

As of the filing of this Annual Report, we had no off-balance sheet arrangements or obligations, other than those related to surety bonds of an insignificant amount.

Recent Accounting Pronouncements

Our recent accounting pronouncements are summarized in Note 2 to our consolidated financial statements included elsewhere in this Form 10-K.

ITEM 7A.*QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK*

We have interest rate risk primarily related to borrowings under the Senior Credit Agreement. Borrowings under the Senior Credit Facilities bear interest at an annual rate equal to an applicable margin plus, at our option, either (a) a base rate determined by reference to the highest of (i) the applicable prime rate, (ii) the federal funds rate plus 0.50% and (iii) a LIBOR rate determined by reference to the costs of funds for United States dollar deposits for an interest period of one month, adjusted for certain additional costs, plus 1.00%, which base rate, in the case of the Term Loan Facility only, shall be no less than 2.25%, or (b) a LIBOR rate determined by reference to the costs of funds for United States dollar deposits for the interest period relevant to such borrowing, adjusted for certain additional costs, which, in the case of the Term Loan Facility only, shall be no less than 1.25%.

As of December 31, 2015, we had outstanding borrowings of $1,803.5 million (before unamortized debt discount) under the Senior Credit Agreement. The LIBOR-based interest rate on the Term Loan Facility and the Revolving Facility were each LIBOR plus 2.50%. The Term Loan Facility is subject to a LIBOR floor of 1.25% and there is no LIBOR floor on the Revolving Facility.

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

In January 2012, we executed three interest rate swap agreements with an aggregate notional amount of $640.0 million to reduce the variability of interest payments associated with the Term Loan Facility. For the year ended December 31, 2015, our interest rate swap agreements were designated as a cash flow hedge so that changes in the fair market value of the interest rate swap agreements were included within other comprehensive income.

A change in interest rates on variable rate debt may impact our pretax earnings and cash flows. However, due to a floor on the floating rate index of 1.25% under the Term Loan Facility, as of December 31, 2015, our interest rates must increase by more than 100 basis points before our interest expense or cash flows are affected. Based on our outstanding debt as of December 31, 2015, and assuming that our mix of debt instruments, interest rate swaps and other variables remain the same, the annualized effect of a one percentage point change in variable interest rates would have minimal impact on our earnings and cash flows.

In the future, in order to manage our interest rate risk, we may refinance our existing debt, enter into additional interest rate swap agreements, modify our existing interest rate swap agreements or make changes that may impact our

ability to treat our interest rate swaps as a cash flow hedge. However, we do not intend or expect to enter into derivative or interest rate swap transactions for speculative purposes.

ITEM 8. ***FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA***

Information with respect to this Item is contained in our consolidated financial statements beginning on Page F-1 of this Annual Report.

ITEM 9. ***CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE***

None.

ITEM 9A. ***CONTROLS AND PROCEDURES***

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

Under the supervision and with the participation of our Chief Executive Officer (CEO) and Chief Financial Officer (CFO), management has evaluated the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rule

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13a-15(e) and Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the Exchange Act)) as of December 31, 2015. Based upon that evaluation, our CEO and CFO concluded that, as of December 31, 2015, our disclosure controls and procedures were effective to ensure that the information that we are required to disclose in the reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in SEC rules and forms and such information is accumulated and communicated to our management, including our CEO and CFO, as appropriate, to allow timely decisions regarding required disclosure.

Report of Management on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act). Our internal control over financial reporting is a process that is designed under the supervision of our CEO and CFO, and effected by our board of directors, management and other personnel, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with United States Generally Accepted Accounting Principles (GAAP). Our internal control over financial reporting includes those policies and procedures that:

i. Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets;

ii. Provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures recorded by us are being made only in accordance with authorizations of our management and board of directors; and

iii. Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on our financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies and procedures may deteriorate.

Management has conducted its evaluation of the effectiveness of internal control over financial reporting as of December 31, 2015, based on the framework in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Management s assessment included an evaluation of the design of our internal control over financial reporting and testing the operational effectiveness of our internal control over financial reporting.

Management reviewed the results of the assessment with the audit committee of the board of directors. Based on its assessment and review with the audit committee, management concluded that, at December 31, 2015, we maintained effective internal control over financial reporting.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting that occurred during the year ended December 31, 2015 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

ITEM 9B. ***OTHER INFORMATION***

None.

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PART III

ITEM 10. *DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE*

Directors and Executive Officers

The following table sets forth information with respect to current members of our board of directors as well as information relating to our current executive officers (ages are as of March 1, 2016).

Name	Age	Position
Neil E. de Crescenzo	54	Chief Executive Officer, Director
Randy Giles	58	Chief Financial Officer
Alex Choy	53	Executive Vice President Research and Development, and Chief Information Officer
Jason Erdell	42	Executive Vice President Technology-enabled Services
Douglas M. Ghertner	40	Executive Vice President Chief Sales Officer
Kriten Joshi	44	Executive Vice President Products
Dennis Robbins	45	Chief Accounting Officer
Gregory T. Stevens	50	Executive Vice President, General Counsel and Secretary
Howard L. Lance	60	Chairman of the Board of Directors
Philip M. Pead	63	Director
Pamela J. Pure	55	Director
Phillip W. Roe	55	Director
Neil P. Simpkins	49	Director
Justin Sunshine	33	Director
Allen Thorpe	45	Director

Neil E. de Crescenzo. Mr. de Crescenzo, 54, has been our Chief Executive Officer and a member of our board of directors since September 2013. Prior to joining Change Healthcare, Mr. de Crescenzo served as the Senior Vice President and General Manager of the Global Health Sciences business of Oracle Corporation from June 2008 to September 2013. Prior to joining Oracle in 2006, Mr. de Crescenzo spent 10 years at IBM Corporation, including his last role as senior executive for Global Healthcare Business Consulting Services. Mr. de Crescenzo received a B.A. in Political Science from Yale University and an M.B.A. from Northeastern University. As a member of Change Healthcare s senior management team, Mr. de Crescenzo provides our board of directors significant management and leadership experience gained by having served in multiple management and leadership positions within large providers of software and technology products and services. In addition, our board of directors benefits from Mr. de Crescenzo s many years of experience in the healthcare software and information technology industries.

