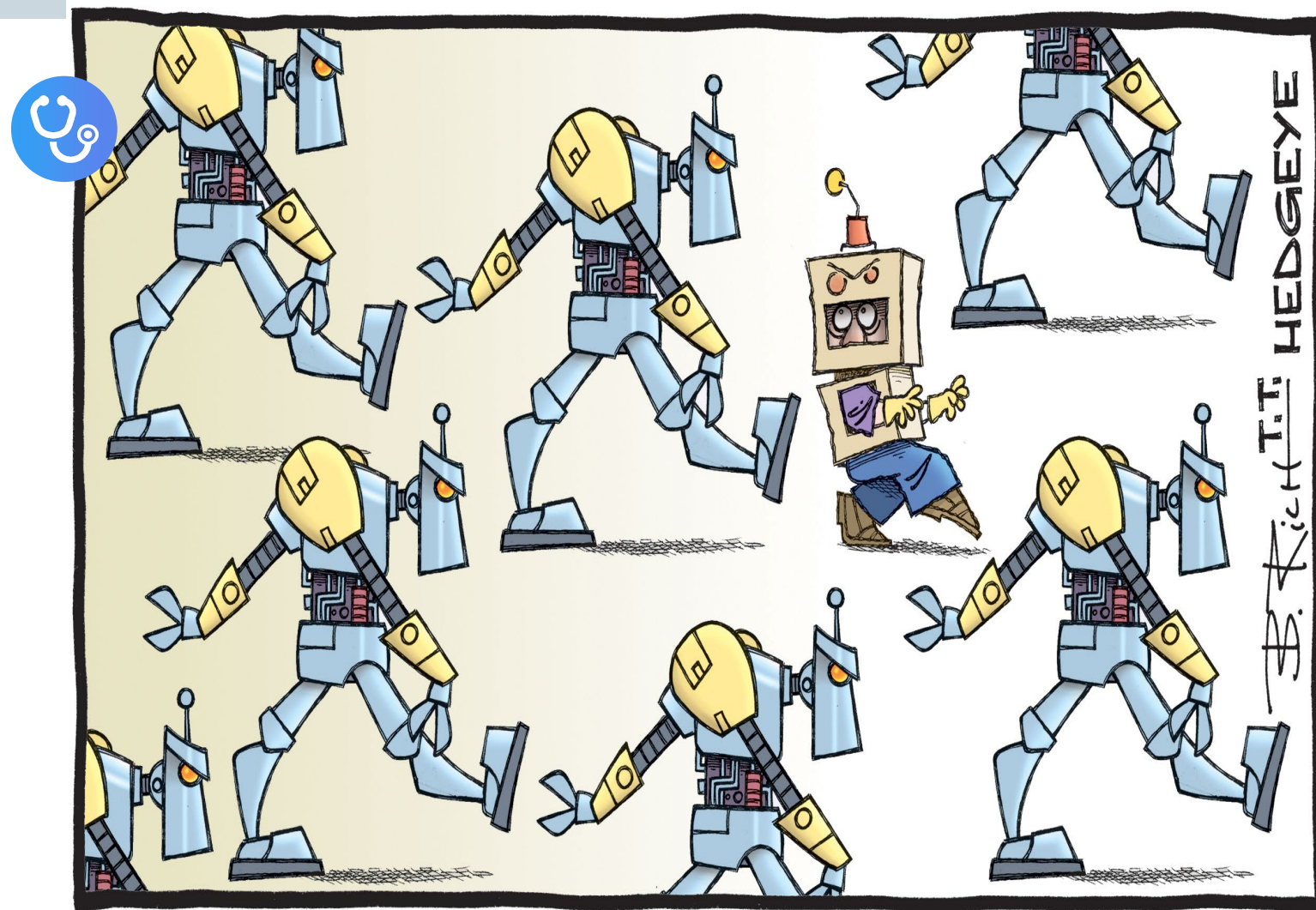


HEDGEYE

Health Care Position Monitor Update

Mednax Update Following UNH Coverage Decision

February 24, 2020



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Please submit questions* to
qa@hedgeye.com

