UC Irvine Recap: The Price of Trump

It's the House, Not Just the Senate, on ACA & Debt Ceiling Crises

Summary

The UC Irvine HC Forecast Conference is usually a must-attend event for us, but this year even more so: With Price as Secretary of HHS and Trump as President, we wanted the DC dish from the Washington panel more than ever this year to try to quantify the Price of Trump. We learned a lot, but only recap the key takeaways below. Inside, there's more on tenor and tone, strategy, tax reform and numbers. We weave in the recent leak of the GOP replacement plan that repeals the 'Caid expansion in 2020 and moves to per capita spending limits, the worst of all worlds for GOP governors, not to mention the governed, in our view. The bottom line: We make no change to our thesis, i.e., that the ACA issue is still a potential negative for the hospitals, as chaos still reigns in our nation's capital.

Company	Symbol	Price (2/24)	Rating Prior	Rating Curr	PT
Amedisys, Inc.	AMED	$48.40	–	Neutral	$33.00
Community Health Systems, Inc.	CYH	$9.22	–	Neutral	$7.50
HCA Holdings, Inc.	HCA	$87.07	–	Neutral	$78.00
HealthSouth Corporation	HLS	$42.22	–	Neutral	$44.50
Kindred Healthcare, Inc.	KND	$7.60	–	Neutral	$5.00
LifePoint Health, Inc.	LPNT	$64.10	–	Neutral	$57.00
Quorum Health Corp	QHC	$8.29	–	Neutral	$3.00
Tenet Healthcare Corp.	THC	$21.99	–	Neutral	$22.80
UnitedHealth Group Incorporated	UNH	$163.06	–	Buy	$178.00

Source: Bloomberg and Mizuho Securities USA

Key Points

It will likely be the House, not just the Senate, that could have problems passing Repeal/Replace/Whatever – and the issue will be the Medicaid Expansion. There's the Freedom Caucus on one side and the Tuesday Group on the other, both with about 50 votes, which means that Ryan needs both to agree with each other and they don't. But if it passes, it will almost certainly have to pass with changes to the Medicaid program, including either per capita limits or block grants. While that's bad for hospitals and Medicaid MCOs, they'd each see cuts/ taxes repealed as well.

The debt ceiling issue is a looming crisis – something has to be done by 3/15/17 – and the structural deficit issue has only intensified in the context of ACA repeal, given the impact that ACA cuts and value-based programs have had on reducing per capita spending on Medicare/Caid. The number of 'capitas' just keeps growing too fast. Tax reform and ACA issues could materially increase the deficit: will that matter to Congress and the White House?

Value-based care is working and permeating much of the private sector as health plans refocus on primary care physicians, enabling them with analytics and best practices that drive better outcomes at lower costs. That's not good for post-acute facilities, particularly skilled nursing (which has been our thesis all along), not great for hospitals (avoidance of the ER was a big theme, again part of our thesis) and it's good for those who can provide higher quality and specialized home based services. But it's best for the health plans and other organizations focused on patient-centered care, particularly primary care practices. That's UNH and may be others now that they are refocusing their efforts on the business rather than mergers, at least in the case of two of the bigger ones.

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Three Key Take-Aways

- It will likely be the House, not just the Senate, that could have problems passing Repeal/Replace/Whatever – and the issue will be the Medicaid Expansion. There's the Freedom Caucus on one side and the Tuesday Group on the other, both with about 50 votes, which means that Ryan needs both to agree with each other and they don't. But if it passes, it will almost certainly have to pass with changes to the Medicaid program, including either per capita limits or block grants.
    - It's still impossible to make a call on this, but it doesn't look good for the expansion – it will be up to the 19 GOP governors who expanded Medicaid to save the program.
    - That's about 11 million covered lives, by the way.
    - And no, it wouldn't be good for hospitals or Medicaid managed care plans, but the version of repeal that is floating around now would restore the DSH cuts and repeal the Health Insurance Industry Tax. So that's at least something.
- The debt ceiling issue is a looming crisis – something has to be done by 3/15/17 – and the structural deficit issue has only intensified in the context of ACA repeal, given the impact that ACA cuts and value-based programs have had on reducing per capita spending on Medicare/Caid. The number of 'capitas' just keeps growing too fast. Tax reform and ACA issues could materially increase the deficit: will that matter to Congress and the White House?
- Value-based care is working and permeating much of the private sector as health plans refocus on primary care physicians, enabling them with analytics and best practices that drive better outcomes at lower costs. That's not good for post-acute facilities, particularly skilled nursing (which has been our thesis all along), not great for hospitals (avoidance of the ER was a big theme, again part of our thesis) and it's good for those who can provide higher quality and specialized home based services. But it's best for the health plans and other organizations focused on patient-centered care, particularly primary care practices. That's UNH.

