November 25, 2024

[CNC, MOH, ELV, THC, HCA, CYH, UHS]: Growing Overhang from Medicaid Legislative Reforms, But Watch for Vulnerable GOP Pushback

Key Takeaways: The risk overhang from potential Medicaid reforms to **managed care organizations**, **hospitals**, **behavioral facilities**, and other **providers** focused on these low-income enrollees will likely grow as the Trump administration staffs up and Congress seeks offsets for its tax bill and / or spending priorities next year. With Medicaid being a clear Republican target, we highlight the most disruptive *legislative* agenda items below, listed in order of their estimated federal deficit impact, which, if enacted, would financially stress the states and – in turn – would have bleed-through risk to Medicaid insurers / providers. We nevertheless suspect that vulnerable GOP members and some Red States will balk at implementing the most aggressive of these approaches.

POLICY	SUPPORTERS	ESTIMATED DEFICIT IMPACT
Medicaid block grants to states based on a base year's state spending level and indexed for future growth	Project 2025, FY25 Republican Study Committee Budget, Cassidy in 2017	$836B/10 years
Removal or reduction of traditional FMAP) floor from statutory 50% level	Paragon Health	$667B/10 years if eliminated $529.9B if reduced to 40% and phased in over 8 years (likely affecting CA, CT, DC, MA, NJ, NY)
Medicaid expansion FMAP reduction from 90% to traditional FMAP levels, potentially triggering termination (e.g. AZ, AR, IL, IN. MI, MT, NH) or sunsetting	FY25 Republican Study Committee Budget, Cassidy in 2017	$604B/10 years but less depending on timeframe and minimum level
Medicaid per-capita caps on federal spending for respective eligibility categories	Project 2025, FY25 Republican Study Committee Budget, Cassidy in 2017	$501B/10 years
More frequent Medicaid eligibility verifications	House Ways and Means Chair Jason Smith, Cassidy in 2017	$160B/10 years
Mandate or allowance of Medicaid work requirements on some or all of Medicaid enrollment (in 2020, 13 Medicaid expansion states and 7 non-Medicaid expansion states sought/secured Medicaid waivers with work requirements)	Mandate: Paragon Health, America First, Project 2025, FY25 Republican Study Committee Budget, House Budget Chair Jodey Arrington (R-TX), House Ways and Means Chair Jason Smith (R-MO) Allowance: Incoming Senate HELP Chair Bill Cassidy (R-LA) in 2017	$109B/10 years under a mandate Unknown impact if under allowance
Same FMAP for Medicaid administrative costs	Supporters unknown; included in CBO deficit reduction report	$68B/10 years (admin services)
Limit / eliminate state provider tax's hold harmless threshold at 6% of net patient revenues	Project 2025, FY25 Republican Study Committee Budget, Cassidy in 2017	$41B/10 - $526B/10 depending on the limit and timeframe
Shortened Medicaid presumptive eligibility	Arrington, Cassidy in 2017	No known or informal score

Source: Congressional Budget Office, Paragon Health Institute, America First Policy Institute, Kaiser Family Foundation, Better Care Reconciliation Act of 2017, Capitol Policy Partners

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Centene Corp (CNC)

Price:	$60.37
52-Week High:	$81.42
52-Week Low:	$57.20

Molina Healthcare Inc (MOH)

Price:	$290.79
52-Week High:	$423.92
52-Week Low:	$272.69

Elevance Health Inc (ELV)

Price:	$402.55
52-Week High:	$567.26
52-Week Low:	$391.02

Tenet Healthcare Corporation (THC)

Price:	$143.63
52-Week High:	$171.20
52-Week Low:	$65.90

HCA Holdings Inc (HCA)

Price:	$324.93
52-Week High:	$417.14
52-Week Low:	$245.84

Universal Health Services Inc (UHS)

Price:	$197.94
52-Week High:	$243.25
52-Week Low:	$133.70

Why Medicaid Remains in the Crosshairs:

- Long-held Republican orthodoxy that the program is bloated, overfunded, untargeted, and of poor quality due to federal policies, with a belief that decision-making should be brought back to the states.