*Answered at the end of the call

Health Care Position Monitor

HEDGEYE

For Week of February 24, 2020

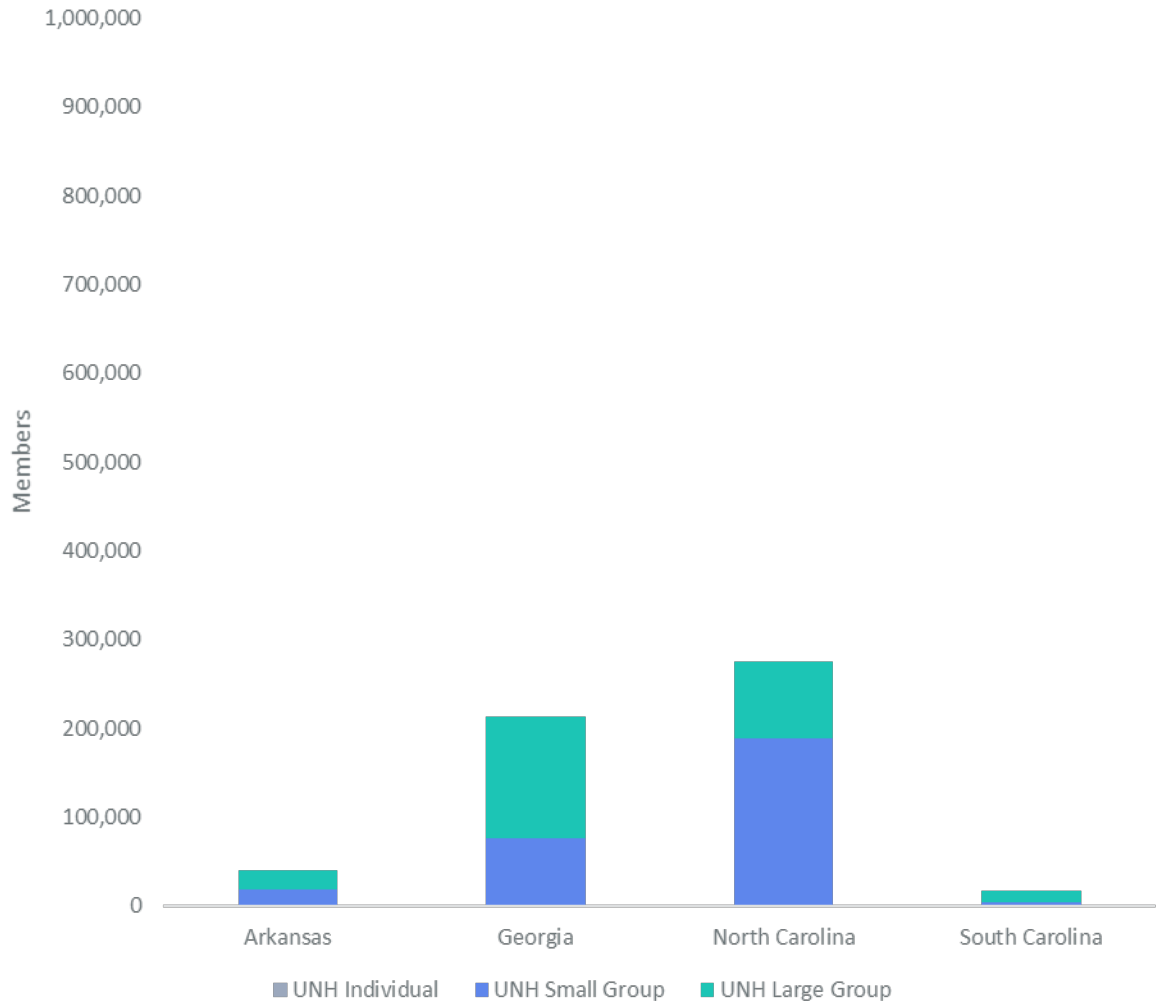
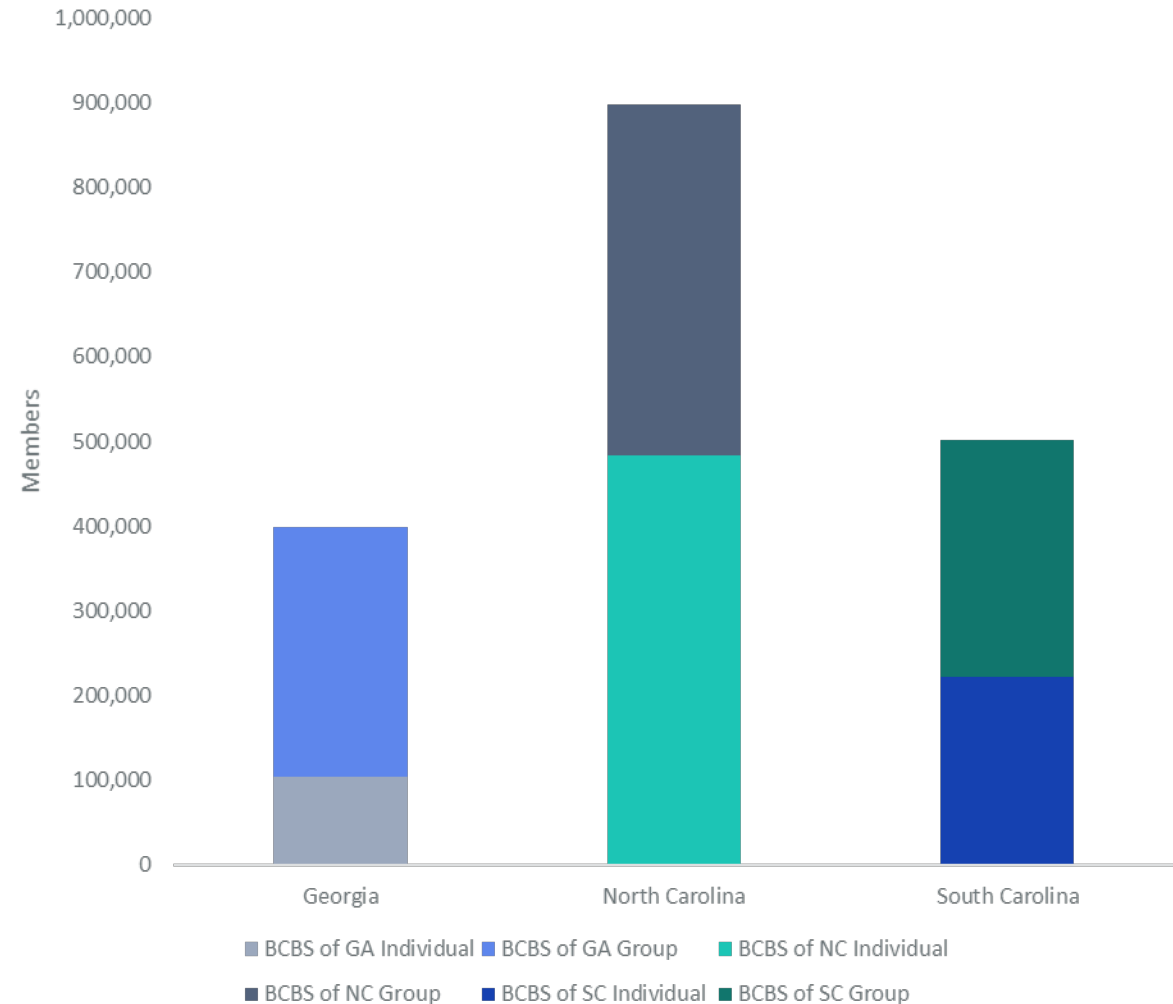
Best Ideas - Longs						Best Ideas - Shorts					
		Price	Mkt Cap (\$B)	Trend	Tail			Price	Mkt Cap (\$B)	Trend	Tail
LONG						SHORT					
Active Longs						Active Shorts					
MD	MEDNAX, Inc.	\$ 25.45	\$2.1B	✓	✓	HQY	HealthEquity Inc	\$ 71.38	\$5.1B	×	×
AMN	AMN Healthcare Services, Inc.	\$ 69.75	\$3.3B	✓		NVTA	Invitae Corp.	\$ 22.99	\$2.3B	×	×
ANTM	Anthem, Inc.	\$ 276.48	\$70.1B	✓							
ILMN	Illumina, Inc.	\$ 294.30	\$43.3B	✓	✓						
THC	Tenet Healthcare Corporation	\$ 33.16	\$3.4B	✓	✓						
GH	Guardant Health, Inc.	\$ 78.48	\$7.4B	✓	✓						
ZBH	Zimmer Biomet Holdings, Inc.	\$ 156.39	\$32.2B	✓	✓						
Long Bias						Short Bias					
TDOC	Teladoc Health, Inc.	\$ 105.84	\$7.7B			DXCM	DexCom, Inc.	\$ 240.22	\$21.9B		
MYGN	Myriad Genetics, Inc.	\$ 21.02	\$1.6B			EXAS	Exact Sciences Corporation	\$ 95.28	\$14.0B		
TXG	10x Genomics Inc Class A	\$ 88.98	\$1.9B			UNH	UnitedHealth Group Incorporated	\$ 289.22	\$274.0B		
SGRY	Surgery Partners, Inc.	\$ 18.01	\$0.9B			DVA	DaVita Inc.	\$ 81.34	\$10.4B		
UHS	Universal Health Services, Inc. Class B	\$ 138.13	\$11.1B			HCA	HCA Healthcare Inc	\$ 145.93	\$49.5B		

