UC Irvine 2016 Insights: Watch the Regulation, Not the Legislation

Politics Aside, 2016 a Critical Year as CMS Shoots for 50% Value-Based Target

Summary

If we had to pick one conference to attend each year, the UCI HC Forecast Conference would be it: no where else can we get real-time insights from DC budget & HC players, updates on California's unique HC markets, a glimpse into coming innovations, academic theories & business realities and a healthy dose of politics from a distinguished group of speakers. Pain for subacute, change for Medicare Advantage & Alternative Payments for all.

Key Points

Continuity is important: this was our 18th appearance (this analyst is the 'Wall St. View' and wrap-up speaker) at the 25th HC Forecast conference, which has had many of the same speakers over the years, so we know when something changes. This year was especially good and hot: with the Presidential election taking on unforeseen dynamics, how could it be otherwise? The high level important points are as follows: Look for discussions around moving Medicare Advantage rate methodology from a fee-for-service benchmark to an 'alternative payment system.' That could be either a blessing or a curse depending on whether a new system cuts rates or lets the private sector redesign the benefits and make a little money. MSUSA's post-acute view confirmed: a much faster pace and scope of change is real. There is real movement in DC to both push volumes to lower cost post-acute settings, but likely with constraints on reimbursements and excess utilization FIRST. Not good for subacute volumes (SNFs), good for home health - but watch out for more scrutiny of utilization as payments rise over time. Neg for KND, subacute volumes; potentially LT positive for UNH if MA moves away from FFS; hospitals mixed, but okay in ST.

The Politics (of HC and generally) are still extreme: the conservative think tank presenters were even more conservative than before, while the more liberal presenters defended the ACA. That's 'as usual.' But it was clear from the keynote by Norm Ornstein and the commentary around election year politics that the establishments on both sides of the aisle are shocked by Trump's supremacy this late in the game. They have no idea how the health policy/ACA debate would fare under a Trump presidency and can't predict that even a fully Republican DC could work with Trump to repeal/replace. But House Speaker Ryan seems to be preparing for this...watch the House Task Force on health for the next 'replace' blueprint, under either a Trump or Democratic administration, assuming the Senate stays Red, which might not happen.

Company	Symbol	Price (2/19)	Rating Prior	Rating Curr	PT
Amedisys, Inc.	AMED	$35.82	–	Buy	$49.00
Community Health Systems, Inc.	CYH	$14.60	–	U-P	$14.40
HCA, Inc.	HCA	$67.62	–	Buy	$102.00
HealthSouth Corporation	HLS	$31.32	–	Buy	$40.00
Kindred Healthcare, Inc.	KND	$8.96	–	Neutral	$9.00
LifePoint Health, Inc.	LPNT	$61.16	–	Neutral	$59.40
Tenet Healthcare Corp.	THC	$23.82	–	Buy	$30.00
UnitedHealth Group Incorporated	UNH	$117.68	–	Buy	$131.00

Source: Bloomberg and Mizuho Securities USA

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A Unique Event

For 25 years running, the UC Irvine Paul Merage School of Business' Center for Health Care Management and Policy has sponsored the Health Care Forecast Conference. It is a unique event that brings together academics, clinicians, policy makers, Hill staff, think tank thinkers, regulators and members of the business community. The conference timing is intentionally set for the end of President's Day week, i.e., during Congress' recess, so that speakers from the heart of the health care policy world can attend (which often wreaks havoc with our earnings season plans). Politics and policy take center stage on the first day, with the economic outlook and a review of the Federal budget and priorities kicking off the first session. The Washington panel follows, and it is this panel that often has the most influence over our stock calls for the next year. Norm Ornstein, Resident Scholar at the American Enterprise Institute and political commentator extraordinaire, treats the audience to his unvarnished and increasingly concerned views on the American political process and environment. The afternoon of the first day is rounded out by the California panel, a key element of the conference beyond just its California location as that state is often the leader in innovative health care structures and policy. The morning of the second day starts with the innovation panel and finishes with the 'business' view. This year, the theme for the last panel was consolidation. The author of this report has been the closing speaker at the conference for, she's told, 18 years. Her job is to give the Wall Street view of the topic at hand, but it is really to wrap up the conference, get the audience re-engaged in the topics and controversies at hand and tackle some of the most controversial issues raised during the conference. We're told that we're especially well-suited to the task, but leave that for others to decide.

