October 21, 2024

Managed Care Policy Puts and Takes

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Key Takeaways: We remain optimistic about the long-term policy outlook for the managed care industry, despite the puts and takes for different business lines associated with the outcome of the upcoming elections on Nov. 5. Looking across **Obamacare**, **Medicaid**, **Medicare Advantage (MA)**,and **pharmacy benefit managers (PBMs)**, we view most risks as manageable, but acknowledge the sentiment risks they provoke among investors with respect to overall profitability and volumes.

The recent margin degradation and reduced/withdrawn earnings guidance reported by UNH,ELV and CVS last week helps set a lower baseline for growth since it will take time to work through the various concerns stemming from higher utilization, upcoding, use of specialty medicines, and timing misalignment arising from Medicaid redeterminations. This week's focus will therefore be on CNC and MOH's earnings to evaluate the extent to which these factors are more widespread.

Separately, the November election brings additional legislative / regulatory risks, but also opportunities for specific business lines, which we outline below. Collectively, they afford a mixed picture, but much depends on each company's exposure and ability to weather any changes. With current polling showing roughly toss-up odds, we have broken down our expectations for either a Trump or Harris victory, helping investors prepare for either eventuality. To summarize:

- Obamacare and Medicaid business lines are most vulnerable for retrenchment under a Trump victory, whereas MA fares the best, even with rate updates in low single-digits.
- A Harris victory removes overhang, and brings ongoing support for funding and expansion, for Obamacare and Medicaid business lines, whereas MA continues to face additional headwinds and a flattish rate environment.
- PBMs likely remain a target under either Harris or Trump from both a headline and policy perspective.
- Commercial health insurance (excluding Obamacare) is likely insulated under either outcome as well, given that material federal ERISA reforms or changes in tax treatment are unlikely.

As it relates to antitrust enforcement, we agree with the conventional wisdom that the M&A environment would likely improve under Trump, meaning that potential deals (e.g., CI / HUM) may pass more easily. That said, the various lawsuits / investigations already in motion would likely persist – e.g., the FTC's administrative complaint against the PBMs (CVS, CI, UNH) and the reported DOJ investigation into UNH's vertically integrated design and monopolistic control – given ongoing concerns about drug pricing, rising healthcare costs, and concentrated vertical actors in healthcare. Those efforts would likely be used as leverage for the Trump

UnitedHealth Group Incorporated (UNH)	
Price:	$575.18
52-Week High:	$608.63
52-Week Low:	$436.38

Humana Inc (HUM)	
Price:	$263.53
52-Week High:	$527.18
52-Week Low:	$213.31

CVS Health Corp (CVS)	
Price:	$58.18
52-Week High:	$83.25
52-Week Low:	$52.77

Elevance Health Inc (ELV)	
Price:	$425.28
52-Week High:	$567.26
52-Week Low:	$397.98

Centene Corp (CNC)	
Price:	$61.46
52-Week High:	$81.42
52-Week Low:	$61.62

Oscar Health Inc (OSCR)	
Price:	$15.85
52-Week High:	$23.79
52-Week Low:	$4.72

Cigna Corp (CI)	
Price:	$320.83
52-Week High:	$370.82
52-Week Low:	$253.95

Molina Healthcare Inc (MOH)	
Price:	$288.03
52-Week High:	$423.92
52-Week Low:	$282.96

administration to try to extract policy concessions to lower healthcare prices. If Harris wins, we do not see her reversing course or loosening antitrust policy from the Biden administration.

Obamacare (OSCR, CNC, ELV, MOH)

Lame duck. We do not expect any material movement on legislation to extend the enhanced ACA premium tax credit, despite the pressure insurers, hospitals, and left-leaning groups have tried to assert as they highlight the need to act long before the Dec. 31, 2025 expiration. For context, 19.7 M exchange enrollees of the 21.4 M total enrolled (92%) received these subsidies to help pay their monthly ACA plan premiums. Enacted as part of the American Rescue Plan Act and later extended in the Inflation Reduction Act, these enhancements included:

- Removing the subsidy cliff and allowing individuals with household incomes greater than 400% of the federal poverty level (FPL) to be eligible;
- Capping the amount enrollees pay towards Obamacare premiums for a benchmark silver plan at no more than 8.5% of their income; and
- Offering zero-premium plans to individuals with incomes less than 150% FPL.

For the upcoming 2025 open enrollment period, which starts November 1, we expect sign-ups will exceed 2024's record due to the ongoing financial support for outreach and enrollment, the availability of the enhanced subsidies, the program's perceived overall stability, and potential churn from those losing Medicaid coverage during state redeterminations.