Disclaimer

Hedgeye's "bias" represents Hedgeye's outlook on companies currently under Hedgeye's review, or for which timing is not right for greater coverage. Hedgeye may or may not provide further commentary on any or all companies represented on the bench and representation of a company on the bench does not forecast whether Hedgeye will or will not issue any additional material on that company.

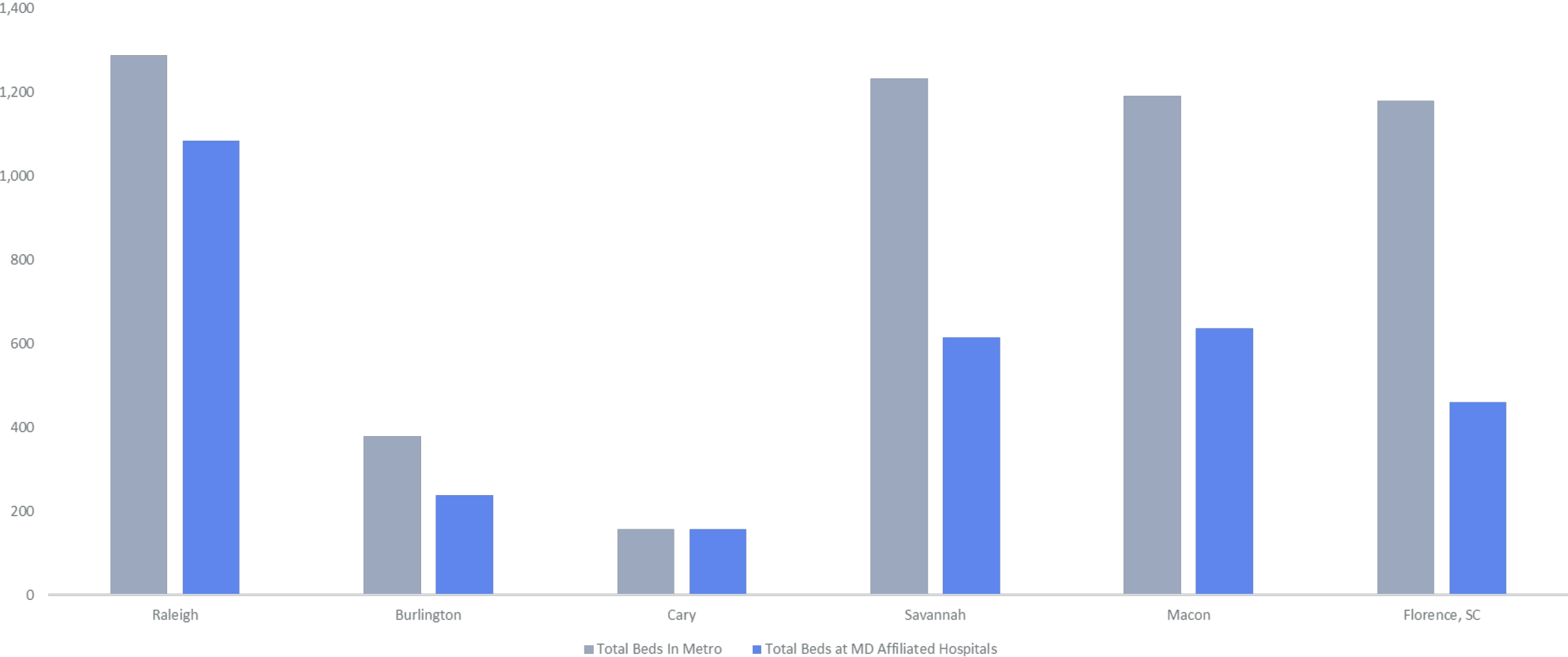
UNH v Blues

As with most markets UNH is not the dominant insurer



North Carolina Leads with Market Power Dynamic

Hospitals are highly concentrated



Federal “Surprise Billing” Legislation

Applicability

- Applies to all insurer types including individual and group, regardless of insured or self-insured
- Applies to emergency services and “ancillary” hospital services: anesthesiology, pathology, radiology, neonatology

Patient Responsibility

- Patient subject to cost-sharing as if service was delivered in-network
- Plan covers service as if in-network and applies cost-sharing to deductibles as appropriate

