HARVARD T.H. CHAN | SCHOOL OF PUBLIC HEALTH

Envision Health and Out-of-Network Billing

> *"In the face of prolonged macro challenges in our industry, we are taking proactive and decisive actions to improve operational performance, convert out-of-network services to participating, or in-network status, and execute on a strategy that will be core to our long-term success."*
>
> Christopher A. Holden, President and CEO of Envision Healthcare (EVHC)[1], January 4, 2018.

Envision's 2017 third quarter results were well below analysts' expectations, pushing share prices down 40% in the week following the earnings announcement. Hurricanes in two of EVHC's key markets, Texas and Florida, had suppressed revenues; other negative forces included a reduction in patient demand for physician services, and a downturn in the growth of net revenue per patient encounter. In addition, the company was facing increasingly negative publicity over their practice of out-of-network billing to patients.

In the fall of 2017, EVHC announced the intention to shift away from out-of-network billings, which had been a key revenue source for its largest division, EmCare. EmCare was a national physician services outsourcing company; two-thirds of its revenue was from providing emergency physician coverage to hospital Emergency Departments (EDs). Out-of-network billings were estimated to represent over 60% of EmCare's billing over the period 2011–2015, and represented about $1 billion of the company's $3.7 billion in revenue in 2016, before its December 2016 merger with AmSurg.[2]

Amid growing negative publicity documenting the prevalence of surprise medical bills and the dominant role that EmCare played in generating them, coupled with class action lawsuits and growing pressures from contracting health systems, health insurers, and federal and state legislators to stop the practice, the company declared its intention to move doctor services in-network over the next 18–24 months. By year-end 2017, EVHC had shifted 40% of EmCare's out-of-network care to in-network by signing contracts with insurance companies that EmCare had not been willing to contract with in the past.

---

[1] Envision Healthcare. "Envision Healthcare Provides Business and Governance Update". 1/4/2018, Nashville TN. http://investor.evhc.net/press-release/2018/envision-healthcare-provides-business-governance-update

[2] Court, E. "Company behind surprise medical bills say it is making a change." MarketWatch, Nov 6, 2017. https://www.marketwatch.com/story/company-behind-surprise-medical-bills-says-its-making-a-change-2017-11-01

One big question was whether EVHC could achieve its goal of 75% in-network billing by the end of 2018 without hurting its bottom line. Poor third quarter results in 2017 put even greater pressure on the company to find ways to enhance revenues and reduce operating expenses to address shareholder expectations.

Background on Emergency Care in the United States

In the decades after World War II through the early 1990s, hospitals changed the way they met the manpower needs of hospital EDs. ED coverage evolved from part-time staffing based on rotating on-call obligations of the hospital's entire admitting staff, or by house staff in teaching hospitals, to 24/7 coverage by board-certified emergency medicine (EM) specialists. The rise of specialized EM training allowed EDs to become a source of diagnosis and treatment for a wide range of problems beyond the traditional fare of life-threatening trauma and heart attacks.

ED use has risen dramatically since the 1990s. In the first millennial decade, ER use grew at twice the rate of population growth, while hospital bed capacity shrank by 198,000 beds. By 2011, there were over 4,500 EDs in the US and approximately 40,000 physicians who treated over 130 million episodes; roughly 20% of the population visited an ED annually. EDs were disproportionately used by the poor and uninsured, at least in part because it was against the law to turn them away; half of all acute care visits provided to Medicaid and CHIP beneficiaries, and two-thirds of acute care visits provided to the uninsured, were provided in the ED. The acuity of visits rose with the increase in EM capabilities; for instance, between 2001 and 2010, EM physician claims at the highest severity codes went from 27 % to 48% of Medicare visits.

As volume and acuity increased, the percentage of hospital admissions from the ED also grew, from 34% in 1993 to 50% by 2009. Two-thirds of non-elective admissions were through the ED, and non-elective admissions were the primary source of growth in hospital admissions since 2003. While the ED as a source of hospital admissions has grown, primary care physician (PCP) referrals for hospital admissions have declined by at least 10%, and by 24% for non-elective admissions. In one survey, 75% of PCPs reported that the primary reason that they stopped referring patients directly to the hospital for non-elective admissions was due to health plan administrative barriers or to the patient's lack of adequate health insurance. In interviews, many PCPs explained that the safest and easiest course of action when they felt a patient needed a non-elective admission (not requiring immediate ED stabilization) was to send the patient to the ED rather than to undertake the time and effort required for the PCP to arrange a direct admission. Nearly half of patients seeking non-trauma-related care reported in one survey that they did not even try to contact their primary provider before heading to the ED, and 80% of those who did contact their PCP were advised to go directly to the ED.