TRUMP WIN. Not surprisingly, a Trump victory with a GOP sweep threatens the continuation of enhanced ACA premium subsidies that are set to expire at the end of 2025. While the knee-jerk reaction is that the Republicans would let these tax credits lapse, we doubt Trump wants to be seen as killing a popular benefit. Hence, we think there is a path for a partial extension, along with more affordable health insurance options that would compete with the federal program.

- **Regulatory Policies.** This likely brings greater competition for Obamacare plans and experimentation with skinnier benefits / cheaper plan designs. The first Trump administration finalized policies to expand short-term medical plans, allow for association health plans to avoid Obamacare rules, and give states greater flexibility to revise exchange offerings, but these were later reversed by Biden. We expect their resurrection in a second Trump term, and to also see efforts to develop a subsidized high-risk pool, narrower benefit / network requirements, and greater tailoring to individual healthcare spending.
- **Legislative Policies.** While the ACA itself is no longer a high priority for Trump or the GOP, the Dec. 31, 2025 expiration of enhanced premium tax credits forces the issue, especially as they coincide with expiration of Trump's 2017 tax cuts. If there is to be any relief, it will likely come at the last minute and as part of a major legislative deal. While many expect these subsidies to lapse altogether in light of the competing priorities and $335B cost of a permanent extension, we see a path forward for *some* of the enhancements to persist given their popularity. This would include reinstatement the subsidy cliff on higher-earners while also: (A) retaining the 8.5% of income limit on individual premium contributions for those making 100%-400% FPL (in 2024, 19.1 M were in this range, with 15.4 M making less than 250% FPL); and (B) offering of zero-premium plans for the very poor.

Over the longer term, a GOP Congress would also likely welcome legislation to allow broader marketing of skinnier, cheaper exchange plans, greater coordination of exchange plans with health savings accounts (HSAs), a more attenuated age-rating ratio to reduce costs for younger enrollees, and/or subsidized federal high-risk pools for those with multiple expensive illnesses.

HARRIS WIN. A Harris win suggests a multiyear extension of the enhanced subsidies, especially since it will likely be part of negotiations on the 2017 tax cuts.

- **Legislative Policies.** Despite pressure to act earlier in the year, we don't think Congress will do so until late 2025. Meanwhile, we doubt discussions to revise the exchange program or materially expand benefits (e.g., vision, hearing

aids, in-home care) rank high on the list of competing spending priorities.

- **Regulatory Policies.** Major changes seem unlikely, with the exception of enhanced oversight of marketing and enrollment to clamp down on bad agent actors who have reportedly switched enrollees into different Obamacare plans without their consent.

Medicaid (CNC, MOH, ELV, UNH, CVS)

Lame duck. We do not expect any material federal legislative or regulatory Medicaid changes during the lame duck. The only exception would be, as part of a FY25 spending bill, another postponement of the reduced Medicaid bonuses to disproportionate share hospitals (DSH), which have been punted since 2014. Meanwhile, the timing mismatch between the largely concluded state Medicaid enrollment redeterminations and the rebasing of program rates to reflect current enrollees' acuity is not going to be resolved during this period, or any time soon.

This issue, cited by insurers for hurting Q3 results and future earnings guidance, demands time, sizable claims data, and multiple discussions with state officials to determine whether changes are needed to ensure rates are actuarially sound. Such resolution could take at least a.

Meanwhile, despite the draw down in Medicaid enrollment stemming from the redetermination process (which overall numbers show are still higher than pre-pandemic), we expect state Medicaid rolls to *increase* given that ~30% of those enrollees found to have been inappropriately removed tend to re-up for Medicaid once again, and we also tend to see Medicaid sign-ups during the ACA open enrollment period when people see they may qualify.

TRUMP WIN. A GOP sweep likely reignites past debates over the Medicaid program, spending, enrollment, and care quality. Given that major Medicare benefit changes are unlikely payfors of higher priorities like tax cuts, Medicaid affords an attractive savings target via lowering the rate of future spending growth, limiting enrollment, and redirecting spending towards a smaller subset of people presumed most in need, as recommended by right-leaning think tanks. Such legislative and/or regulatory changes would likely encourage more states to contract with Medicaid insurers to run their programs, but at potentially lower rates across fewer beneficiaries with less generous benefic packages.