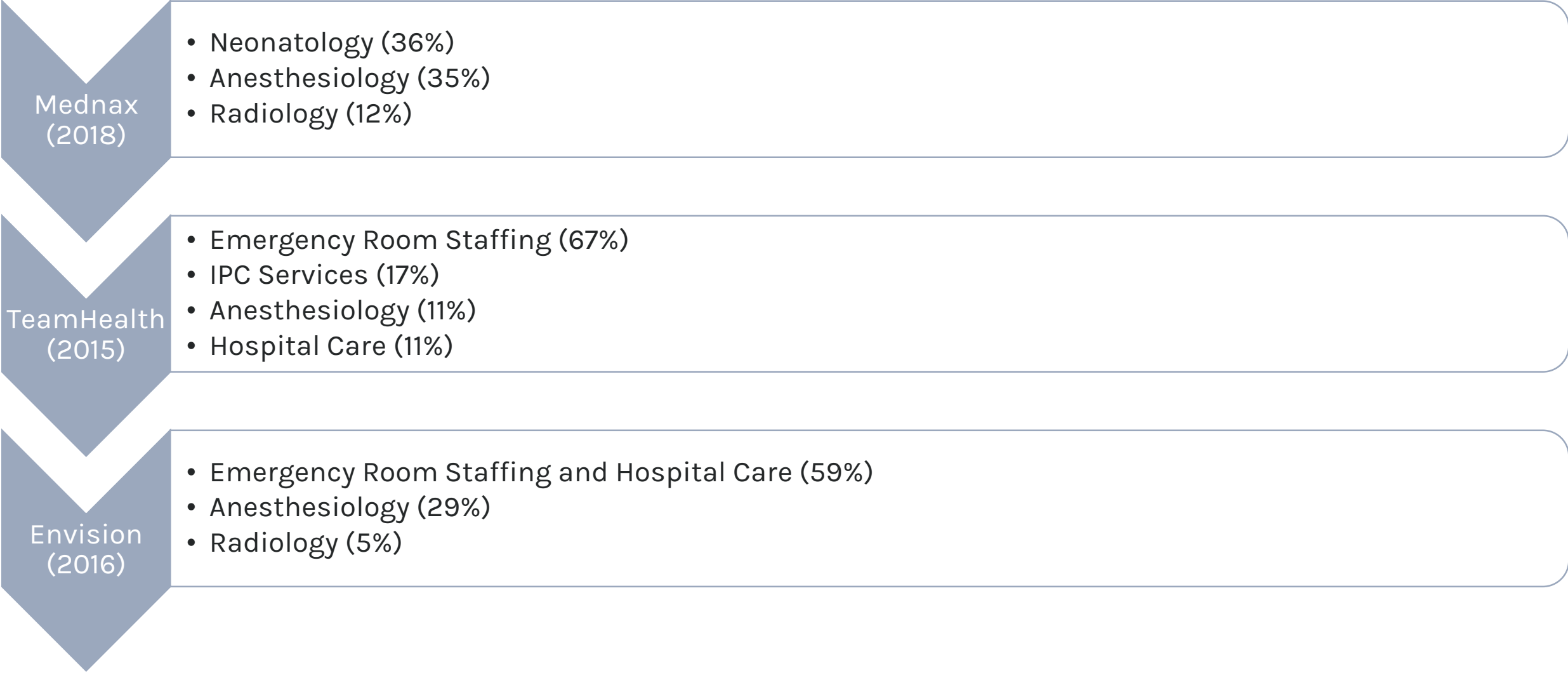
Provider Reimbursement

- Default price paid by plan to provider would be plan’s median in-network rate for same service
- Possible dispute resolution process for bills over \$750/\$1250
- Ways & Means version calls for dispute resolution in all cases

Timing

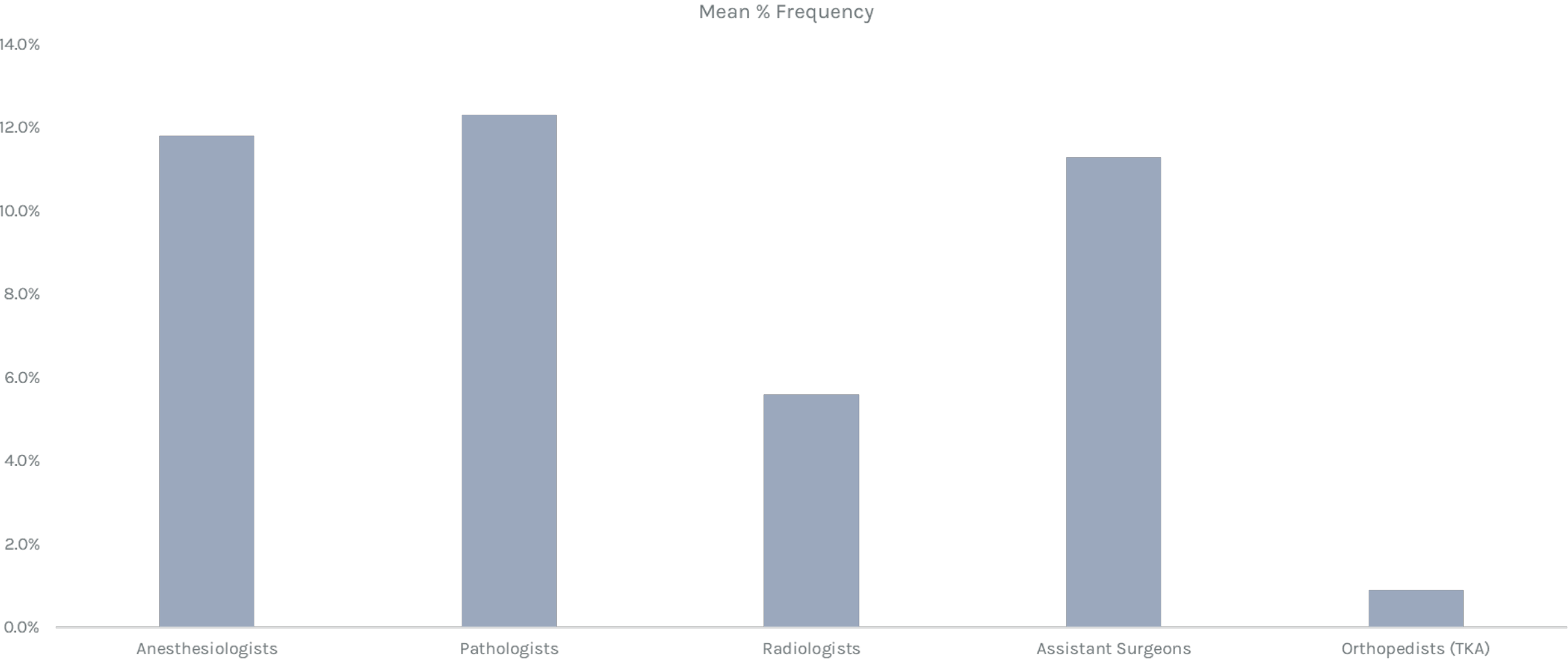
- Mostly effective in 2021 Plan Year
- Consideration deferred until May 2020