Emergency care was generally profitable for hospitals. One study found that in 2009, average ED profit margins were 7.8%, but varied significantly by payer and by whether or not the patient was admitted to the hospital. Those admitted were significantly more profitable than those who were not; the profit margin was entirely due to privately-insured patients, who generated profit margins of almost 40%. Medicare, Medicaid and the uninsured generated significant losses, at -

15.6%, -35.9%, and -54.4% respectively.[3] If the Medicare patient was admitted, however, the profit margin was a positive 18%. Medicare was the payer for about 50% of admissions originating in the ED as of 2009, up from around 45% in 1993; private insurance covered about 25% of such admissions in 2009, down slightly from 28–30% in the prior fifteen years. Medicaid represented about 12–15% of inpatient admissions originating in the ED over the period 1993–2009.

The Evolution of the EM Specialty

EM is a relatively recently established specialty; the first EM residency program began in 1970, and the specialty reached board-status in 1986. EM residency training covered a wide range of specialties, including anesthesiology, cardiology, critical care, neurology, obstetrics/gynecology, ophthalmology, pediatrics, psychology, resuscitation, toxicology, trauma, disaster management, and wound management. The American College of Emergency Physicians, founded in 1968, led the drive for specialized education and board-certification, a move that was resisted, at first, by physicians in internal medicine, family practice, trauma surgery, cardiology, and other specialties who traditionally rotated through the ED and sometimes attracted new patients for their practices from their on-call duties.

One industry insider observed that an unusual aspect of EM culture was a mindset of being a shift worker who will hold out when hospital demand exceeds supply (e.g., weekends in rural areas) to get paid the highest hourly offer. This behavior generated considerable stress on hospital managements trying to maintain an open ED 24/7, and opened the door for the emergence of contract management groups (CMGs) to relieve management of the burden of ED staffing. As of 2017, two-thirds of hospitals outsourced their EDs, and about a third of those contracted with large national outsourcing firms.

As of 2013, roughly 22% of the total EM physician workforce were employed by national CMGs; another 12% worked for regional CMGs, and 31% worked for local CMGs. The remaining 35% were self-employed. An organization called AAEM (American Academy of Emergency Medicine) was formed in 1993 to represent board-certified EM physicians on issues related to fair business practices with respect to CMGs. See **Exhibit 1** for average EM physician income relative to other specialties.

CMGs hire and manage EM physicians, manage ED operations, and bill third parties for services delivered in the ED. CMGs collect revenues, take a cut for administrative fees, and pay the EM physicians, often on an hourly rate. The two leading national CMGs were EmCare and Team Health, which collectively had a 30% share of the outsourcing market. Many of the hospitals outsourcing to the large national CMGs were small, rural EDs that had difficulty attracting board-certified EM physicians.

[3] Wilson M and Cutler, D. "Emergency Department Profits are Likely to Continue as The Affordable Care Act Expands Coverage." *Health Affairs*. May 2014 33:5.

Commonly in the ED context, CMGs enforce noncompete agreements. These contracts, sometimes a lengthy 20 pages, contain elaborate limitations on physicians' ability to work for rival hospitals over a specified period of time—ultimately creating undue restrictions on hospitals' hiring practices and the ability for subject physicians to have flexibility in their place of work. In particular, if physicians signed such a noncompete agreement, they could be ineligible to work in certain community hospitals. The practice of enforcing noncompete agreements in the ED context was initiated and backed by the founding members of the American Academy of Emergency Physicians (AAEM). Over time, however, noncompetes became highly controversial, with such sentiments as the following: "The noncompete clauses should fall like the Berlin Wall, with a federal law as an effective antidote against them. Otherwise, we'll continue to see our friends roughed up by the high handed. We've already lost too many good physicians who initially had vague career goals in mind. We now have to stem the exodus of some of the best and brightest in our specialty."[4] In more recent years, the AAEM has taken a stance against noncompetes, stating that such agreements are a "violation of public policy and medical ethics."[5]

EmCare

EmCare, now a division of EVHC, began organizational life in 1972 as a privately-owned CMG, providing physician staffing to emergency rooms of large hospitals in Texas. It became a national company in the 1990s through acquisitions. In 1997, EmCare was acquired by a private company that also owned American Medical Response (AMR), a private ambulance company. In 2005, the private company sold controlling interests in the two subsidiaries to another private group, which took the combined subsidiaries public as Emergency Medical Services (EMSC), with $1.6 billion in revenues. In 2011, a private equity firm acquired ownership of EMSC. In 2013, the private equity firm renamed EMSC "Envision Healthcare Holdings" (EHH) and took it public again. Most recently, in December 2016, EHH merged with AmSurg, a national chain of ambulatory surgery centers, and became Envision Health (EVHC). In 2017, EVHC announced plans to divest AMR and focus on physician and ambulatory services.