Randy Giles. Mr. Giles, 58, has been our Chief Financial Officer since April 2014 and served as our Executive Vice President Finance from February 2014 to April 2014. Prior to joining Change Healthcare, Mr. Giles was an Executive Vice President from November 2010 to April 2011 and Executive Vice President, Chief Financial Officer and Treasurer for Coventry Health Care, Inc. from May 2011 to June 2013, when Coventry was acquired by Aetna. Prior to joining Coventry, Mr. Giles held numerous executive positions for UnitedHealthcare, the commercial health benefits division of UnitedHealth Group, Inc., including serving as CEO of two of UnitedHealthcare s health plans in

Texas and Division/Region CFO for several markets from August 1993 to October 2010. Prior to joining UnitedHealthcare, Mr. Giles held senior level positions at various health plans and began his career at Ernst & Young. Mr. Giles received a B.A. in Political Science and Economics from the University of North Carolina and an M.B.A. with concentrations in Finance and Accounting from Emory University.

Alex Choy. Mr. Choy, 53, has been our Executive Vice President Research and Development and Chief Information Officer since January 2014. Prior to joining Change Healthcare, Mr. Choy served as the Global Vice President, Product Development at Oracle Corporation from January 2013 to December 2013. Prior to that, Mr. Choy served as the Vice President Engineering for enterprise software products for Adobe Systems from May 2006 to December 2012. Prior to joining Adobe, Mr. Choy held senior level engineering and development positions at Interwoven, Veritas Software, Tandem, Sun Microsystems and Hewlett-Packard. Mr. Choy received a B.S. in Computer Science from the University of California, Berkeley and a Masters Degree in Computer Science from Stanford University.

Jason Erdell. Mr. Erdell, 42, has been our Executive Vice President Technology-enabled Services since January 2015. Prior to joining Change Healthcare, Mr. Erdell held numerous executive positions for MedAssets from November 2010 to December 2014, including serving as the Managing Director of Consulting and Professional Services and the General Manager of Workforce Solutions. Prior to joining MedAssets, Mr. Erdell was Senior Vice President of Enterprise Accounts for The Broadlane Group, a healthcare group purchasing organization acquired by MedAssets in November 2010. Prior to joining The Broadlane Group in May 2009, Mr. Erdell

held senior level positions for Gap Inc., Booz Allen Hamilton and Hewlett-Packard. Mr. Erdell received a B.S. in Operations Research and Industrial Engineering from Cornell University and an M.B.A. from the Kellogg School of Management at Northwestern University.

Douglas M. Ghertner. Mr. Ghertner, 40, has been our Executive Vice President Chief Sales Officer since January 2016. Prior to that, Mr. Ghertner served as our Executive Vice President of Consumer Engagement since November 2014 when we acquired Change Healthcare Corporation. Prior to the acquisition, Mr. Ghertner served as the President and Chief Executive Officer of Change Healthcare Corporation (now known as Change Healthcare Engagement Solutions, Inc.) from July 2011 to November 2014. Previously, Mr. Ghertner held various leadership positions at CVS Health, most recently as Senior Vice President of Client Solutions. Mr. Erdell received a B.S. in Commerce from Washington and Lee University and an M.B.A. from the Terry College of Business at the University of Georgia.

Kriten Joshi. Mr. Joshi, 44, has been our Executive Vice President Products since December 2013. Prior to joining Change Healthcare, Mr. Joshi was Global Vice President of Healthcare Product Strategy for Oracle Corporation s Health Sciences Global Business Unit from December 2006 to December 2013. Prior to joining Oracle, Mr. Joshi served in senior strategy roles in IBM s Global Sales and Distribution organization from 2003 to 2006. Prior to that, Mr. Joshi was with McKinsey and Co. Mr. Joshi received a B.S. in Mathematics from the California Institute of Technology and a Ph.D. in Physics from the Massachusetts Institute of Technology.

Dennis Robbins. Mr. Robbins, 45, has been our Chief Accounting Officer since April 2015 and has served as a Vice President of Finance for Change Healthcare since September 2008. Previously, Mr. Robbins held various leadership positions at Ernst & Young LLP from August 1993 to September 2008, most recently as Senior Manager. Mr. Robbins received a B.S. in both Finance and Accounting from Tennessee Technological University and has been a Certified Public Accountant since 1993.

Gregory T. Stevens. Mr. Stevens, 50, has been our Executive Vice President, General Counsel and Secretary since July 2008. Prior to joining Change Healthcare, Mr. Stevens served as Chief Administrative Officer, General Counsel, Secretary and Chief Compliance Officer of Spheris Inc. from July 2003 to June 2008. During February 2010, Spheris filed a voluntary petition under Chapter 11 of the United States Bankruptcy Code in order to facilitate the sale of Spheris pursuant to Section 363 thereunder to MedQuist Holdings, Inc. Previously, Mr. Stevens served as General Counsel and Secretary of Luminex Corporation and as the Senior Vice President and General Counsel for Envoy Corporation. Prior to joining Envoy, Mr. Stevens practiced corporate and securities law with Bass, Berry & Sims PLC. Mr. Stevens received a B.A. in Economics and History and a J.D. from Vanderbilt University.