Physician Practice Management Companies



Frequency of OON Billing at In-network Hospitals

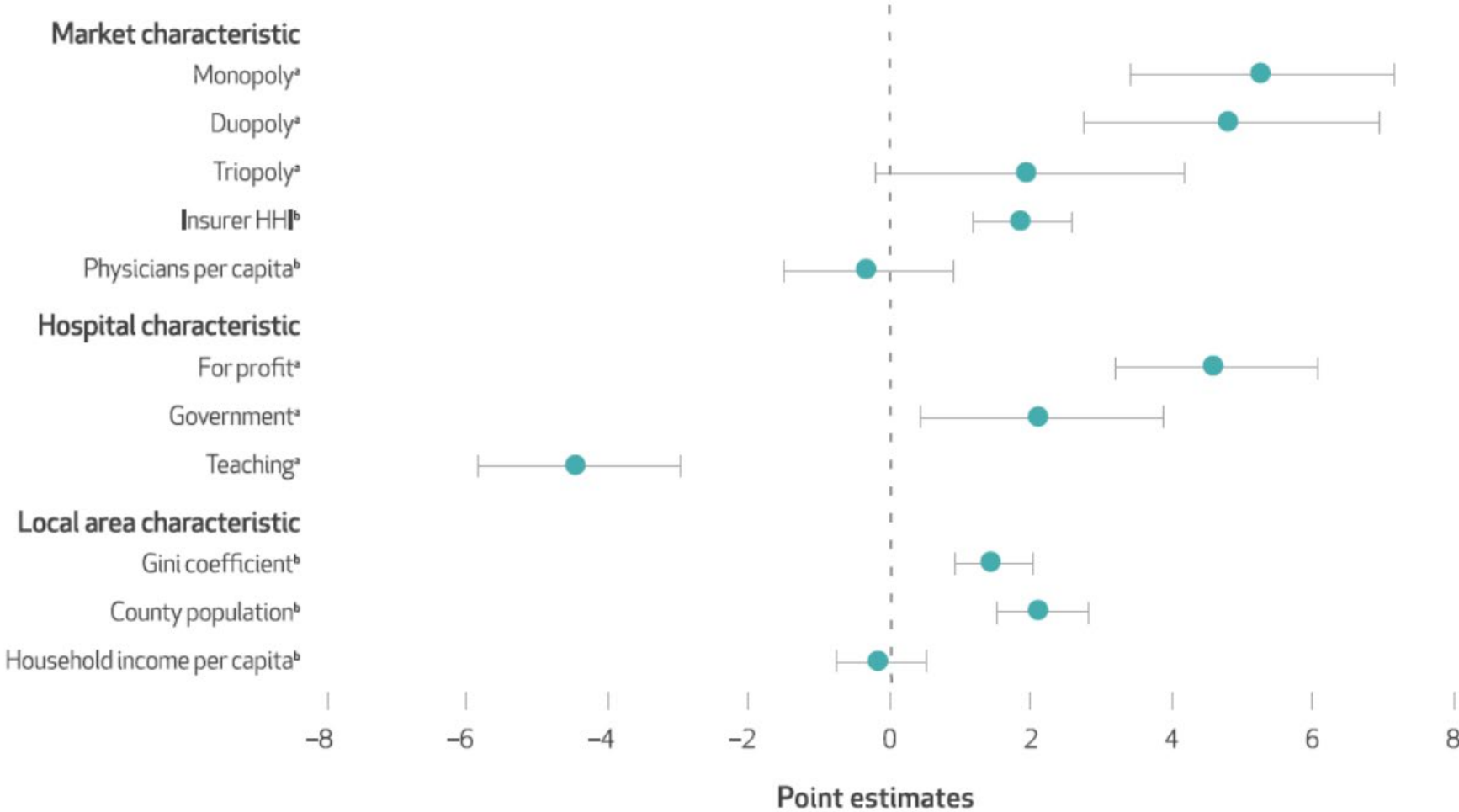
Excludes Emergency Department Billing



Profile of Markets with OON Billing

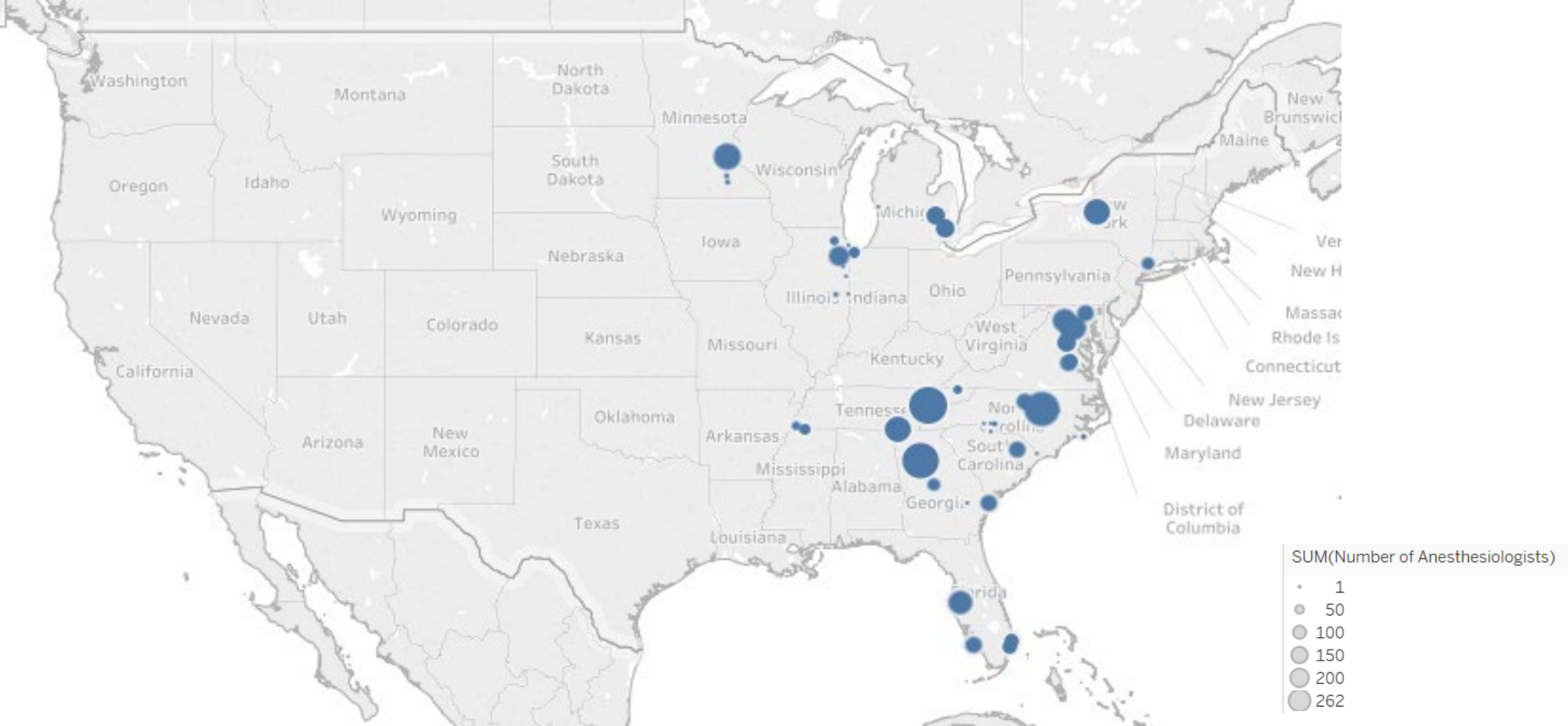
Most frequently occurs with hospital monopolies or near monopolies and with for-profit