A Unique Event for 26 Years Running

The UC Irvine Paul Merage School of Business' Health Care Forecast Conference, hosted by the esteemed Paul Feldstein, Professor Emeritus, and Margaret Wong, Associate Director of the Center for Health Care Policy, is a unique event: it brings together a mix of presenters and attendees from academia, politics, business, the clinical world and the regulatory community

in an intimate setting. It is specifically held during the Congressional recess so that Congressional staff and lobbyists can attend. From our perspective, it has historically given us the best insight into the likely legislative, regulatory and policy initiatives for the next year of any other source.

This year was, given the backdrop of the drama and chaos that is Washington, no exception.

For one thing, the conference is in California: if there is one state that is sweating bullets over the potential elimination of the Medicaid expansion and other aspects of Repeal, it's that state. It has the most successful state exchange, a vibrant (yet still flawed) Medicaid program and it has some of the lowest costs of insurance (due to the prevalence of HMOs), both for exchanges and other types of insurance plans.

For a second thing, the Washington panel wasn't the only panel that gave good insight into what's likely to happen to Repeal/Replace-whatever and budget issues. The first panel's presentations, which is usually an entertaining look at the usual dry topic of the economic outlook and budget realities, couldn't help but be tinged with almost a sense of futility at discussing budget facts – the frustration that long-time DC policymakers have with the circus that is DC today was palpable, even in discussions of structural deficits. But the Washington panel did live up to our expectations and brought us some nuanced insights that we might not have gained had we not attended.

For a third thing, the clinical panel this year was chock full of *results* from deeply-analytics-based value-based care programs that validate our concerns about facility-based care (both hospitals and SNFs). And we thought it good that those presentations weren't made by Optum or OptumCare because it validates our view (maybe a hope, for the sake of our nation's economy) that the value-based train has left the station.

But before we proceed to the real gist of this report, we must comment about something that surprised us. In years past, we had always sensed a fairly conservative bent to the 'crowd' at the conference. Orange County business leaders were usually well-represented. The more conservative free-market panelists often received a warm welcome at past conferences, even though there had always been plenty of clearly liberal voices arguing for coverage of the uninsured and against high deductible plans.

This year, the crowd was decidedly more progressive, with the vast majority supporting the ACA in a quick poll of the first day audience done by one of the speakers. In fact, the anti-Repeal sentiment was palpable, as was the sense of outrage over some of the commentary and actions coming out of Washington.

That may not be a surprise, given that Trump lost Orange County, but we're talking about the Washington folks too.

In fact, we expected the Conservative/Republicans (we were told by one that to be a Conservative didn't automatically make one a Republican) to be crowing over their victory and the opportunity to finally repeal/replace.

Not so. They were decidedly subdued, working hard not to disparage their long-hoped-for GOP control over the White House, but seemingly also trying to distance themselves from Trump's so-called populist rhetoric and actions.

In fact, the person with the broadest smile was the one whom we least expected to be smiling – Nancy Pelosi's senior staff member for health care issues, Wendell Primus. As they say in DC, it's a lot harder to be in leadership and a lot easier to be the opposition. So perhaps there's hope for a sensible solution for failing exchanges that sit on top of a law who's Medicaid, quality, reimbursement and value-based care initiatives are clearly working.