Howard L. Lance. Mr. Lance, 60, has served on our board of directors since November 2012 and became the chairman of our board of directors in February 2013. Mr. Lance served as the Chairman, President and Chief Executive Officer of Harris Corporation from January 2003 until December 2011. Mr. Lance serves as chairman of the board of directors of Summit Materials, Inc. and as a director of Ferrovial S.A. Mr. Lance served as a director of Eastman Chemical Company from 2005 to 2014, Stryker Corporation from 2009 to 2014 and Aviat Networks, Inc. from 2007 to 2009. Mr. Lance received a B.S. in Industrial Engineering from Bradley University and an M.S. in Management from Purdue University. Mr. Lance brings to our board of directors extensive leadership and management skills developed through his prior service as a senior executive officer and director of large, public companies.

Philip M. Pead. Mr. Pead, 63, rejoined our board of directors in November 2012, having previously served on our board from February 2009 through August 2011. Mr. Pead has served as President and Chief Executive Officer of Progress Software Corp. since December 2012. Mr. Pead previously served as Executive Chairman and Interim Chief

Executive Officer of Progress Software Corp. from November 2012 to December 2012, and as Non-Executive Chairman beginning in July 2012, having joined the Progress Software Corp. board of directors in July 2011. Prior to that, Mr. Pead served as Chairman of the board of directors of Allscripts Healthcare Solutions, Inc. from August 2010 through April 2012 following Allscripts s acquisition of Eclipsys Corporation where he had served as President and Chief Executive Officer since May 2009. Mr. Pead also served as a director of Eclipsys from February 2009 until its acquisition by Allscripts. Mr. Pead received a B.S. in Economics from the University of London and a Business Administration Diploma from Harrow College of Technology. As the former chairman of the board of directors and executive officer of publicly-traded healthcare technology companies, Mr. Pead brings to Change Healthcare and our board of directors his leadership skills and intimate knowledge of the industry. Mr. Pead also has significant and varied management expertise, developed in roles of increasing responsibility throughout his career, including the integration of acquired companies, improving operating efficiencies and margins, managing complex regulatory compliance matters and growing the business, all of relevance to Change Healthcare.

Pamela J. Pure. Ms. Pure, 55, has served on our board of directors since January 2012. Ms. Pure has served as Chief Executive Officer of HealthMEDX, LLC since December 2011. Prior to that, Ms. Pure held numerous executive positions for McKesson Corporation and its affiliates since 2001, including her last role as Executive Vice President, McKesson Corporation and President, McKesson Technology Solutions from 2004 to 2009. Ms. Pure received a B.S. in Public Health from the University of North Carolina. Ms. Pure brings to our board of directors more than 25 years of experience in the healthcare information technology and services industry.

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Phillip W. Roe. Mr. Roe, 55, joined our board of directors in November 2015. Mr. Roe has served as the Chief Executive Officer of Martin Ventures, a private family-owned venture company, since June 2015. Mr. Roe previously served as Senior Vice President, Finance of Tenet Healthcare from October 2013 to May 2015 following Tenet s acquisition of Vanguard Health Systems where he served as the Executive Vice President, Chief Financial Officer and Treasurer since November 2007. Prior to that, he served as Senior Vice President, Controller and Chief Accounting Officer of Vanguard Health Systems since July 1997. Mr. Roe received a B.S. in Accounting from Oklahoma Christian University and is a certified public accountant. As a member of our board of directors, Mr. Roe contributes more than 20 years of experience in the healthcare industry and significant financial experience as a former chief financial officer of a public company.

Neil P. Simpkins. Mr. Simpkins, 49, became a member of our board of directors in November 2011 and served as the chairman of our board of directors through February 2013. Mr. Simpkins has served as a Senior Managing Director in the Private Equity Group of Blackstone since December 1999. From 1993 until the time he joined Blackstone, Mr. Simpkins was a Principal at Bain Capital. Prior to joining Bain Capital, Mr. Simpkins was a consultant at Bain & Company in London and in the Asia Pacific region. Mr. Simpkins has led Blackstone s acquisitions of TRW Automotive Holding Corp., Vanguard Health Systems, Team Health, Apria Healthcare Group, Summit Materials, Gates Corporation and Change Healthcare. He currently serves as a director of Gates Corporation, Apria Healthcare Group and Summit Materials. Mr. Simpkins graduated with honors from Oxford University and received an M.B.A. from Harvard Business School. Mr. Simpkins has significant financial and investment experience and possesses executive management and strategic skills gained through his experience with other Blackstone portfolio companies. Mr. Simpkins also brings to us his additional board experience with several public and private companies which helps us informally benchmark our practices.

Justin Sunshine. Mr. Sunshine, 33, joined our board of directors in March 2014. Mr. Sunshine is a Principal in the Private Equity Group at Blackstone, with a focus on the healthcare sector. Mr. Sunshine has worked in both the New York and London offices, and has been involved in the execution of Blackstone s investments in the Intertrust Group, the ATC Group, Scout24, Apria Healthcare Group and Change Healthcare. Prior to joining the Private Equity Group, Mr. Sunshine was an Associate within Blackstone Advisory Partners from August 2009 to September 2011. Prior to Blackstone, Mr. Sunshine worked as a consultant in the strategy practice at Accenture. He currently serves as a member of the board of directors of Apria Healthcare Group. Mr. Sunshine received a B.B.A. in Finance from the University of Texas at Austin and an M.B.A. from the University of Chicago Booth School of Business. Mr. Sunshine has been engaged in the private equity industry for several years and brings to us his financial and investment experience that he gained while working on complex transactions related to other Blackstone portfolio companies.