Correlations between hospitals' selected characteristics and frequency of out-of-network billing



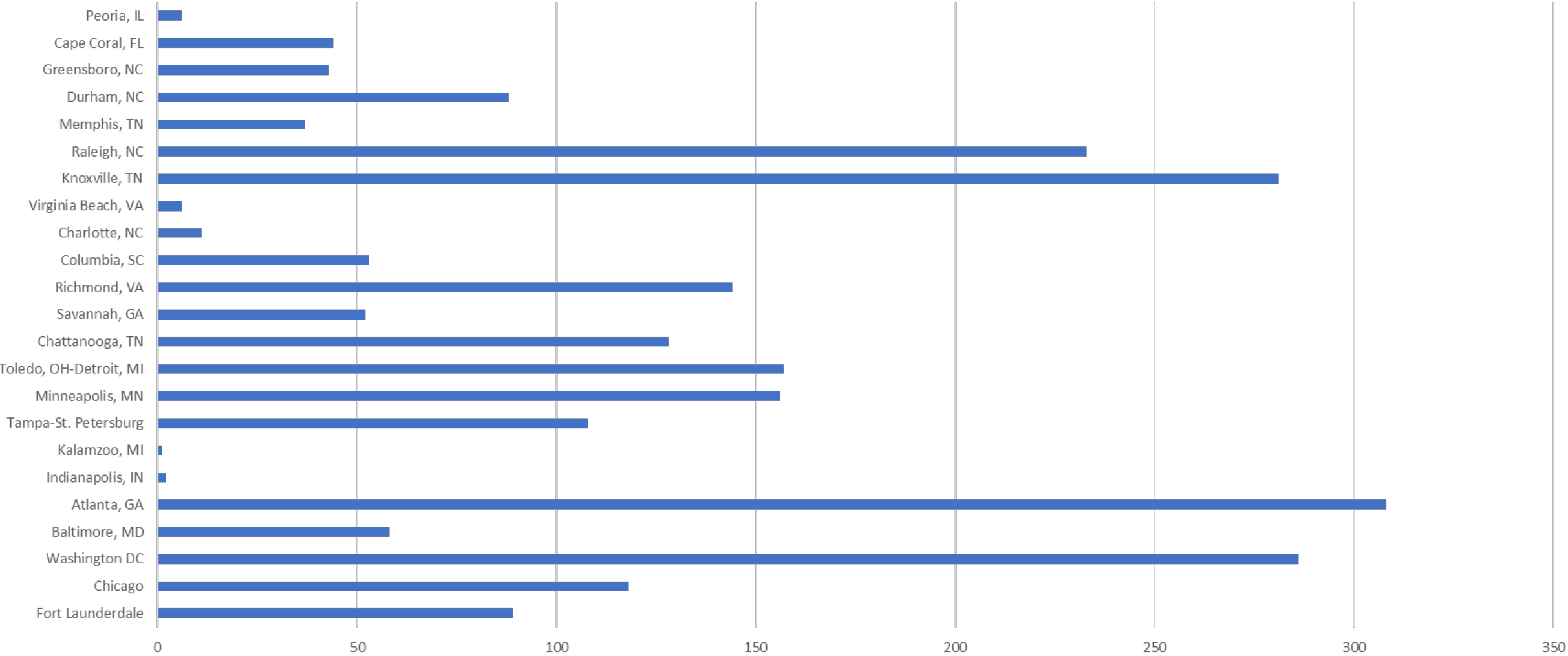
MD Anesthesiologist

Geographical Concentration



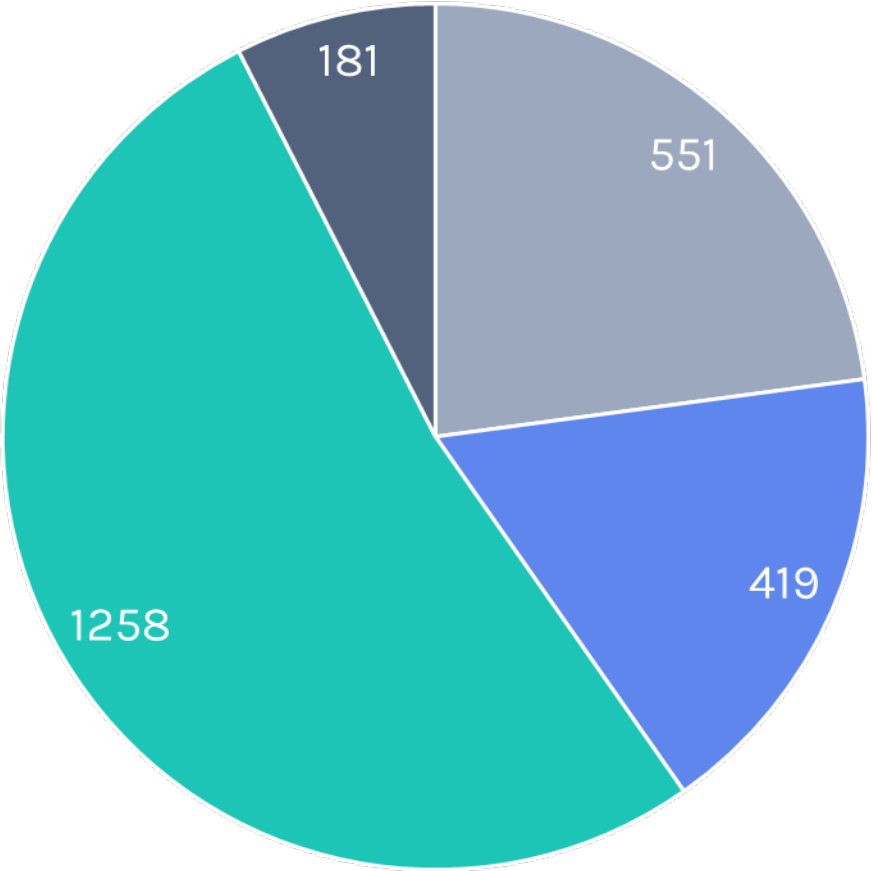
Hospital Market Concentration