Key Takeaway: The HOUSE May Not Be Able to Pass Repeal/Replace

The Most Surprising Thing: It's the House that's the Problem, Not Just the Senate – Doing the House Math

One truism in Washington is that it is much easier to be in opposition than in leadership, and with a nominally republican president, the job of the Congressional GOP leadership is even harder: that's because legislation that's passed in the 115th Congress has more than a snowball's chance of becoming law.

So it was much easier in the late 114th Congress for Speaker Ryan to corral his unwieldy group of Republicans into voting for a repeal bill that passed both houses and that was vetoed by President Obama.

Now, though, what passes matters.

So now, the fight gets tough.

And in particular, it's likely to be tough for Speaker Ryan because he has approximately equal-sized, almost diametrically opposed caucuses he needs to satisfy. On the hard right is the Freedom Caucus. At the other end is the more 'centrist' (moderate is a dirty word apparently) Tuesday Group. Both have about 50 members (actually, 54 in the Tuesday Group). As of 2/16/17, there were 238 Republicans and 193 democrats with 4 vacancies according to the US House of Representative Press Gallery.

Let's see, 50 from 238 is 188.

The GOP needs BOTH the Freedom and Tuesday caucuses to vote for whatever replacement scheme it brings to the floor. If it loses either one or even half of both, the bill fails.

The sticking points could be many, but the most obvious one is the issue of the Medicaid expansion. The Freedom Caucus is against it and just made life harder for Ryan by endorsing the 2015 repeal bill that also repealed the Medicaid expansion. So they seem dug-in and have proved in the past that they want the leadership to come to them and that they won't bend.

The Tuesday Group (and the Democrats by and large) generally come from bluer states and from states that expanded.

Add to that, the Republican Governors of the 19 red states that expanded Medicaid are putting pressure on the leadership to keep the expansion and to not eviscerate funding for Medicaid.

So no wonder Wendell Primus, who played a pivotal role in passing the ACA, wasn't as gloomy as we thought he'd be. All the Democrats have to do is stand there. And while that may promote tribalism in Congress, they can do more to protect the ACA by standing pat then by working with the GOP to dismantle it, at least that was the sentiment voiced by several of the presenters.

Oh, and then there's the Senate – no matter what passes the House, the Senate has retained its ability to move slowly and be unable to pass legislation – especially given that the Senate is generally more moderate and Republicans don't have 60 votes. In fact, as in 2009-2010, the marginal voter plays the biggest role. Right now, Collins and Murkowski (Maine and Alaska, respectively) are the pivot point. But the problem for Senate Majority Leader McConnell is that once those two or three are satisfied, two or three other Republicans can become pivotal.

Thus, it seems that repair, rather than replace, might be the ultimate answer from the Senate side. Something like the Cassidy/Collins plan was mentioned as a possible framework for such a bill, but Dean Rosen (who also worked for Senator Frist on the MMA '03) suggested that it 'peaked too soon,' meaning that had it been introduced later in the process, it might have been the bill that formed the framework of something that could pass both Houses.

The GOP Replacement Bill: Something to Make Everyone Unhappy…

In the midst of this conference, just when we thought we had something really insightful, former House Speaker Boehner publicly said that he too thought the House would have trouble passing repeal/whatever.

With respect to timing, the House has already passed its self-imposed deadline of having a bill in committee by 1/27/17. However, mark up is supposed to begin this week (the week of 2/28/17), and the consensus view was that something would start being marked up the week after. To that end, the GOP House revamped the Better Way plan , shifting it decidedly toward the Freedom Caucus position. It would end the Medicaid expansion as of 1/1/20 and rescind subsidies as of 1/1/19. It would create high risk pools (one former

California and Colorado health insurance regulator at the conference told us, "I've run high risk pools….they don't work.") and would pay for it in part by implementing something similar to the Cadillac Tax that the GOP supposedly wanted to repeal before.

To create coverage, it would use tax credits based on age – not income. The tax credit for an older person would be only 2x that of a younger person : $4,000 for a 60 year old and $2,000 for a 30 year old. Oh, the benefits of being covered by one of the most generous health insurance programs in the country: clearly the House has no idea how much it costs to buy insurance, nor does it seem to care if the poor and ill die.