We're not the only ones who see value in the conference. Year after year, the same people attend, either as speakers or observers, but occasionally (as was the case this year), some new speakers are invited to weigh-in on the topics and add a new dimension to the discourse. But we are the only Wall Street Analyst to attend and that's just fine by us. It's not often in this instant information age that we can get a bit of a jump on the rest of the Street and get that jump from publicly available information and in an open forum. Now we'll share what we learned.

It's Wall Street, So Here's the Bottom Line:

Very Rapid Pace, Broad Scope and Value-Driven Change in Medicare Reimbursement Regulation and Policy is Confirmed

Participants in the Federal Budget, Washington and Business panels confirmed two key observations that we made in our 9/30/15 'What if Atlas Shrugs Part II' report on the post-acute sector, i.e.:

a) that CMS is acting faster, more broadly and with more determination than ever before to move the Medicare reimbursement system away from FFS and toward risk- and value-based payment arrangements; and

b) That the near-term goal is to dramatically reduce the use of inpatient care post-acute care and to replace it with community and home-based alternatives.

c) Moreover, these panelists expect that CMS could expand bundling beyond CJR (mandatory hips/knees) to CABGs, something we sensed from our recent dinner with Northwell Health's management.

d) The Oliver Wyman consultant, Sam Glick, on the Business panel, further agreed with our view of the timing of changes (i.e., before the actual pilot starts) and the extent (hospitals get paid the DRG rate anyway in the first year or two, so systems will likely implement new discharge patterns across all of their hospitals irrespective of whether they're in the bundled payment pilot, just as Northwell Health has done).

This confirms our concerns about KND (Neutral, PT $9) and unrated Genesis (GEN) and private HCR Manor Care (related company is HCP, who owns HCRMC's real estate, and which is covered by MSUSA's Rich Anderson).

Hospitals Aren't Fully in the Clear: But We See Little Census/Volume Impact until at Least 2018

The panelists pointed out that bundling for hips and knees under CJR would likely inevitably lead/force the hospitals to consider shorter lengths of stay for the initial procedures in the later years of the mandatory pilot in order to avoid reimbursement hits for failing to hit cost reduction targets.

We agree and have begun to consider the implications of that, but believe that hospitals will easily be able to meet cost reduction targets in the first two years by shifting discharge patterns to reduce subacute inpatient stays. After that, as has been the case with many 'disease management' programs, it is harder to hit the cost reduction targets: that's when we think that hospitals will look to perhaps shift hips from inpatient to ambulatory (no pun intended) procedures. By then technology should catch up with payment incentives.

- Importantly, we began to sense among the policy types that regulators/policy makers are beginning to look at how Medicare can reduce hospital spending overall. After whacking home health, skilled nursing, hospice and MA, it may be the hospitals' turn again, and that probably includes IRFs.

- But there were no specific or targeted cuts mentioned and, more importantly, NO sense of imminence here.

- HCA remains one of our two top picks for February 2016 and is Buy-rated with a $102 one-year PT. THC is Buy-rated with a $30 one-year PT as there is now an activist shareholder involved.

Medicare Advantage: Population Demographics Could Drive a Move Away from FFS Benchmarks to 'Alternative Payment Method'

A number of speakers on the Budget and Washington panels noted that the rapid aging of the population and the impact on the budget and specific health care programs. The most obvious one is, of course, Medicare, and the most obvious part of Medicare to be affected is Medicare Advantage. Its membership is growing faster than FFS and soon looks likely to dominate the payment system.