Allen R. Thorpe. Mr. Thorpe, 45, has been a member of our board of directors since September 2008. Mr. Thorpe joined Hellman & Friedman in 1999 and has served as a Managing Director of Hellman & Friedman since 2004. At Hellman & Friedman, his primary areas of focus are healthcare and financial services. Prior to joining Hellman & Friedman in 1999, Mr. Thorpe was a Vice President with Pacific Equity Partners and a Manager at Bain & Company. Mr. Thorpe serves as a director of Edelman Financial Services and Pharmaceutical Product Development, Inc. and is a member of the advisory board of Grosvenor Capital Management Holdings, LLLP. He was formerly a director of Sheridan Holdings, Inc., Artisan Partners Asset Management Inc., LPL Financial Holdings Inc., Activant Solutions, Vertafore Inc., Mondrian Investment Partners Ltd., Gartmore Investment Management Limited and Mitchell International. Mr. Thorpe received an A.B. from Stanford University and an M.B.A. from Harvard Business School. As a member of our board of directors, Mr. Thorpe contributes his strategic, financial, healthcare and capital markets expertise through his career with equity investment firms. Mr. Thorpe also contributes insights on board leadership developed through his service on several boards of Hellman & Friedman s portfolio companies.

Section 16(a) Beneficial Ownership Reporting Compliance

None of our directors, executive officers or beneficial owners of more than 10% of our equity securities is required to file reports pursuant to Section 16(a) of the Exchange Act with respect to their relationship with us because we do not have equity securities registered pursuant to Section 12 of the Exchange Act.

Governance Matters

Composition of our Board of Directors

Pursuant to the stockholders agreement among Change Healthcare, Parent, the Investor Group and the other equity holders of Parent, including certain members of our senior management (as amended, the Stockholders Agreement), Parent s board of directors must be comprised of at least five members, three of whom are designated by Blackstone, one of whom is designated by Hellman & Friedman and one of whom is our chief executive officer. Blackstone may increase the size of Parent s board of directors to eight directors at any time to accommodate the election of three independent directors to be selected by Blackstone in consultation with Hellman & Friedman. According to the terms of the Stockholders Agreement, we are required to take all necessary action to cause the persons constituting Parent s board of directors to be appointed as members of our board of directors unless Blackstone or Hellman & Friedman otherwise elects. In the event that Hellman & Friedman ceases to hold 25% or more of its initial ownership interest in Parent, it will no longer be entitled to designate a director for election to Parent s or our board of directors or to a

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consultation right with respect to the election of independent directors. Blackstone has the right to appoint and remove (in consultation with Hellman & Friedman) all independent directors on Parent s and our board of directors and fill vacancies created by reason of death, removal or resignation of all such independent directors. In addition, for so long as certain investment funds associated with Goldman, Sachs & Co. continue to hold, together with their affiliates, at least 10% of the 2020 Notes, we have granted GS Mezzanine Partners V Institutional, L.P. a right to (i) designate a non-voting observer to our board of directors, (ii) consult with our management on matters relating to our operations, (iii) access our facilities, properties, books and records and (iv) receive additional information as it may reasonably request from time to time.

In November 2015, the size of our board of directors was increased to eight, and Mr. Roe was elected to serve as an independent director on each of Parent s and our board of directors along with Ms. Pure and Mr. Pead. Mr. Thorpe serves on the board of directors of both entities as a designee of Hellman & Friedman, and Messrs. Lance, Simpkins and Sunshine serve as designees of Blackstone. In addition, Mr. de Crescenzo, our chief executive officer, serves on each of Parent s and our board of directors.

Board Committees

Our Stockholders Agreement requires that our board of directors maintain the following three standing committees: an audit committee, a compensation committee and a nominating committee. Each of the standing committees operates pursuant to a written charter. The following is a brief description of these standing committees of our board of directors, including their membership and responsibilities during 2015.

Audit Committee. The audit committee assists our board of directors in fulfilling its fiduciary oversight responsibilities by reviewing: (i) the integrity of financial information, (ii) the performance of our internal audit function and systems of internal controls and (iii) our compliance with legal and regulatory requirements. In addition, the audit committee has direct responsibility for the appointment, compensation, retention (including termination) and oversight of our independent registered public accounting firm. The audit committee also reviews and approves related party transactions in accordance with our Related Party Transaction Policy. See Part III, Item 13, Certain Relationships and Related Transactions, and Director Independence Related Party Transactions Policies and Procedures of this Annual Report.

The audit committee is currently comprised of Messrs. Pead (chair), Roe, Sunshine and Thorpe. During 2015, the audit committee was comprised of Messrs. Pead, Sunshine, Thorpe and Roe, who joined the committee in November 2015. Because we do not have any securities listed on a national securities exchange or on an automated quotation system, our board of directors is not required to have on the audit committee a person who qualifies under the rules of the SEC as an audit committee financial expert or as having accounting or financial management expertise under the similar rules of the national securities exchanges. While the audit committee has not designated any of its members as an audit committee financial expert, we believe that each of the current members of the audit committee is fully qualified to address any accounting, financial reporting or audit issues that may come before the audit committee.

Compensation Committee. The compensation committee (i) reviews and recommends policies relating to compensation and benefits of our directors, employees and certain other persons providing services to us and (ii) is responsible for reviewing and approving the compensation of our senior management. The compensation committee is currently comprised of Messrs. Simpkins (chair), Lance and Thorpe. The same individuals comprised the compensation committee throughout 2015.