And, to make governors unhappy, the plan would implement per capita Federal payments for Medicaid beneficiaries. But not to worry, there's $100 billion set aside for state 'innovation' grants to fund the high risk population. At least that's better than the $3B proposed by now-Secretary of HHS Price in his May 2015 repeal offering.

As for a mandate of sorts, the plan includes a requirement for continuous coverage, with a premium penalty to be paid for those who don't sign up for or maintain continuous coverage. But that's not a mandate and not a penalty…it's continuous coverage…right?

There was some talk that the scoring of this draft may have come back from CBO with very bad news for the leadership – which may be why the White House won't guarantee that 'replace' will cover everyone currently covered.

The draft is expected to undergo material revision as it works through committees and both Houses…if it even gets to the Senate.

As for the impact on the health care stocks: bye bye to Medicaid means bad news for hospitals and those health plans that benefitted from the expansion. On the other hand, the states will probably need more help than ever from managed care to control Medicaid spending, at least that was the view of one of the speakers from Covered California, the California state exchange. And he should know. And hospitals would get relief from DSH cuts.

Key Takeaway: The # of Capitas Still Matter

Presentation on Federal Budget Issues

Bill Hoagland, Sr. Vice President of the Bipartisan Policy Caucus, is a deeply experienced Washington hand. He's a republican (the small 'r' is a compliment) who worked for Senator Bill Frist when he was majority leader, so he knows the Senate and Congress from the inside-out and has been at the center of action when key health care initiatives (the Medicare Modernization Act of 2003) were passed. So in our view, he knows from whence he speaks.

His points were these – and we think they're important:

1. Even if the current Congress doesn't add to the deficit, the deficit will reverse its narrowing trend and streak higher over the next 10 years, driven by the rising numbers of Medicare eligibles – the capitas.

    a. That's despite the progress made in cutting spending per capita.

    b. By 2027, under current law, the deficit is expected to be $1.4 *trillion* or 5% of GDP (CBO data).

2. The looming debt limit is a cause for concern: If Congress doesn't act, with the national debt now at $20.335 trillion (106% of GDP), on March 16, 2017, the debt limit will be raised to the previous debt level plus the amount of borrowing that has occurred since the limit was extended las fall. The current limit is $18.4 trillion – and assuming that Congress will find time to prevent default, a further suspension until next summer or fall seems likely. That is, of course, if the Senate can agree….and if Ryan can control the fiscal conservatives of the Freedom Caucus in the House.

    a. Very soon, then, investors should look for this debt limit issue to rise to the forefront of the Congressional debate, which might distract from consideration of repeal/whatever of the ACA.

3. Debt held by the 'public,' really China and Japan in large part, is on its way to matching the peak of borrowing during WWII. Put that against the backdrop of political rhetoric about China and currency.

4. Social Security is in deep trouble. By 2031 or so, the trust fund won't have enough money to pay the full amount of scheduled benefits (per the Trustees Report 2016). The amount payable is projected to be 31% below scheduled benefits. As this analyst is a mere 6.5 years away from that magic age of full eligibility, and she's not alone among baby boomers, that's not good.

5. The driver of both the Deficit and the Social Security issues is just that – the impact of the aging baby boom and the lack of population growth behind us. It's NOT per capita spending on health care per a JAMA article from 2016 cited by the presenter:

    a. Per capita Medicare spending growth has been declining since 2000, with acceleration after the 2010 passage of the ACA. By 2014, Medicare per capita spending had declined about 0.5% (a combination of both rate and utilization cuts caused this, based on our other work).

    b. Ditto for per capita Medicaid spending, which growth turned negative in the 2005-2010 period and during 2010 through 2014 declined at a rate of -1% per year.