Currently, rates and rules for MA are set through a complex and cumbersome process that uses the FFS rate as the benchmark for the MA rate increase. The Advance Notice (Call Letter) just came out last Friday (and it looks to be up just over 3% all-in for most plans) for the preliminary rate, with the final rate due on April 1.

- The argument put forth by the panelists is simple: as MA becomes the majority method for payment/delivery of Medicare benefits, why should its rate be tied to the minority and unmanaged fee for service program?

- We agree: it's logic and math, so how could we not. But as always, the devil will be in the details.

- The impetus appears to be the overarching plan to move 50% of CMS' Medicare payments to value-based systems by 2018, up from 30% this year. MA is a big chunk of its payments and it too needs to move to a more value-based and, we argue, modern and simple structure.

In theory, the plans would be able to really put their capabilities to work in benefit design, cost containment and patient management under an Alternative Payment Method scheme. However, we can also see where CMS could take this as an opportunity to add complexity rather than eliminate it and also to therefore cut reimbursement, rather than keep it budget-neutral.

Importantly, discussions around this concept are just beginning: this is one of the reasons we go to the conference – we get the 'heads-up' several seasons ahead of time. APMs are, for now, just something to watch, in our view. Look for CMS to engage study groups and solicit comments on structures for MA as an APM in the coming years.

UNH is our other top pick for February 2016 and is the largest player in the MA space. Our one-year PT is $131.

The Budget, Politics and Health Policy: Some Bravery amidst the Bunkum

First, it's a Presidential election year, so little is expected to come out of Congress in the form of legislation, but that's okay. The last budget deal was a two-year deal: Congress does NOT need to pass a budget this year. Obama's budget, not that it ever

had a chance of passage, was therefore even less meaningful in terms of the legislative agenda than usual, even for a lame duck President.

Second, that doesn't mean that nothing is being done. In particular, the GOP House leadership has formed a task force Co-Chaired by the elite of the GOP House leadership (Brady – Ways & Means; Upton – Energy & Commerce; Kline – Education & Workforce; Price – Budget) with the objective of creating the GOP platform's plan for replacing the ACA. According to the presenter, Jim Capretta of the Ethics and Public Policy Center, this is not the usual useless task force and it is expected that the output will be used to guide the party under a Republican president to repeal and replace quickly and effectively.

- The report is due in late spring/early summer 2016, so watch for that.

Of course, the party machinery didn't count on Donald Trump leading the race and looking, at least at this time, as if he could be the nominee. Trump may not take kindly to having anyone dictate policy, even the House GOP leadership.

By the way, as the presenter noted (and confirming our thought as well), this was exactly the same structure used by Senator Max Baucus to create what became the core of the Senate version of the ACA and later the law itself. So this isn't a random idea: it's a well-tested method of crafting a policy document that could pass Congress.

Third, both the ACA and MACRA (the SGR fix law) impose a massive regulatory legislative authority on CMS. Remember those roughly '2,000' instances of 'the Secretary shall…' devise the regulations supporting the ACA? The agency has been working through that, but now has to write the rules that implement the doc fee fix.

The smart guys on the panel, all policy experts, weren't exactly sure how CMS was going to be able to do that, but then again the same skepticism was expressed about how CMS could implement the coverage provisions of the ACA, too.

- The point is that CMS is going to have a busy year, so expect a lot of late Friday press releases outlining new policies and payment methods in 2016/17.

- Regulations, not legislation, will likely make the headlines this year.

Fourth, and we can't stress this enough, the 'political tribalism,' as Norm Ornstein terms it, is clearly increasing and has led us to have, among other even more important problems, a dysfunctional health care system. For example, one of the budget panelists, newcomer G. William Hoagland of the Bipartisan Policy Center, to the very brave chance of being a Conservative who acknowledged that with the aging of the population, the only way to address the soaring deficit will be to raise revenue. We respect him for acknowledging that party doctrine can't trump (no pun intended) facts and for taking that chance.