As of 2015, EmCare serviced 10% of all EDs in the US, providing 18 million patient encounters in 42 states and the District of Columbia. It also provided anesthesiology, hospital medicine, radiology, and surgical services to healthcare facilities. It hired or subcontracted with physicians and other healthcare professionals to provide professional services within the healthcare facilities with which it contracted, along with billing and collection, risk management, and other administrative services. Two-thirds of EmCare's 2015 revenues of $3.6 billion came from ED staffing. Eighty-three percent of its revenues came from billings to third parties and patients; the remaining 17% came from billings to hospitals and physician groups for administrative services only.

The services that EmCare provided to customers included the following:

[4] Keaney, James K. *The Rape of Emergency Medicine*. American Academy of Emergency Medicine, 1992, p. 303.
[5] https://www.aaem.org/resources/key-issues/em-contracts/restrictive-covenants

- Contract management: providing an on-site medical director at each facility to work with facility management on strategic initiatives, quality improvement programs, and practice improvements such as documentation and utilization patterns
- Staffing of qualified physician and other medical professionals
- Recruiting specialized physicians through proprietary recruiting support systems and databases
- Scheduling to ensure 24-hour coverage at each facility without disruption from physician illness or personal emergencies
- Operational Improvement Assessments to enhance operating and triage systems, turnaround times, patient flow
- Practice Support services to independent physician groups seeking stand-alone management services such as billing and collection, scheduling, and risk management

Exhibit 2 provides EmCare's operating history from 2013–2015, as an operating division of EHH. **Exhibit 3** provides EHH operating history from 2013 through the first nine months of 2016, prior to its merger with AmSurg.

Out-of-Network Billing

In July 2017, the *New York Times* ran a story called "The Company Behind Many Surprise Emergency Room Bills,"[6] describing the phenomenon of out-of-network billing in hospital emergency rooms. Patients in limited network insurance plans such as HMOs would go to an in-network emergency room for care, and later receive an unexpected and sometimes unusually high bill from the emergency room physician for which the patient was responsible, because the physician did not have a contract with the insurer's network. This occurred in 20% of in-network emergency room visits nationwide, but in 15% of hospitals, out-of-network billing rates were over 80%. A substantial share of those 15% outsourced their ED staffing needs to EmCare.

While sometimes a physician did not have a contract with an insurer's network because the plan or product was new to the market or had very small market share, EmCare made it part of their strategy to not seek contracts with insurers because then it was free to charge patients whatever it wanted. The company also believed that this practice put pressure on insurers to seek EM contracts at higher rates than they might otherwise have been willing to pay.

The problem of out-of-network care was also noted for other physician specialties, including surgeons, anesthesiologists, and radiologists. One analysis by America's Health Insurance Plans (AHIP), an insurance advocacy group, put the excess cost billed to consumers at $3.2 billion per year.[7] However, emergency care was particularly susceptible to out-of-network billing because

[6] Creswell J., Abelson R., Sanger-Katz M. "The Company Behind Many Surprise Emergency Room Bills," *New York Times*, July 24, 2017. https://www.nytimes.com/2017/07/24/upshot/the-company-behind-many-surprise-emergency-room-bills.html

[7] America's Health Insurance Plans (AHIP). (2015). Charges Billed by Out-of-Network Providers: Implications for Affordability. Retrieved from https://www.ahip.org/charges-billed-by-out-of-network-providers-implications-for-affordability/

patients have no opportunity to find out whether a doctor is in-network during an emergency. Most patients assumed that all physicians at an in-network facility were also in-network.

The AHIP analysis reviewed 2013–2014 private insurance claims and identified out-of-network billing for over one million high acuity ED visits; the average amount billed was $972, compared to the Medicare rate of $176 (552% higher than Medicare). States showed wide variation in out-of-network rates relative to Medicare; for instance, the rate was 337% of Medicare in Massachusetts, 711% in Florida, and 672% in Texas (see **Exhibit 4**). The study estimated the potential excess annual cost to consumers of EM out-of-network visits to be $921 million.