6. Tax reform was also discussed: President Trump's outline (it's not a full plan yet) would reduce the current $39,931 billion of tax revenue by about $5,300 billion (that's a deficit increase). The House GOP Better Way plan would be less worse for the deficit (and national debt) issue – it would only increase the deficit by about $2,400 billion, according to the Tax Policy Center. Other estimates put the increase in the deficits for both plans at lower levels, but none of the estimates are budget neutral (all data form CBO, Tax Policy Center).

    a. And we confirmed in our discussion that no plan is yet being negotiated in either the House or Senate Committees, just as there is no economic growth bill yet being discussed.

    b. Timing of tax reform is, as we've previously written, the end of 2017 at best. It would require another reconciliation bill (i.e., the FY2018 budget bill) if ACA repeal/whatever is done in the first bill for the FY2017 budget.

7. And in a moment of levity, we saw an analysis of local health outcomes as a predictor of the presidential race for counties that swung from one party in 2012 to the other in 2016: those that swung to the Republicans/Trump were disproportionately sicker (much sicker) than those that swung to the Democrats/Clinton. In fact, the sicker the population, the bigger the swing for Trump. That data was from The Economist in an article published on 11/16/16.

8. Regarding the important unemployment rate: data from Jim Glassman, a long-time presenter at the conference from JP Morgan Chase, examined the issue of those who 'vanished' from the government's workforce measurement. He views the official unemployment rate of 4.8% as missing about 200 bp due to those people who are either under- or unemployed, but not yet returned to the workforce.

In other words, we have a looming debt crisis, a looming deficit crisis and we're cutting taxes. Makes sense, right?

Key Takeaway: Data-Driven Value-Based Primary Care Bends the Cost Curve

Value-Based Care is Working

A common thread across several of the presentations over the two days of the conference was the success that health plans and primary care physicians, as well as innovative companies, are having in materially improving outcomes and lowering costs, especially for the highly acute part of the population. Whether it was Blue Shield of California, or Landmark Health (a relatively new player made up of former Caremore and HealthCare Partners execs as well as others), or the presentation from a Harvard Medical School professor, value-based initiatives generally showed that keeping patients healthier, in

their homes and out of post-acute facilities led to substantially lower costs and better health outcomes.

Landmark works with health plans in four states currently, soon to be six, that have difficulty managing their severely acute populations. These high risk patients account for 5% of membership and 50% of costs in some cases. Through a combination of analytics-based decision-making by primary care physicians and the provision of intensive supportive care in the home, one of Landmarks plans was able to reduce hospital stays by more than 40% at substantial savings to its customer.

Conversely, Dr. Michael McWilliams of Harvard presented data about Medicare Shared Savings Program ACOs. Recall that these are partnerships between hospitals and physicians and specifically exclude health plans from the organization (which we have always thought was bizarre, if not a mistake). Unsurprisingly (at least to us), these programs *did not result in the reduction of hospital stays, but took a big bite out of skilled nursing facility utilization.* As a result, the savings, at least at first blush, don't look to be large. Why would they be: what hospital will voluntarily empty its beds to have the ACO save money?

It's always surprised us that smart people don't understand that.

On the other hand, there is a lot of data from UNH (and probably CI too) that suggests that when doctors and health plans form ACOs, ER and hospital utilization drops like a stone (on average probably around 13%).

Still, it's very clear that the need to provide the right care, at the right time, in the right place, for the right reason at the right price is driving the health care train, irrespective of whether the GOP eviscerates the ACA or not.

Price Target Calculation and Key Risks

Amedisys, Inc.

Our $33 one-year PT is based on a PEG of 0.5x on 34% projected EPS growth from ’16E to ‘17E and an 8.1x EV/EBITDA multiple on 2017E.

Risks to our target include: repeal/replacement of the ACA and bundling, execution, reimbursement, investigation (an active hospice investigation is ongoing in New England and West Virginia and AMED currently operates under a corporate integrity agreement) and legislative risk, among others.

Community Health Systems, Inc.