In another example, the ACA has problems that simple legislative fixes would address, yet they can't be corrected because the 'tribes' can't cross party lines to do the logical thing. To get the SGR fix done, the then-House-leaders had to have their staffs act in secret collaboration to find pay-fors…even though the entire Congress wanted to get that monkey off its back once and for all and while it was 'cheap.' To do the work of the nation, seasoned Hill staffers from opposing parties had to engage in ridiculous levels of intrigue to avoid having anyone make the connection that they were working together for the common good. Discovery would have meant failure and accusations of betrayal of the 'party.' The resulting legislation, which of course did finally pass, has to be suboptimal, i.e., the best that could be gotten under the circumstances, not the best that could be gotten done. We wonder if we're alone in being concerned about the future if doing the right thing for the country is deemed an act of betrayal?

Repeal/Replace? Or Repeat?

As we noted above, our favorite panel is the Washington panel on the morning of the first day of the conference. Never one to shy away from a bit of controversy and always one to be eager to learn more about politics and policy, the panel rarely disappoints. This year, it was 'hot.'

First, we had a couple of new participants: the aforementioned James Capretta and Keith Fontenot. Mr. Capretta is clearly a Conservative, a Bush 43 administration alumni, while Mr. Fontenot is not. Keith was at OMB and CBO and was directly involved in preparing for implementation of the ACA. He is now the Director of the Government Relations and Public Policy department of Hooper, Lundy & Bookman, PC. Returning for a second year was Wendell Primus., Ph.D., who is the Senior Policy Advisor on Budget and Health issues for Nancy Pelosi: he's clearly not a Conservative. Finally, rounding out the panel, Joseph Antos, Ph.D. returned for his annual stint as the voice of the Conservative view of all things ACA. Joe is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI). He is also a friend (despite his politics).

Second, the topic was 'hot:' It was, of course, the notion of replacing the ACA. The AEI recently published a bound document (70 pages) entitled, "Improving Health and Health Care: An Agenda for Reform" sponsored by ten authors. Joe Antos and Jim Capretta (who is a visiting fellow at the AEI) and Gail Wilensky are among them. The bones of the plan were presented to the attendees. The bullet point version:

- Retention of employer-based tax preference (of health insurance benefit expense) with an upper limit;
- Refundable tax credits to defray the cost of non-employer coverage;
- "Continuous coverage protection" (more on this one below);
- Transition (from the ACA to the new replacement plan)
- Divide Medicaid into able-bodied/children and disabled/elderly (interesting);
- Separate Medicaid per-capita payments to states

- Integrate the able-bodied and their kids into the private insurance system (so no more CHIP and Medicaid for them: we knew there was a catch).

http://www.aei.org/wp-content/uploads/2015/12/Improving-Health-and-Health-Care-online.pdf

At least in this instance some thought and work went into crafting a replacement. We've looked through the document and there are some interesting notions there. For example, the states would get more power to regulate insurance (gee, didn't they have that if they wanted to set up an exchange?) and providers/participants in the health care industry would have more freedom to innovate. We like that.

But it's the continuous coverage provision that intrigued the audience. When the panel was asked what that was, we were told that it would:

- 'require that the uninsured/those with pre-existing conditions be guaranteed coverage if they lost their job (or presumably if their ACA plan is replaced)

- …and they would have a year to buy such coverage or else face a fine.'

Gee, that sure does sound just like something familiar…oh yes, the individual mandate.

Naturally, this analyst couldn't help remarking upon that observation out loud.

And then something interesting happened. We've often wondered why the Democrats take so much from the GOP. They just seem to wither up under the constant assaults. Then we experienced it…'WHO ARE YOU?' we were asked. Now it's likely that the panelist really just simply want to know who was asking the question, but it sure made people in the audience act like Democrats under fire from the right. It will surprise no one that we answered and pressed our point.