A National Bureau of Economic Research study published in July 2017 explored the nature, extent, and source of out-of-network billing for emergency care in the United States[8] by reviewing all emergency claims for one national insurer over the period 2011–2015. The authors found that out-of-network physicians charged, on average, 637% of Medicare payment rates, compared to in-network commercial rates of 266% of Medicare rates. Two of the largest national ED staffing companies had different strategies: one, Team Health, had an average out-of-network billing rate of 13%, while EmCare averaged 62%. Other behaviors described in the study were that when EmCare took over a new contract, hospital facility payments increased by 11%, due largely to a 5% increase in imaging rates and a 23 % increase in the rate at which patients were admitted to the hospital. In addition, the study found that EmCare physicians were 43% more likely than the prior contract group to bill for the EM visit at the highest acuity code.

The Rise of Narrow Network Insurance Plans for Privately-Insured Beneficiaries

The likelihood that a patient would inadvertently receive out-of-network services increased with the growth of narrow-network plans.[9] Narrow network plans offered certain advantages over broader network plans. In particular, they increased competitiveness among payers because they negotiated lower rates and selected the best providers who offered high quality care at lower costs. Narrow network plans could offer premiums that were 17–20% lower than broad network plans. As a result, insurers competed more on underlying plan value, an important development in light of regulatory changes such as the Affordable Care Act (ACA) that minimized payer competition based on patient health risk. In addition to changing the competitive dynamics of payers, narrow network plans were believed to induce favorable competition among providers, as they vied for fewer contracts with insurers by demonstrating high value care, conceivably improving the quality and costs of services provided.[10]

Narrow network plans grew in prevalence after the ACA and were frequently included in plans offered on ACA-sponsored insurance exchanges. By 2015, there were 2,930 network plans

---

[8] Cooper, Z; Morton FS, Shekita, N. "Surprise! Out of Network Billing for Emergency Care in the United States." Working Paper 23623. National Bureau of Economic Research. July 2017.
[9] McKinsey Center for U.S. Health System Reform. "Hospital Networks: Evolution of the configurations on the 2015 exchanges." April 2015. In this article, the term "narrow network" was defined as when less than 70% of hospitals in an insurance rating area are participating; ultra-narrow is when 30% or less of the hospitals participate. http://healthcare.mckinsey.com/sites/default/files/2015HospitalNetworks.pdf
[10] Alain Enthoven, Consumer-Choice Health Plan, *New Engl. J. Med.* 298:650-8; 709-20 (1978).

offered on the exchanges; of those, 22% were narrow hospital network, and another 17% were ultra-narrow hospital networks. **Exhibit 5** describes the frequency of narrow network offerings on the insurance exchanges in 2015. It was likely that physician participation was similarly constrained in these networks. While many consumers purchased the narrow network plans because of the lower prices, many did not understand the limits on provider access that the plans represented.

More recently, growing pressures to reduce healthcare costs caused the preponderance of narrow network plans to not only increase on the exchanges but also among private commercial payers.[11] The adequacy of HMO networks has long been regulated, but these measures were dated and largely at the state level, providing virtually no standardized metrics for determining adequacy of plan coverage. Conversely, PPO networks were broader, and patients enrolled in PPO plans could see any provider they wanted in their network. However, PPOs were starting to implement tiered plans in which co-pays and other out-of-pocket expenses for enrollees increased depending on which tier a provider was in.

Due to the growth of narrow network plans, many patients experienced unfamiliar challenges, including a limited provider capacity and greater geographic dispersion of providers.[12] Such downstream effects increased out-of-network costs for patients and reduced patient satisfaction in their health plans. In a nationally representative Consumer Reports survey done in March 2015,[13] 70% of privately-insured Americans gave their health plan a grade of B or better; but among respondents who had received a surprise medical bill, 58% gave their plan a grade of C or lower. Most of those receiving a surprise bill did not understand their rights to appeal or know which state agency handled health insurance complaints. In this survey, of respondents who received a surprise bill that was not satisfactorily resolved (e.g., by having the insurer pay the provider), 75% paid the bill in full (sometimes through a payment plan); 10% negotiated a lower payment with the provider. Only 3% were able to get the provider to write-off the bill.