Nominating Committee. The nominating committee (i) assists our board of directors in identifying and recommending individuals qualified to serve as directors of the Company, (ii) recommends to our board of directors director nominees for each committee of our board of directors, (iii) reviews and considers candidates who may be suggested by any of our directors or executive officers, or by any of our stockholders, if made in accordance with the Stockholders Agreement, our certificate of incorporation, bylaws and applicable law and (iv) reviews succession plans relating to senior management. The nominating committee is currently comprised of Messrs. Simpkins (chair), Lance and Thorpe. The same individuals comprised the nominating committee throughout 2015.

Code of Business Conduct and Ethics

We have adopted a Code of Business Conduct and Ethics that applies to all directors, officers and employees, including the principal executive officer, principal financial officer, principal accounting officer or controller and persons performing similar functions. The Code of Business Conduct and Ethics is available on the Investors page of our website at http://changehealthcare.com/about/investors under the heading Corporate Governance after selecting the Learn More button. We plan to post any amendments to the Code of Business Conduct and Ethics on our website.

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ITEM 11. *EXECUTIVE COMPENSATION*

Compensation Discussion and Analysis

Overview

The following discussion analyzes our executive compensation program with respect to our named executive officers for the year ended December 31, 2015 and the material elements of the compensation packages awarded to such officers. The individuals whose compensation is discussed below are our Chief Executive Officer, Neil E. de Crescenzo; our Chief Financial Officer, Randy Giles; our Executive Vice President Research and Development and Chief Information Officer, Alex Choy; our Executive Vice President Technology-enabled Services, Jason Erdell; and our Executive Vice President Products, Kriten Joshi. We collectively refer to these individuals in the following discussion as our named executive officers.

The Role of the Compensation Committee

The responsibilities of our compensation committee include:

- reviewing and approving corporate goals and objectives relevant to the compensation of the Company s senior management;
- evaluating the performance of the Company s senior management;
- determining and approving compensation of the Company s senior management;
- reviewing and approving the following as they affect the Company s senior management: all cash-based and equity-based incentive awards, employment agreements, severance arrangements, any change in control agreements and any special or supplemental compensation and benefits;
- overseeing and administering our equity incentive plans, our 401(k) Plan and Health and Welfare Plan;
- making recommendations to our board of directors with respect to compensation philosophy and policies for director compensation;
- reviewing periodically the Company s compensation policies and practices to ensure that they properly incentivize employees to act in the long-term best interests of the Company and do not encourage excessive risk taking;
- reviewing and discussing with management the compensation discussion and analysis, when required by SEC rules for inclusion in our applicable filings;

reviewing and discussing with management the compensation committee report, when required by SEC rules for inclusion in our applicable filings; and

monitoring compensation matters and retaining appropriate advisors to assist in the evaluation of such compensation matters.

The compensation committee works directly with our chief executive officer to set annual compensation of each of our named executive officers other than our chief executive officer. To this end, our chief executive officer completes an evaluation of each such named executive officer, makes recommendations regarding the compensation of such officer and presents his evaluations and compensation recommendations to the compensation committee.

After considering our chief executive officer s evaluations and recommendations and such other factors as the nature and responsibilities of each named executive officer s position, the named executive officer s experience, Change Healthcare s achievement of corporate goals, the named executive officer s achievement of individual goals and competitive industry compensation, the compensation committee sets the annual compensation of our named executive officers. The compensation committee then sets the compensation of our chief executive officer in a meeting at which the chief executive officer is not present. The compensation for each of our named executive officers is set and recommended for adoption at meetings of the compensation committee generally held in the first quarter of each year.

Compensation Philosophy and Objectives

Our compensation program is centered around a pay-for-performance philosophy and is designed to reward our named executive officers for their abilities, experience and efforts. We believe our solutions reflect the individual and combined knowledge and performance that our compensation programs are structured to reward. Our ability to attract, retain and motivate the highly-qualified and experienced professionals who are vital to our success as a company is directly tied to the compensation programs we offer.

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We believe that having compensation programs designed to align executive officers interests with those of Change Healthcare in achieving positive business results and to reinforce accountability is the cornerstone to successfully implementing and achieving our strategic plans. In determining the compensation of our named executive officers, we are guided by the following key principles:

Competitiveness of Compensation. Compensation should be responsive to the competitive marketplace so that we continue to be able to attract, retain and motivate talented executives.

Accountability for Overall Business Performance. A portion of compensation should be tied to our overall performance so that our named executive officers are held accountable through their compensation for the performance of Change Healthcare as a whole.

Accountability for Individual Performance. A portion of compensation should be tied to the named executive officer s own individual performance to encourage and reflect individual contributions to our performance.

Alignment with Stockholder Interests. A portion of compensation should be tied to our financial performance through equity awards to align our named executive officers interests with those of our stockholders.

We seek to maintain a performance-oriented culture and a compensation approach that rewards our named executive officers when we achieve our goals and objectives, while putting at risk an appropriate portion of their compensation against the possibility that our goals and objectives may not be achieved. Consistent with this philosophy, we have sought to create an executive compensation package that balances short-term versus long-term components, cash versus equity elements and fixed versus contingent payments in ways that we believe are most appropriate to motivate our named executive officers.

Overview of Components of Compensation

Compensation for our named executive officers consists of the following key components:

- base salary;
- annual cash bonuses; and
- equity-based awards.

The first component of named executive officer compensation is base salary, which is intended to secure the services of the executive and compensate him for his functional roles and responsibilities.

The second component is an annual cash bonus opportunity, which is based upon a combination of Company and individual performance. These cash bonus opportunities are intended to link executive pay directly to achievement of annual Company operating and/or other performance objectives. We believe this compensation component aligns the interests of our named executive officers with the interests of our stockholders in the pursuit of short- to medium-term performance that should create value for our stockholders.