MD Anesthesiology Markets Ranked by Metro HHI



Distribution of MD Anesthesiologist by Market Type

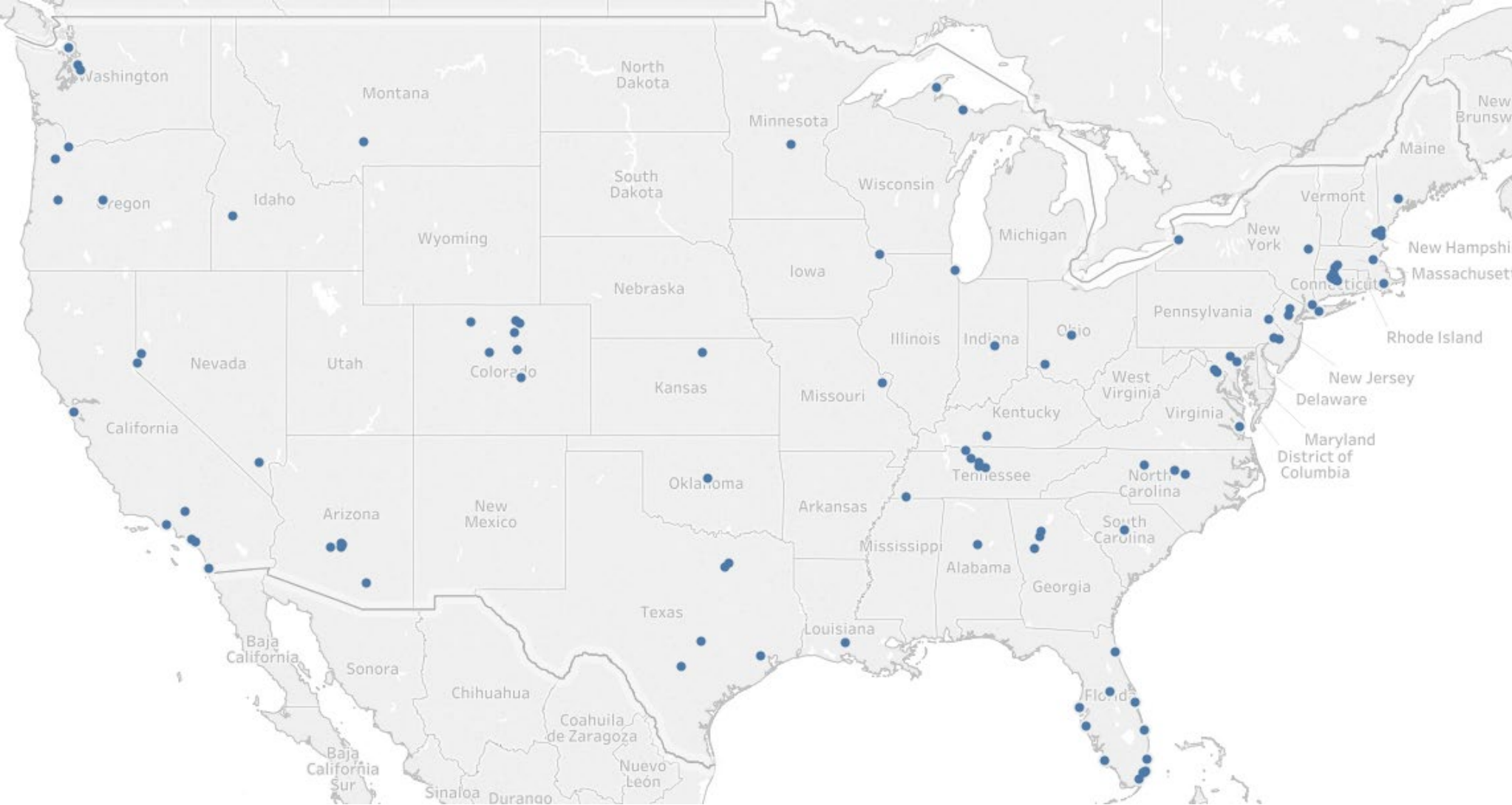
About half work in highly concentrated markets



- Unconcentrated
- Moderately Concentrated
- Highly Concentrated
- Very Highly Concentrated