Our valuation of $7.50 is based on 7.1x our 2017E EV/Pro Forma EBITDA and 7.5x our 2017E Pro Forma EBITDA on a guidance basis, including the assumed $2.3B in sale proceeds as cash. We now expect FCF to be modestly positive in 2017, but still pressured, and see volume guidance as a risk., On the other hand, CYH's stronger than expected recent performance could set up a near-term refinancing and relief versus the 2018/2019 maturity wall. On balance, while we think more of a multiple discount could be warranted, the high level of leverage makes this multiple only a slight discount to leading peers.

Risks to our rating and price target include, but are not limited to, better than expected asset sale results or the involvement of an activist investor, or the acquisition of shares by deep value investors. Factors weighing on valuation include, but are not limited to, relief of the following: 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 asset sales and a highly levered balance sheet. However, CYH may be more successful at cost cutting and growing volume than we think and that could cause upside surprise to be reflected in the stock price. CYH has not yet finalized the value of the CVR, which could result in unexpectedly higher settlement and/or legal costs above the reserve level. ACA repeal risk, along with the risks associated with Medicaid block grants and Medicare privatization also exist.

HCA Holdings, Inc.

Our valuation of $78 is based an equal blend of our $96.49 DCF (5% WACC, 60% debt/total cap, 0% terminal growth), EV/EBITDA less NCI on 2017E multiple of 7.1x and a P/E of 10.6x our 2017E adjusted EPS of $7.37 or $68.41.

Risks to valuation include, but are not limited to, repeal/replacement of the ACA, 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 repeal of all of the provisions of the ACA and the implementation other recent legislation (MACRA and IMPACT), along with the potential for privatization of Medicare and block grants for Medicaid.

HealthSouth Corporation

Our 12-month price target of $44.50 is 9x our 2017E EBITDA of $811mm (vs. $828mm), at the below the low end of post-acute facility trading ranges of 9-11x due to the risks around Medicare reimbursement and repeal/replacement of the ACA.

Risks to valuation include, but are not limited to, repeal/replacement of the ACA, 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 $5 for KND shares is based on 11.9x EV/Core EBITDA less NCI and 6.3x EV/Core EBITDAR. Given our post-acute sector concerns, we see these multiples as reasonably valuing KN, especially given risks to LTACH criteria, bundling and potentially Medicare reimbursement.

Risks to our PT and rating include but are not limited to: repeal/replace the ACA, 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 $57 is based on a 8x multiple on our 2017E EV/EBITDA less NCI, which rises to 7.5x, which includes an estimate of future capex liabilities as 'debt.' We think this multiple is appropriately reflecting likely inpatient volume pressures, the margin-dilutive impact of acquisitions in the near term plus capex commitments associated with them and balanced by its moderately levered balance sheet and smaller, but still positive, 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 and the risk of repeal, Medicaid block grants and Medicare privatization.

Quorum Health Corp

With our below-guide $170mm EBITDA estimate and with serious total net leverage of 6.0x our corresponding $233mm LTM CA EBITDA estimate, the EV multiple explodes in our target price model. At our new target of $3, the stock would trade at 8.2x guidance-basis EBITDA. But if the assets are sold, $3 is only 6.7x our new estimate. While our PT is more than 10% from the current stock price, the low dollar price makes the stock highly volatile.

Risks to our rating and price target include, but are not limited to: repeal/replace the ACA, execution, reimbursement, litigation, regulation, investigation and other market and government-based risks. In addition, QHC, formed through a spin-off from CYH, is a very new company just having been formed on 4/29/15. Thus, it has a limited track record and has had much time to execute on its strategic plan. Our estimates, and therefore our rating and price target, are thus based on extremely limited company-specific information. We expect the shares to be very highly volatile given the small float and high degree of leverage, and the risk of repeal of the Medicaid expansion and the potential for the privatization of Medicare and Medicaid block grants.

Tenet Healthcare Corp.

Our $22.80 PT is based on 6.5x our estimated impact on 2017E EBITDA of the combination of better than expected hospital segment cost cuts of $45 mm, asset sales representing $73mm of EBITDA sold at 10x and the potential for 100 bp lower volume growth. The combined impact suggests a stock price of $22.80. Risks to our price target include, but are not limited to, repeal/replace the ACA, pricing pressure from government and private payors, continued soft volume growth, HITECH payment risk, execution risk (including closing transactions in a timely fashion) and further deterioration of bad debt. Risks associated with health policy changes, ACA repeal,

Medicaid block grants, privatization of Medicare all factored into our target multiple as well, along with the company's highly levered capital structure.