Impact of Out-of-Network Billing on Patients

The impact of out-of-network, often "surprise," medical bills on patients caused financial problems for many of those patients. Twenty percent of privately-insured non-elderly adults reported problems paying medical bills in the United States in 2016. Risk factors included having health insurance with high deductibles, lower household income, and poor health. A 2015 survey of adults who reported having trouble paying a medical bill found that 32% had received a surprise bill from an out-of-network provider. In that survey, bills from ED physicians represented the largest share of problem bills for patients. Insured patients receiving out-of-network EM bills were often expected to pay the full bill or any difference between what

[11] Mark A. Hall and Paul B. Ginsburg. A Better Approach to Regulating Provider Network Adequacy. USC-Brookings Schaeffer Initiative for Health Policy, September 2017.
[12] Ibid.
[13] Surprise Medical Bills Survey. May 5, 2015. Consumer Reports. http://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf

their insurer negotiated with the provider and the provider's charge (known as "balance billing").[14]

Forty percent of families with problems paying medical bills reported that these bills had a major impact on their lives, from having to forego vacations and household expenditures, to cutting back on basic expenses such as food and clothing, skipping needed medical and dental care, using up their entire savings, and for a few, declaring personal bankruptcy.[15] In addition, surprise billings could lead to financial distress that might deter patients from pursuing timely care they may require in the future.[16]

Regulatory Response

Policies that could protect privately-insured patients from the expense of surprise medical bills required a delicate balancing of the interests of consumers, health insurers, and providers. Complicating the issue further, states had no jurisdiction over self-insured employer-based insurance, which represented almost 60% of all privately-insured workers; only federal remedies applied to self-insured employer plans. To date, no federal proposals have been put forth, although some federal legislators have indicated concern about the prevalence and impact of surprise billing on patients.

Providers are concerned that they will be forced into limited network plans without any leverage over the rates they are paid. Insurers fear that they will be asked to settle the bill through an externally-dictated rate that could make staying out-of-network even more attractive to providers, or be expected to pay substantially higher rates that then must be passed on through premiums. Both groups tend to point the finger at the other. The AHIP study concluded that "the findings of this study underscore the value of the networks organized by health insurance plans to ensure that consumers have access to a wide range of affordable high-quality health care providers and the importance of protecting consumers from excessive out-of-network charges."[17] The AAEM, on the other hand, offered three reasons for surprise bills: "first, insurers are deliberately narrowing their provider networks in order to shift more costs onto their customers (patients) and protect or increase their profit margins […] Second, health insurance premiums […] have skyrocketed under Obamacare. This has driven many consumers to high deductible policies in an attempt to lower their premiums […] And third, patients seem to have forgotten—or never knew—that most physicians, including hospital-based specialists like emergency physicians, are small businessmen and women who own their own practice. Patients

[14] Hamel, L., Norton, M., Pollitz, K., Levitt, L., Claxton, G., & Brodie, M. (2016). The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey. *Kaiser Family Foundation*.
[15] https://www.kff.org/report-section/the-burden-of-medical-debt-section-3-consequences-of-medical-bill-problems/
[16] Smith, K. T., Monti, D., Mir, N., Peters, E., Tipirneni, R., & Politi, M. C. (2018). "Access is necessary but not sufficient: Factors influencing delay and avoidance of health care services." *MDM Policy & Practice*. Advance online publication. doi:10.1177/2381468318760298
[17] AHIP Center for Policy and Research. "Charges Billed by Out-of-Network Providers: Implications for Affordability." September, 2015. P. 5.

often falsely assume that if the hospital is in network with their insurer, all the physicians there will be too."[18]

Few states have any regulatory or legal provisions to address out-of-network billing. The Affordable Care Act required that states review health plans on the health exchanges for network adequacy; if the provider rates were too low, the network might not attract enough providers to meet adequacy standards. However, as of 2017, only six states had a comprehensive approach to address out-of-network billing, and 15 more had partial approaches. The remaining 29 states and DC did not have laws or regulations that addressed the issue.[19]

Four specific elements of protection have been adopted:

- disclosure and transparency in general or at the point of service;
- balance billing prohibitions in certain situations (most commonly the emergency setting);
- hold-harmless provisions that require insurers to settle with the provider in certain settings, such as emergency care;
- setting adequate payment rules, such as requiring payment rates that are set at some percentage above Medicare, or the average in-network payment rate, or requiring an independent dispute mediation to settle on the rate.[20]