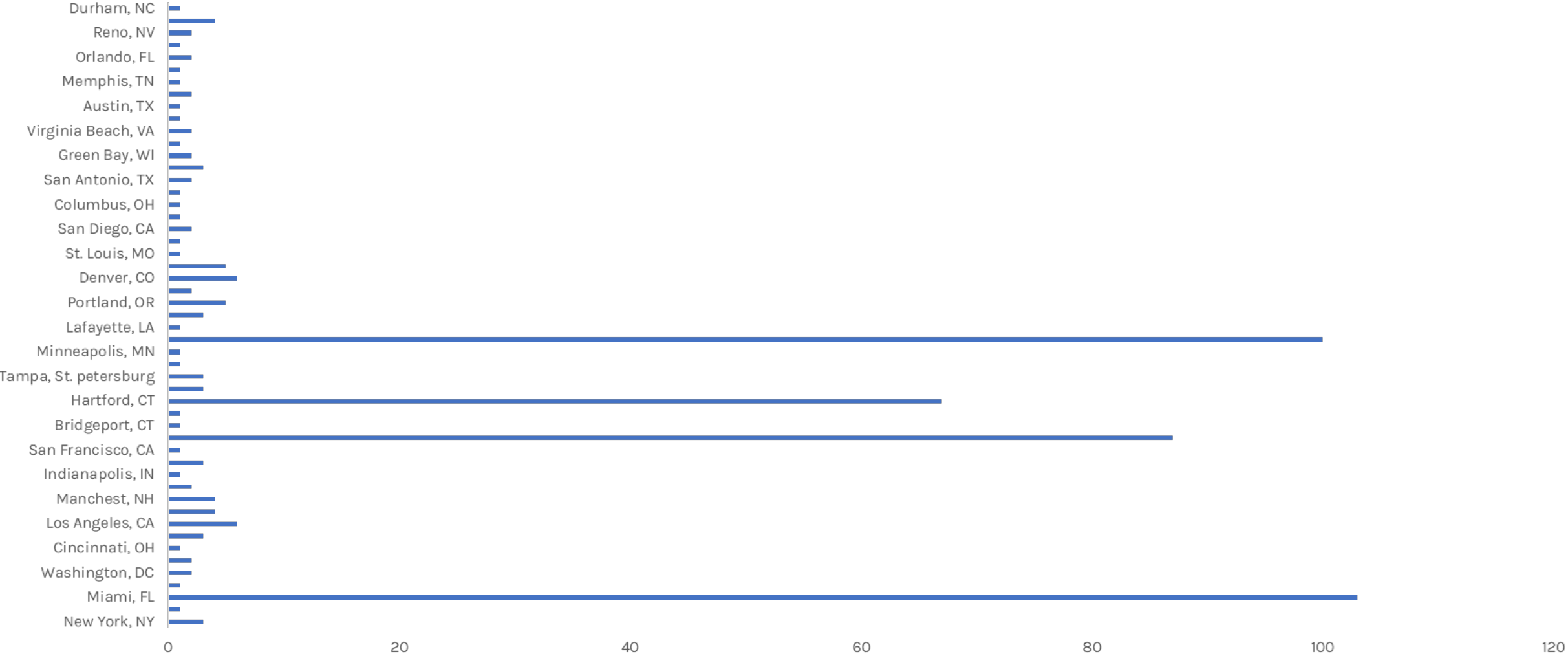
MD Radiologists

More Geographically Diverse with limited concentration

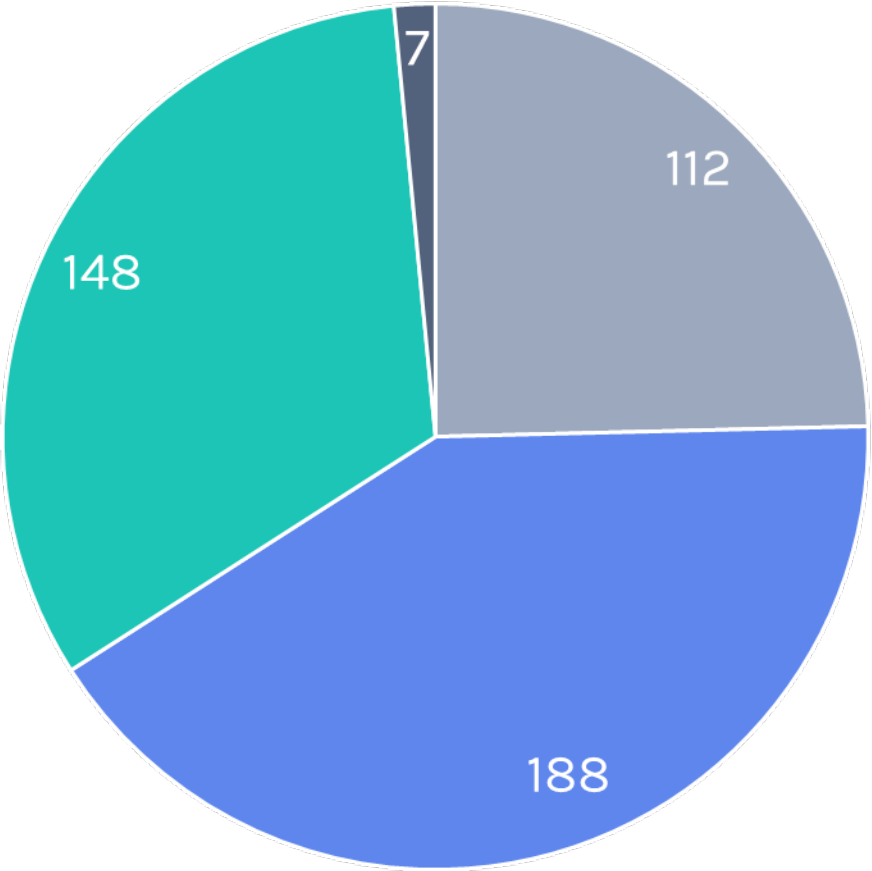


Hospital Market Concentration

MD Radiology Markets Ranked by Metro HHI



Radiologists and Market Concentration



- Unconcentrated
- Moderately Concentrated
- Highly Concentrated
- Very Highly Concentrated

MD v PhyCor

PPM 2.0 or history repeating itself?



- Focused on three specialties with limited market power: Neonatology, Anesthesiology and Radiology
- Negotiates variety of payment approaches including FFS, HMO and PPO
- Two layers of non-competes: one with contracted hospital and one between MD and physician/CRNA; no buy-out



- Established in response to managed care pressures of 1990s
- Rolled-up multi-specialty clinics including primary care and medical specialty under 40 year contracts
- Negotiated capitated arrangements with payers
- Difficulty managing clinics created pivot to PPM in late 1990s
- PPM arrangements included a \$150,000 buyout of non-compete

[1] 340B Drug Discount

- Allows NFP hospitals to purchase drugs at a discount, be reimbursed at normal rate and keep the delta
- In 2018, CMS changed reimbursement for Medicare drugs from ASP+6% to ASP-22.5% applied in a budget neutral way
- 340B encourages hospitals to acquire physicians practices especially when high priced drugs are involved

[2] Interoperability

- Large hospitals systems, especially elite academic research centers use data blocking strategies and indifference to limit access to records
- Pending rules would end many of the practices that limited physician access

[3] Site Neutral Payments

- In 2015, Congress required site neutral payments for certain clinic codes to be paid on a site neutral basis
- Law went into effect in FY2017
- CMS extended to other codes in FY2019.
- Lawsuit pending

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(203) 562-6500