UnitedHealth Group Incorporated

Price Target Methodology: Our $178 one-year PT is based on a 50/50 blend of our DCF model using a 2.5% long-term growth rate, of $178 and a target P/E of 18.5x our 2017E Adjusted EPS of $9.50. Blending the two equally yields our $178 1-year price target for UNH shares.

Key Risks: Among the key risks to our rating and price target are repeal/replace the ACA, 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, but is not limited to, 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. Political/health policy risks could be significant and future national health policy remains highly uncertain.

Companies Mentioned (prices as of 2/24)

Amedisys, Inc. (AMED- Neutral $48.40)
HCA Holdings, Inc. (HCA- Neutral $87.07)
Kindred Healthcare, Inc. (KND- Neutral $7.60)
Quorum Health Corp (QHC- Neutral $8.29)
UnitedHealth Group Incorporated (UNH- Buy $163.06)
Community Health Systems, Inc. (CYH- Neutral $9.22)
HealthSouth Corporation (HLS- Neutral $42.22)
LifePoint Health, Inc. (LPNT- Neutral $64.10)
Tenet Healthcare Corp. (THC- Neutral $21.99)

IMPORTANT DISCLOSURES

The disclosures for the subject companies of this report as well as the disclosures for Mizuho Securities USA Inc. entire coverage universe can be found at https://msusa.bluematrix.com/sellside/Disclosures.action or obtained by contacting EQSupervisoryAnalystUS@us.mizuho-sc.com or via postal mail at Equity Research Editorial Department, Mizuho Securities USA Inc., 320 Park Avenue, 12th Floor, New York NY, 10022.

Investment Risks and Valuation Methods can be located in the following section of this research report - Price Target Calculation and Key Risks.

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None

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Mizuho Securities USA Inc. and or its affiliates makes a market in the following securities: UnitedHealth Group Incorporated, HCA Holdings, Inc., Community Health Systems, Inc., Tenet Healthcare Corp., LifePoint Health, Inc., Kindred Healthcare, Inc. and HealthSouth Corporation

Mizuho Securities USA Inc. and or its affiliates has received compensation for investment banking services for UnitedHealth Group Incorporated and HCA Holdings, Inc. in the past 12 months.

Mizuho Securities USA Inc. and or its affiliates expects to receive or intends to seek compensation for investment banking services for UnitedHealth Group Incorporated in the next 3 months.

Mizuho Securities USA Inc. and or its affiliates has managed or co-managed a public offering of securities for UnitedHealth Group Incorporated and HCA Holdings, Inc. in the past 12 months.

Mizuho Securities USA Inc. and or its affiliates have provided investment banking services for UnitedHealth Group Incorporated and HCA Holdings, Inc. who are or were clients in the past 12 months.
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I, Sheryl R. Skolnick, Ph.D., hereby certify that the views expressed in this research report accurately reflect my personal views about any and all the subject companies. No part of my compensation was, is or will be, directly or indirectly, related to the specific recommendations or views expressed in this research report.

Rating Definitions

Mizuho Securities USA investment ratings are based on the following definitions. Anticipated share price change is based on a 6- to 12-month time frame. Return expectation excludes dividends.

Buy:	Stocks for which the anticipated share price appreciation exceeds 10%.
Neutral:	Stocks for which the anticipated share price appreciation is within 10% of the share price.
Underperform:	Stocks for which the anticipated share price falls by 10% or more.
RS:	Rating Suspended - rating and price objective temporarily suspended.
NR:	No Rating - not covered, and therefore not assigned a rating.

Rating Distribution

(As of 2/24)	% of coverage	IB service past 12 mo
Buy (Buy)	43.62%	40.77%
Hold (Neutral)	53.02%	39.24%
Sell (Underperform)	3.36%	50.00%

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