The third component is equity-based awards which provide a long-term incentive component to named executive officer compensation packages. Equity-based awards granted to our named executive officers align a portion of our named executive officers compensation to the interests of our investors and to each other, further reinforcing collaborative efforts for their mutual success. Equity-based compensation also fosters a long-term commitment from our named executive officers to the Company and balances the shorter-term cash components of compensation that we provide.

In addition, our named executive officers are eligible to receive the same benefits that we provide and to participate in all plans that we offer to other full-time employees, including health and welfare benefits and participation in our 401(k) Savings Plan.

We also provide our named executive officers with severance payments and benefits in the event of an involuntary or, in certain cases, constructive termination of employment without cause and accelerated equity award vesting in connection with a change in control of the Company.

Base Salary

We provide each named executive officer with a base salary for the services that the executive officer performs for us. This compensation component constitutes a stable element of compensation while other compensation elements are variable. Base salaries are reviewed annually and may be increased in light of the individual past performance of the named executive officer, company performance, any change in the executive s position within our business, the scope of his responsibilities and any changes thereto and his tenure with the Company.

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During 2015, the base salary for Messrs. de Crescenzo, Giles, Choy, Erdell and Joshi was $721,000, $463,500, $437,750, $360,000 and $437,750, respectively. For 2015, base salaries comprised 72%, 75%, 73%, 21% and 75% of the total compensation for Messrs. de Crescenzo, Giles, Choy, Erdell and Joshi, respectively. To date, none of the named executive officers has received a salary increase in 2016.

Annual Cash Bonuses

We provide our named executive officers with the opportunity to share in our success through annual bonuses awarded under our bonus program for management employees (the Management Bonus Program). The Management Bonus Program provides Change Healthcare s senior management and certain key employees the opportunity to earn compensation in addition to their base salaries up to a target bonus potential. The compensation committee has general authority for oversight and interpretation of the Management Bonus Program. The compensation committee, with the recommendations of our chief executive officer (other than with respect to himself), is responsible for (i) setting annual objective performance targets, (ii) reviewing actual performance and (iii) determining the amount of the compensation payable to each named executive officer.

Under the Management Bonus Program, a participant s annual target bonus is calculated as a percentage of the participant s annual base salary as of the end of the fiscal year, with the target percentages generally being aligned with the participant s level and role at the Company. The funding of bonuses under the Management Bonus Program is dependent on achievement of annual objective performance targets by the Company as a whole and of the operating division or divisions of which a participant is a part, if applicable. The amount of compensation a participant is eligible to be paid under the Management Bonus Program is determined primarily on the basis of objective Company performance measures determined by the compensation committee each year, such as Adjusted EBITDA and revenue.

After reviewing the actual performance of the Company, the compensation committee, with recommendations of our chief executive officer (other than with respect to himself), then undertakes a subjective evaluation of each named executive officer s performance. The compensation committee does not rely on preset formulas, thresholds or multiples in the subjective portion of its evaluation but rather relies upon its and our chief executive officer s judgment after careful consideration of subjective factors such as an executive s performance during the year against established goals, leadership qualities, operational performance, business responsibilities, long-term potential to enhance stockholder value, current compensation arrangements and tenure with the Company.

2015

The compensation committee determined that 50% of the 2015 objective performance measures were based on Adjusted EBITDA targets and 50% were based on revenue targets under the Management Bonus Program. For the year ended December 31, 2015, annual cash bonuses were linked to achievement of Adjusted EBITDA within a range of $371 million to $441 million and achievement of revenue from $1.37 billion to $1.63 billion. We believe the combination of these performance factors and the proportionate weighting assigned to each reflected our overall Company goals for 2015, which balanced the achievement of revenue growth and improving our operating efficiency. These measures were calculated in the same manner as reported in our financial results.

For 2015, our named executive officers target annual cash bonuses as a percentage of base salary were 100% for Mr. de Crescenzo; 85% for each of Messrs. Giles, and Joshi, 80% for Mr. Choy and 70% for Mr. Erdell.

At the compensation committee s first quarter 2016 meetings, the compensation committee reviewed the Company and individual performance results for 2015. The compensation committee, without input from Mr. de Crescenzo, determined the actual amount of cash bonuses to be paid to Mr. de Crescenzo, and, together with Mr. de Crescenzo s

input, determined the bonus payment for each other named executive officer. Based upon both achievement of Adjusted EBITDA of $404 million and revenue of $1.48 billion and each named executive officer s individual performance review, Messrs. de Crescenzo, Giles, Choy, Erdell and Joshi received bonuses of $280,469, $153,256, $167,746, $100,000 and $144,742, respectively, for 2015.

2016

In November 2015, the compensation committee determined the objective performance measures for 2016 under the Management Bonus Program. For the year ending December 31, 2016, 50% of the objective performance measures will be based on Adjusted EBITDA targets and 50% will be based on revenue targets. After the objective performance measures are calculated, adjustments to the annual cash bonuses payable for 2016 will be made based on the executive s achievement of individual objectives and contributions to us during the year. For 2016, our named executive officers target annual cash bonuses as a percentage of base salary are 100% for Mr. de Crescenzo, 85% for each of Messrs. Giles and Joshi, 80% for Mr. Choy and 70% for Mr. Erdell.