In an attempt to enforce these protections, the US Senate submitted two proposals: the Protecting Patients from Surprise Medical Bills Act and the No More Surprise Medical Bills Act of 2018. Both proposals support measures to limit cost sharing to the amount the patient would owe to an in-network provider, but they do not address underlying issues around network adequacy—specifically, ensuring that health plans provide reasonable access to a sufficient number of in-network physicians and healthcare services. Some experts have proposed integrating other measures such as binding arbitration, or streamlined dispute resolution, which would help regulators determine reasonableness of out-of-network bills, provide patients access to a review process that would support needed out-of-network care, and enable physicians to work collaboratively with patients to assist in justifying the need for care outside of their plan's network.[21] As these experts explain, the goal will be to achieve "harmonization of the competing goals of consumer protection and market innovation in state and federal oversight of health plan networks."[22]

---

[18] Walker, A. "A Resource for Emergency Physicians on Balance Billing, Out-of-Network Fees, and Surprise Bills." AAEM. http://www.aaem.org/UserFiles/BalanceBillingPaper.pdf

[19] http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/jun/lucia_balance_billing_ib.pdf

[20] Hoadley, J., Ahn, S., & Lucia, K. (2015). Balance Billing: How Are States Protecting Consumers from Unexpected Charges?. *Center on Health Insurance Reforms, Georgetown University*.

[21] Hall, Mark A., et al. "Reducing Unfair Out-of-Network Billing-Integrated Approaches to Protecting Patients." *New England Journal of Medicine* (2019).

[22] Ibid.

Looking Ahead

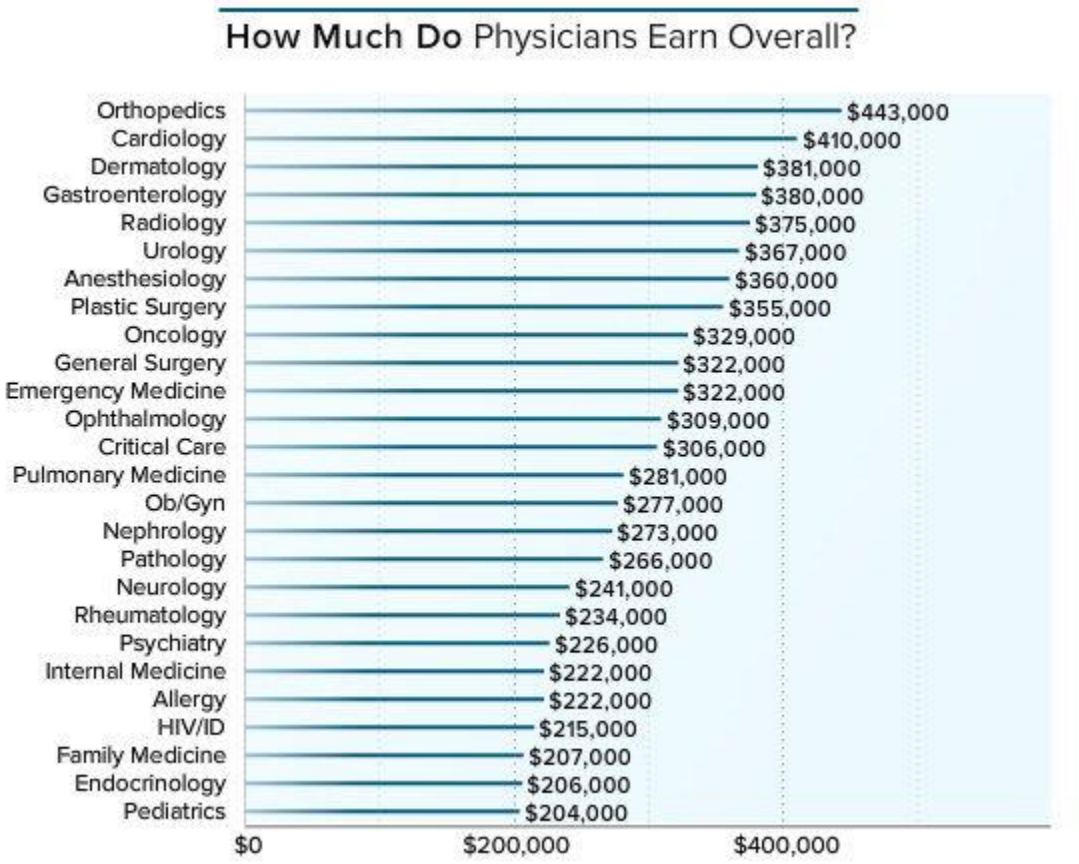
In November 2017, Envision Healthcare reported to investors that it had migrated 40% of its out-of-network care to in-network status, and was committed to reducing out-of-network exposure to less than 5% of total revenue for the company by the end of 2018. Besides external pressures, there were also financial reasons to go in-network; collections from self-paying patients were very slow and created significant bad debt write-offs; in-network payments from insurers would be paid much quicker and at known rates that could stabilize business planning.