And the answer, from the panelist, was as we thought…it's a mandate and it's a fine. There's nothing new here…even though the argument was that the individual has the choice – the government isn't forcing it on them. Gee, seems to us that plenty of individuals make that choice now…the ones who can do math and figure out that the penalty is less than a monthly premium without a subsidy…and the ones who can't do math and don't even know how to access and exchange.

We knew we won the point when the next statement was, 'Well our plan does a lot of other things too.' Yes, we know…so does the ACA…and that's part of the problem.

The point here: this is not a political statement. This is an analytical one – be very, very careful in the coming months as the election season heats up even more and as the House task force releases the blueprint for Congress' ideas to replace the ACA that we don't embrace new names for old failed ideas (the mandate doesn't work to support a balanced risk pool). And, be very careful to really think about other ideas that are new. For example, tax credits. The average family plan today in the individual market costs over $20,000 per year according to one of the presentations. Minimum wage gives a full time worker $14,000 per year. Even at a 100% tax rate, the minimum wage worker doesn't earn enough to credit enough to pay the premium. And that's why there are subsidies. You see, even Democrats can do math.

Concluding Thoughts

The forecasts for the coming year are relatively easy to make: lots more regulation; a faster, broader pace of reimbursement method change for FFS Medicare at a pace never seen before and embracing innovative ideas that put risk onto providers in ways never done before; and continue gridlock in Washington. Oh yes, continued consolidation of providers/payers/doctors, to cope with the continued pressures on top lines and shifting of risk.

Beyond 2016, however, the future is nearly impossible to predict beyond the basic numbers. An aging population, negative rates, slowing growth (part of the reason that the budget is broken is because all of the programs we have today were put in place under the assumption of 3% to 4% growth, not 2%) and a growing health care burden will all have to be dealt with by future Administrations and Congresses. The problem is that no one can yet see how Washington will work with a Trump at the helm and can only predict yet more (and intensive) gridlock with a Clinton or Sanders at the helm. But most can and do predict that it will be hard for the GOP to get behind a Ted Cruz at the helm. Whatever the future brings, it will almost surely result in the passage of one key piece of virtual legislation: The Full-Employment Act for Health Care Analysts.

Price Target Calculation and Key Risks

Amedisys, Inc.

AMED is Buy-rated with a $49.00 one-year PT based on PEG of 0.4x our 2017E EPS of $2.49, up 50% from our 2016E EPS of $1.68 and an EV/EBITDA on 2017E of $169.5mm of 10.1x.

Risks to our target include: execution, reimbursement, investigation and legislative risk, among others.

Community Health Systems, Inc.

Our valuation of $14.40 is based on 6.5x our 2016E EV/EBITDA less NCI, and a 10% FCF yield. These reflect likely volume and mix pressures, coupled with high leverage as well as the remaining CVR risk. Risks to valuation include pricing pressure from government and private payers, continued soft volume growth, additional labor cost pressures, further deterioration of bad debt, integration of HMA and turnaround of HMA, physician losses, competition for acquisitions, the pending spin-off and a highly levered balance sheet.

HCA, Inc.

Our valuation of $102 is based on 9.0x our 2016E EV/EBITDA less NCI, a P/E of 16x our $6.45 2016E EPS, for a PEG of 1.0x, blended with our target FCF yield of 5%. The average of these methods yields our $102 PT, which is also consistent with our $105 value from DCF model using a 4.9% WACC (per Bloomberg) and a 1% terminal growth rate. We believe HCA should trade at the high-end of historical EV/EBITDA trends from 2000-2007 given its clear leadership in FCF generation and the continuing growth opportunities that FCF supports, coupled with the potential EPS accretion from the recently announced $3B share repurchase.