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Equity-Based Awards

Parent Equity Plan

In addition to base salary and cash bonus compensation, each of our named executive officers is provided equity-based award compensation. Parent adopted the Change Healthcare, Inc. Amended and Restated 2009 Equity Incentive Plan (the Parent Equity Plan) in connection with the 2011 Merger. Pursuant to the Parent Equity Plan, 180,950 shares of Parent common stock have been reserved for issuance of equity awards to employees, directors and consultants of Parent and its affiliates. Parent has the authority to grant awards, to set the terms and conditions of such awards and to adopt, alter and repeal rules, guidelines and practices relating to the Parent Equity Plan and any awards granted thereunder. Because we are an indirect wholly owned subsidiary of Parent, awards under the Parent Equity Plan represent an indirect ownership interest in Change Healthcare.

In January 2015, Parent granted a stock option award to purchase shares of Parent common stock under the Parent Equity Plan to Mr. Erdell. Pursuant to an award agreement entered into by Mr. Erdell, he was granted options to purchase an aggregate of 2,000 shares of Parent common stock as follows:

(1) 1,000 Tier 1 Time-Vesting Options, which have an exercise price per share equal to $1,465 (the grant date fair market value as determined by Parent) and vest in equal 20% annual installments on the first through the fifth anniversary of the grant date, subject to the optionee s continued employment through each vesting date;

(2) 500 2.5x Exit-Vesting Options, which have an exercise price per share equal to $1,465, and vest, subject to the optionee s continued employment through the vesting date, on the date when Blackstone has sold at least 25% of the maximum number of Parent shares held by it from time to time, and shall have received cash proceeds in respect of all such Parent shares at a weighted average price per Parent share that is (i) equal to at least 2.5 times Blackstone s cumulative invested capital (measured on a per Parent share basis) in Parent (the 2.5x MOIC Hurdle) or (ii) sufficient to result in an annual internal rate of return on Blackstone s cumulative invested capital in Parent of at least 25% (the 25% IRR Hurdle); and

(3) 500 3x Exit-Vesting Options, which have an exercise price per share equal to $1,465, and vest, subject to the optionee s continued employment through the vesting date, on the date when Blackstone has sold at least 25% of the maximum number of Parent shares held by it from time to time, and shall have received cash proceeds in respect of all such Parent shares at a weighted average price per Parent share that is (i) equal to at least 3.0 times Blackstone s cumulative invested capital (measured on a per Parent share basis) in Parent (the 3x MOIC Hurdle) or (ii) sufficient to result in an annual internal rate of return on Blackstone s cumulative invested capital in Parent of at least 30% (the 30% IRR Hurdle).

No other equity-based awards were made to our named executive officers during 2015.

Co-Investment

Another component of equity based awards is that certain members of senior management, including certain named executive officers, and the board of directors are provided with the opportunity to invest in the common stock of Parent. We consider this investment opportunity an important part of our equity program because it encourages stock ownership and aligns the investing executive officer s financial interests with those of our stockholders. In January 2015, Mr. Erdell purchased 341 shares of Parent common stock at $1,465 per share for $499,565. No other named executive officers co-invested in Parent in 2015.

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Perquisites and Other Benefits

Our named executive officers are eligible to receive the same benefits we provide, and to participate in all plans we offer, to other full-time employees, including health and dental insurance, group term life insurance, short- and long-term disability insurance, other health and welfare benefits, our 401(k) Savings Plan (including Change Healthcare s matching contribution) and other voluntary benefits. Perquisites, however, are not a material component of our executive compensation programs.

In 2015, the only perquisite or other compensation benefits deemed to be other compensation to our named executive officers for purposes of the Summary Compensation Table below were compensation related to Company-requested attendance at Company-sponsored award trips. See Summary Compensation Table below.

Severance and Change in Control Protection

Each of our named executive officers is party to an employment agreement with us governing the terms of their employment with us and future separation, as applicable. Pursuant to these employment agreements, we provide salary continuation and other benefits in the event of involuntary or, in certain cases, constructive termination of employment without cause. Each such employment agreement was negotiated with the respective named executive officer and specifies certain terms of compensation, including an annual rate of base salary and eligibility for an annual cash bonus. Pursuant to these employment agreements, each named executive officer is subject to restrictive covenants, including confidentiality, non-competition and non-solicitation obligations. The employment of each named executive officer under these employment agreements continues in effect until terminated by us or by the named executive officer.

Pursuant to the award agreements under the Parent Equity Plan, the awards granted to each named executive officer include acceleration of vesting features in connection with a change of control (as defined in the Stockholders Agreement). All outstanding unvested (i) Tier 1 and Tier 2 Time-Vesting Options will vest in full to the extent not previously forfeited; (ii) 2x Exit-Vesting Options,which vest, subject to the optionee s continued employment through the vesting date, on the date when Blackstone has sold at least 25% of the maximum number of Parent shares held by it from time to time, and shall have received cash proceeds in respect of all such Parent shares at a weighted average price per Parent share that is (a) equal to at least 2.0 times Blackstone s cumulative invested capital (measured on a per Parent share basis) in Parent (the 2x MOIC Hurdle) or (b) sufficient to result in an annual internal rate of return on Blackstone s cumulative invested capital in Parent of at least 20% (the 20% IRR Hurdle), will become fully vested if either the 2x MOIC Hurdle or the 20% IRR Hurdle is satisfied in connection with the change of control; (iii) 2.5x Exit-Vesting Options will become fully vested if either the 2.5x MOIC Hurdle or 25% IRR Hurdle is satisfied in connection with the change of control; and (iv) 3x Exit-Vesting Options will become fully vested if either the 3x MOIC Hurdle or 30% IRR Hurdle is satisfied in connection with the change of control. In addition, Mr. Giles s restricted share units (RSUs) will vest in full if his employment is terminated (i) by the Company without cause or due to death or disability; (ii) by Mr. Giles for good reason, as defined in his agreement; or (iii) due to a change of control.