Meanwhile a new class-action shareholder lawsuit was announced in October 2017, alleging that EVHC had issued materially false and misleading statements that failed to disclose that EmCare routinely arranged for patients who sought treatment at in-network facilities to be treated by out-of-network physicians, that it billed these patients at rates well above in-network rates, and that EmCare revenues were likely to be unsustainable once this conduct came to light. As a result, the lawsuit alleged, EVHC's public statements were materially false and misleading.

In another EVHC-related legal matter, in December 2017, EmCare agreed to pay the federal government $29.8 million to resolve false-claims act allegations claiming that, from 2008–2012, EmCare received remuneration from Health Management Associates (HMA), a hospital management company, to increase Medicare admissions at HMA hospitals by recommending medically unnecessary admissions. HMA made bonus payments to EmCare ED physicians and tied EmCare's retention of existing contracts to increased ED admissions. This lawsuit was the result of a Qui Tam action initiated by a physician practice that lost its HMA contract to EmCare in 2009.

As one WSJ reporter noted in November 2017, it was "unclear how in-network and out-of-network services will factor into the strategic alternatives Envision is considering to enhance shareholder value." Its stock price plunged 40% in the three months after the release of the disappointing 2017 third quarter results (**Exhibit 6**). In the January 2018 update, the Chairman of the Board, James Shelton, confirmed that "The Board is exploring a full range of alternatives to enhance shareholder value… All options are on the table."

Exhibit 1: Medscape Physician Compensation Report 2016



There was considerable geographic variability in EM physician compensation, ranging from the highest averages in the Southwest ($355,000), South Central ($371,000) and Southeastern ($360,000) regions, and the lowest in the Northeast ($278,000) and Northwest ($294,000). Compensation also varied by setting: EMs practicing in hospital settings earned the most ($329,000) while they earned the least in office-based solo practice ($208,000).

Source: Peckham, C. (2016). Medscape physician compensation report 2016. *http://www.medscape.com/features/slideshow/compensation/2016/public/overview*.

Exhibit 2: Results of Operations for EmCare Division, 2013–2015

$ thousands

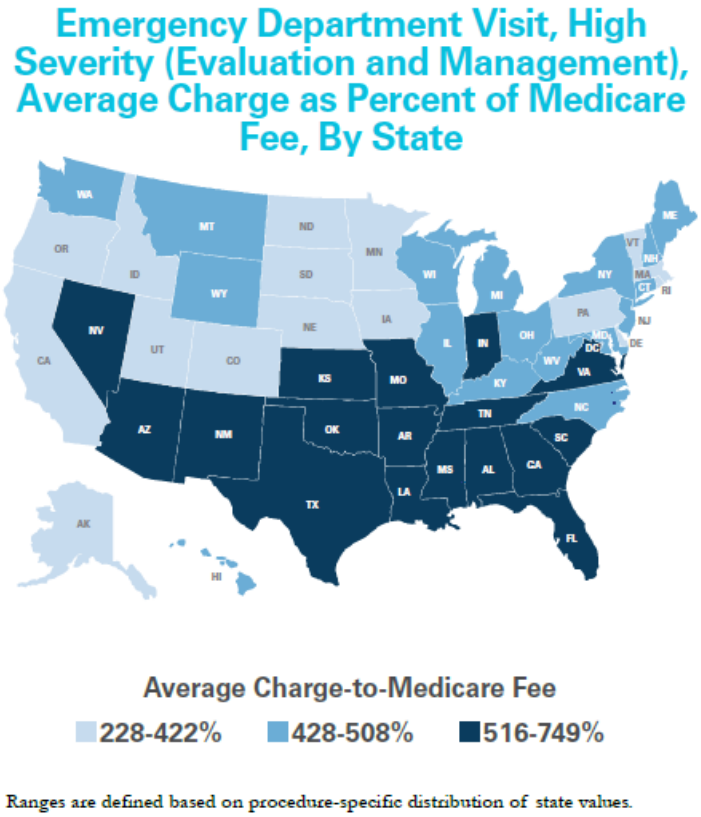
	2015	2014	2013
Net Revenue	3,648,392	2,842,458	2,358,787
Compensation and Benefits	2,922,381	2,258,227	1,860,565
Operating Expenses	195,154	111,624	89,873
Insurance Expenses	95,737	71,855	68,976
Selling, General and Administrative Expenses	68,203	47,979	51,952
Depreciation and Amortization Expenses	97,249	69,242	66,653
Restructuring Charges	30,169	1,036	926
Operating Income before Interest Expense	239,499	282,495	219,842
Operating Margin Before Interest and Taxes	6.6%	9.9%	9.3%