Risks to valuation include pricing pressure from government and private payors, continued soft volume growth, further deterioration of bad debt, competition for acquisitions, increasing labor costs and labor market shortages, HITECH payment risk, a levered balance sheet and the implementation of all of the provisions of the ACA.

HealthSouth Corporation

Our price target of $40 is based on 9.2x our 2016E EBITDA, at the lower end of post-acute facility trading ranges of 9-11x. We believe HLS deserves to trade in this range given its free cash flow generation, but see the shifting mix from organic to acquired growth as likely to keep the target multiple at the lower end of that range. Risks to valuation include cuts in reimbursement from private payors and the government, competition, government investigations and litigation, increasing costs (including but not limited to labor costs), increased government regulation and investigations, and potential bundling of payments.

Kindred Healthcare, Inc.

Our one-year PT of $9 for KND shares is based on a 6.0x EV/Core EBITDAR/10.0 EV/Core EBITDA less NCI. Given our post-acute sector concerns, we see these multiples as reasonably valuing KND.

Risks to our PT and rating include but are not limited to: execution risk, reimbursement risk, changes in upstream (hospital volume) and referral patterns in response to

changing reimbursement methods (especially for KND's LTACHs) and incentives, changes in regulations and the potential for M&A (both as a buyer and as a target).

LifePoint Health, Inc.

Our valuation of $59.40 is based on a blend of a 7.0x multiple on our 2016E EV/ EBITDA less NCI and a target 5% FCF yield using our 2016E FCF per share of $2.52, reflecting likely inpatient volume pressures, the dilutive impact of acquisitions in the near term and balanced by its lightly levered balance sheet and FCF. Risks to valuation include pricing pressure from government and private payors, continued soft volume growth, further deterioration of bad debt and competition for acquisitions, excess dilution from acquisitions due to slower than expected improvement in margins and execution risk.

Tenet Healthcare Corp.

Our target valuation of $30 is based on 7.9x our 2016E EV/EBITDA less NCI, reflecting likely positive volume comps and growth prospects in 2016 & announcement of asset sales needed to achieve guidance and fund share repurchases, balanced by THC's high leverage and positive, but still modest FCF. Risks to valuation include pricing pressure from government and private payors, continued soft volume growth, HITECH payment risk, execution risk (including the closing of several transactions in a timely fashion) and further deterioration of bad debt. Further risks may arise from both criminal and civil investigations of the company and/or its hospitals.

UnitedHealth Group Incorporated

Price Target Methodology: Our $131 one-year PT is based on our DCF model using a 2.5% long-term growth rate, which could prove conservative. This equates to 18.4x our likely too conservative 2016 $7.10 EPS estimate.

Key Risks: Among the key risks to our rating and price target are execution risk; reimbursement and regulatory risks; competitive risks and market risk. Further, UNH is modestly exposed to exchange rate risk, with less than 5% of its revenue derived from its global businesses, principally in Brazil. Execution risk includes risks in both the benefits and services businesses. In the benefits business, estimation of cost trends and other actuarial calculations are critical activities as they influence pricing and reserves for the Company's insurance products. Any misstep there could result in a material and negative effect on the stock price. In addition, the Optum services business is highly innovative and technology driven. Missteps there could lead to the potential for material disappointments in results and multiple compression. Reimbursement and regulatory risk could not only affect pricing, but also members served. The timing and extent of such changes are usually out of the Company's control and therefore could represent exogenous events with negative earnings and stock price implications. Should tax subsidies for Federal Exchange premiums be overturned by the Supreme Court, there could be meaningful downside to multiples, earnings and the stock price.

Companies Mentioned (prices as of 2/19)
HCP, Inc. (HCP- Neutral $28.40)

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(As of 2/19)	% of coverage	IB service past 12 mo
Buy (Buy)	52.51%	37.23%
Hold (Neutral)	46.37%	25.30%
Sell (Underperform)	1.12%	0.00%

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