The protections afforded by the employment and equity award agreements were, and continue to be, designed to provide financial security in the event of certain corporate transactions and/or qualifying termination of employment, as well as consideration for the executive s compliance with post-employment restrictive covenants. We believe that these protections have assisted, and continue to assist, in retaining our named executive officers and provide a basis for continuing the cohesive operation of our business. These payments and benefits are described in more detail in the section entitled Potential Payments Upon Termination or Change in Control.

Risk Guidelines

The structure of our compensation programs is designed to promote behavior that supports value creation for our stockholders. We believe that the attention of our named executive officers and other key employees should be focused upon key strategic, operational and financial measures. To this end, a considerable portion of the compensation packages of our named executive officers and other key employees is driven by our long-term success. By focusing upon our sustained profitability and growth, we believe our compensation programs discourage our named executive officers and other employees from engaging in unnecessary and excessive risk taking.

Accounting and Tax Matters

We account for stock-based payments in accordance with FASB Accounting Standards Codification Topic 718, Compensation Stock Compensation (FASB ASC Topic 718). We operate our compensation programs with the intention of complying with compensation rules under Sections 409A and 162(m) of the Internal Revenue Code of 1986, as amended (the Code). Section 162(m) generally denies a federal income tax deduction for certain compensation in excess of $1 million per year paid to certain executive officers of a publicly-traded equity company. Certain types of compensation are excluded from the deduction limit.

Because we are a privately-owned company, we are not subject to the limitations imposed by Section 162(m). The compensation committee, however, intends to take actions that are deemed to be in the best interest of the Company and its stockholders and to maximize the effectiveness of the Company s executive compensation plans. Accordingly, we presently consider the tax, accounting and disclosure consequences to be influential but not determining factors in the design of our named executive officer compensation packages.

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Compensation Committee Interlocks and Insider Participation

During 2015, none of our executive officers served as a member of the board of directors or compensation committee of any entity that has one or more executive officers who serve on our board of directors or the compensation committee.

Compensation Committee Report

The compensation committee has reviewed the foregoing Compensation Discussion and Analysis and discussed it with management and, based on such review and discussion, recommended to the board of directors that the Compensation Discussion and Analysis be included in this Annual Report.

Submitted by the compensation committee of the board of directors,

Howard Lance

Neil P. Simpkins

Allen R. Thorpe

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Summary Compensation Table

The following table summarizes the compensation earned by each of our named executive officers for the years ended December 31, 2015, 2014 and 2013.

Name and Principal Position	Year	Salary ($)	Bonus ($) [1]	Stock Awards ($)	Option Awards ($) [2]	Non-Equity Incentive Plan Compensation ($) [3]	All Other Compensation ($) [4]	Total ($)
Neil E. de Crescenzo	2015	720,673				280,469	427	1,001,569
Chief Executive Officer	2014	700,000				725,000	10,566	1,435,566
	2013	175,000	25,000		9,876,423	187,600	25,000	10,289,023
Randy Giles[5]	2015	461,163				153,256	575	614,994
Chief Financial Officer	2014	405,000		1,530,000	3,295,742	383,000	5,873	5,619,615
	2013							
Alex Choy[5]	2015	435,543				167,746		603,289
Executive Vice President	2014							
Research and Development and CIO	2013							
Jason Erdell[5]	2015	353,077			1,242,215	100,000	2,406	1,697,698
Executive Vice President	2014							
Technology-enabled Services	2013							
Kriten Joshi[5]	2015	435,543				144,742		580,285
Executive Vice President	2014							
Products	2013							

(1) The amount reported in this column for 2013 reflects a special bonus paid to Mr. de Crescenzo in recognition of significant contributions to the Company.

(2) The amounts reported in these columns for 2015 represent the aggregate grant date fair value of the awards computed in accordance with FASB ASC Topic 718. Additional information regarding the awards is set forth in the tables and notes in the sections entitled Grants of Plan-Based Awards During 2015 and Outstanding Equity Awards at December 31, 2015. Please see Note 13 to the consolidated financial statements for the year ended December 31, 2015 included elsewhere in this Annual Report for more information on how amounts in these columns are calculated.

(3) The amounts reported in this column were paid under our Management Bonus Program.

(4) For 2015, additional compensation includes compensation related to Company-requested attendance at Company-sponsored award trips.

(5) Mr. Giles was not a named executive officer for the year ended December 31, 2013. Messrs. Choy, Erdell and Joshi were not named executive officers for the years ended December 31, 2014 and 2013. Therefore, only compensation for the applicable years in which they served as executive officers of the Company is included in the table.

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Grants of Plan-Based Awards During 2015

The following table summarizes (i) awards granted under our Management Bonus Program and (ii) awards of options to purchase shares of Parent common stock during 2015.

Grant of Plan Based Awards During 2015

		Estimated Future Payouts Under Non-Equity Incentive Plan Awards[1]			Estimated Future Payouts Under Equity Incentive Plan Awards			All Other Stock Awards: Number of Shares or Stock Units	All Other Option Awards: Number of Securities Underlying Options	Exercise or Base Price of Option Awards	Grant Date Fair Value of Stock and Option Awards
Name	Grant Date	Threshold ($)[2]	Target ($)	Maximum ($)[3]	Threshold (#)	Target (#)	Maximum (#)	(#)		($/Sh)	($)[4]
Neil E. de Crescenzo Chief Executive Officer	2/24/2015	180,250	721,000	1,442,000							
Randy Giles Chief Financial Officer	2/24/2015	98,464	393,975	787,950							
Alex Choy Executive Vice President Research and Development and CIO	2/24/2015	87,550	350,200	700,400							