- The need for federal legislative savings to help offset the cost of next year's tax reconciliation bill or other major healthcare spending priorities, such as Medicare physician payment reforms or adjusting / extending some of the enhanced Obamacare subsidies.

We expect the incoming Congress to adopt Medicaid changes into the upcoming budget resolutions (some were included in the House's proposed FY25 budget resolution this past year) and legislative reconciliation drafts. Such moves are likely to be encouraged by some in the administration like Office of Management and Budget Director nominee Russell Vought, a key figure behind Project 2025. Furthermore, we wouldn't be surprised if President Trump's FY26 budget seeks Medicaid reforms. Nominees for HHS Secretary (Robert F. Kennedy Jr.) and CMS administrator (Dr. Mehmet Oz) are unlikely to stand in the way, with neither having much in the way of public statements on the program.

However, it is important to highlight that inclusion in a budget resolution, legislative draft, or a President's proposed budget do ***not*** equate to enactment / implementation, as they must still be included in reconciliation language and be passed into law.

With that being the case, we see several likely sources of pushback to the most disruptive ideas highlighted above. As one would expect, this includes patient groups and the bulk of the entire healthcare industry that fears the loss of customer volumes and higher bad debt levels.

However, more unexpected opposition may come from GOP members of Congress in Red States that expanded Medicaid and those at risk of cuts, as well as those in swing states / districts who are up for reelection in 2026, as well as some GOP-controlled states that don't want to see their uninsured levels skyrocket, have to increase their state health spending, and see federal financial support decline.

We believe that the above legislative policy items would likely survive the Senate's budget reconciliation process, based on the GOP's Better Care Reconciliation Act of 2017 (i.e., the failed ACA repeal-and-replace bill that was sponsored at the time by Sens. Bill Cassidy (R-LA) and Lindsey Graham (R-SC)). Though the language of the potential provisions matters, the Senate Parliamentarian would likely once again sign off on the proposals, even with questions about whether the underlying directives are budgetary in nature.

Should the most aggressive of these *legislative* Medicaid reform ideas fail or be dialed back, as we would expect, risks nevertheless remain for Medicaid insurers and providers, though the extent of the impact would be state- and policy-specific. Such risks would be *regulatory*. CMS is widely expected to approve a rash of state Medicaid waivers in the name of affording greater state flexibility, tailoring the program to fit enrollees' needs, shrinking enrollment, and slowing Medicaid spending growth. Such waivers would likely resemble those encouraged by the Trump administration in 2016-2020, which Biden later rescinded:

- Work and community engagement requirements on the Medicaid expansion and/or traditional Medicaid enrollees (11 approved and 9 pending during Trump 1.0)

- Greater cost-sharing / minimum premium contributions on the Medicaid expansion enrollees (8 approved during Trump 1.0)

- Aggregate per-capita spending caps to control state Medicaid spending growth in exchange for the flexibility to tailor narrower benefits (1 approved – TN during Trump 1.0)

Under this scenario, we suspect several of the ten Medicaid expansion holdout states (e.g., AL, KS, GA, SC) would reverse course and expand if they secure the above reforms and/or pursue partial expansion, such as extending coverage to adults with incomes up to 100% federal poverty level (FPL), instead of the statutory 138% FPL. However, the track record suggests

that these carrots are unlikely to convince other holdouts to move (e.g., FL, MS, TN, TX, WY). Conversely, many of the existing GOP expansion states are likely to seek reforms that would shrink their programs.

Ironically, we doubt that Congress or CMS will target the popular state directed payment (SDPs) programs in Medicaid in the near-term, even though they have fueled sizable Medicaid spending growth. We think the GOP's desire to give states greater control to reform their healthcare systems will serve as a buffer from cuts or restrictions on these policies, which enable states to draw down federal funding to finance additional payments to hospitals and other providers on top of Medicaid managed care reimbursements.

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