Exhibit 3: Statement of Operations for EHH

$ in Thousands (EmCare and AmSurg)

	9 mos 2016	2015	2014	2013
Revenue net of contractual discounts	8,661,352	9,853,009	7,884,953	6,771,522
Provision for uncompensated care	-3784026	-4,405,093	-3,487,309	-3,043,210
Net Revenue	4,877,326	5,447,916	4,397,644	3,728,312
Compensation and Benefits	3427921	3,922,273	3,156,480	2,667,439
Operating Expenses	772877	681,342	487,841	424,865
Insurance Expenses	108799	145,829	120,983	106,293
Selling, General and Administrative Expenses	122336	120,158	90,731	106,659
Depreciation and Amortization Expenses	178075	182,897	146,155	140,632
Restructuring Charges	7726	30,169	6,968	5,669
Operating Income before Interest Expense	259,592	365,248	388,486	276,755
Interest Expense	117751	117183	110505	186701
Income from Operations	141841	248065	277981	90054
Interest income and realized gains on investments, including equity earnings in unconsolidated subsidiary	2316	1025	1760	1586
Other income(expenses)	743	-966	-3980	-12760
Loss on early debt extinguishment	0	0	-66397	-68379
Income before taxes and noncontrolling interests	144900	248124	209364	10501
Income tax (expense) benefit	-53611	-97375	-89498	994
Net income	91289	150749	119866	11495
Net (income) loss attributable to noncontrolling interests	-10118	-5858	5642	-5500
Net income attributable to Envision Healthcare Holdings	81171	144891	125508	5995
Operating Margin Before Interest and Taxes	5.3%	6.7%	8.8%	7.4%
Operating Margin After Tax	2.9%	4.6%	6.3%	2.4%

Exhibit 4



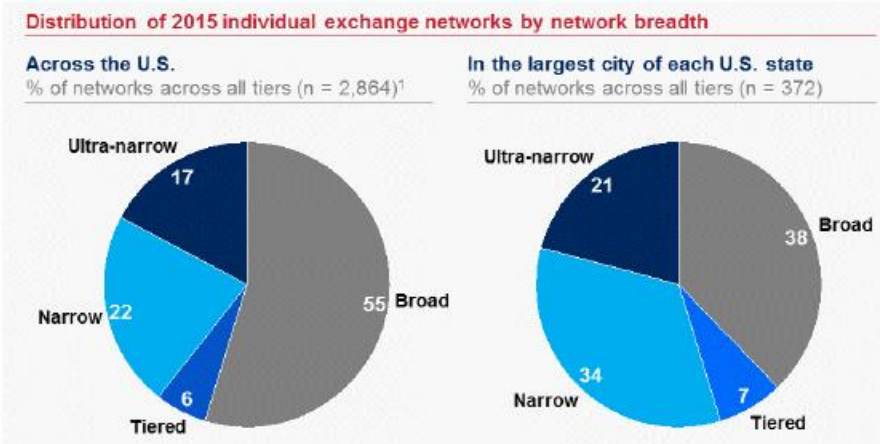
Source: AHIP 2016

Exhibit 5

EXHIBIT 1

2015 consumers are being offered a wide range of network types

Distribution of 2015 individual exchange networks by network breadth



SOURCE: McKinsey Center for U.S. Health System Reform analysis of publicly available network information

Data as of 1.31.2015

1 Of the 2,930 networks in the U.S., 66 are in rating areas that contain no hospitals and thus cannot be assigned a network breadth (breadth is defined by the percentage of hospitals in a rating area that participate in a network). For this reason, the 66 networks are not included in Exhibits 1 and 2.

Exhibit 6

Source: Envision Healthcare Corporation (EVHC) (2013). Profile, business summary. *Yahoo! Finance*. Retrieved from https://finance.yahoo.com/company/envision-healthcare