- **Regulatory Policies.** We think a Trump CMS is likely to provide states with greater control over how they spend federal dollars, who they can enroll, how they charge certain individuals, and which benefits are offered. During the first term, his administration approved state-specific waivers that: (1) imposed work requirements; (2) assessed cost-sharing / minimum premium contributions; and (3) allowed per-capita caps in the form of block grants to control state Medicaid spending growth in exchange for the flexibility to tailor narrower benefits. These waivers were discontinued by the Biden administration but will likely be resurrected by a Trump CMS. While the GOP goal seems to be to shrink the Medicaid program more generally, a Trump CMS will likely endorse state-directed payment programs that enable them to exercise greater control.

- **Legislative Policies.** As mentioned above, a GOP-controlled Congress would likely target Medicaid savings to help offset other spending priorities following the program's expansion during the pandemic. This would include efforts to: (1) codify states' ability to impose work requirements or cost-sharing on at least those that became eligible for Medicaid via the expansion policies; (2) lower the federal Medicaid match formula for upper-income adults to each state's base Medicaid match, which could force some states to automatically reverse their Medicaid expansion; (3) revise the federal Medicaid match formula altogether; and/or (4) reduce state Medicaid provider/insurer taxes, thereby reducing available funds.

HARRIS WIN. Medicaid is an unlikely target. Rather, we think her CMS would continue Biden administration efforts to extend Medicaid coverage to new enrollees while pushing for 12-month continuous coverage for beneficiary subpopulations. We also see her CMS proceeding with the same scrutiny of state-directed payment programs to see how those federal dollars are being used. Lastly, we could see several of the remaining 10 Medicaid expansion holdout states relenting and deciding to expand.

- **Regulatory Policies.** On the positive side, we expect Harris's CMS to encourage states to offer full-year continuous coverage for children and/or vulnerable adults, and to approve waivers to allow for enrollment of individuals no longer in prison or in need of substance abuse treatment. We also think her administration will continue working with states to permit use of federal Medicaid funds to reduce social risk factors that threaten health outcomes and exacerbate health risks, such as housing support, food security, and medical debt reduction. Conversely, her CMS is apt to continue pressing for increased mandatory disclosures by insurers and requiring broader benefit / network adequacy standards. We also expect CMS to continue its heightened scrutiny of state-directed payment programs that funnel additional funds to certain providers. However, any efforts to clamp down on these expenditures are likely years away, after CMS has collected sufficient data for a change in policy.

Medicare Advantage (MA) (HUM, ALHC, UNH, CVS, ELV, CI)

Lame duck. Outside of the low chance that the Biden administration releases its 2026 advance notice on MA rates before there is a new occupant in the White House, the most material MA-related policy that could see action in the lame duck is enactment of the Improving Seniors Timely Access to Care Act. This legislation codifies an earlier CMS rule on prior authorization, further streamlines and standardizes MA plans' use of that tool, and increases oversight / transparency requirements. The combined effect is potentially higher costs on MA insurers while sunsetting policymakers' longstanding concern about inappropriate prior authorization. Given the price-tag (whose bill authors have estimated is less than $8B)], we ascribe a toss-up odds to this measure being added to a must-pass FY25 spending bill.

TRUMP WIN. The knee-jerk reaction is that Trump win bring MA insurers greater insulation from policy headwinds, reducing regulatory headaches and returning the space to the heady days of mid-single digit YoY rate increases. While we agree that the tone under a Trump victory would be more hospitable, we think future MA rates are likely *at best* to be in the low-single digits.

- **Regulatory Policies.** Initially, we think Trump's CMS may act with restraint as it relates to 2026, maintaining much of the status quo on Star Ratings policies, risk adjustment data verification audits, and supplemental benefits, waiting to pursue changes until the 2027 cycle. However, the major exception would be for the MA risk adjustment model in 2026. Recall that the associated changes – whose phase-in started in 2024 and will end in 2026 – drove YoY MA rates below cost growth, an actual rate cut in 2025, along with narrower plan offerings. While this trend is unlikely to be reversed, Trump's CMS is apt to pause the phase-in for 2026 and not proceed with the final year's implementation, likely leading to a net YoY rate increase commensurate with fee-for-service cost growth (2%-3%). Longer term, his CMS would likely be interested in undoing the redesign efforts of the Star Rating program intended to redirect funds toward social determinants of health, loosen the restrictions on supplemental benefit design, and creating demonstration projects to give enrollees more decision-making power.

- **Legislative Policies.** Given other more pressing and costly fiscal priorities, we see little appetite for Trump, even if working with a GOP Congress, to materially boost MA spending via: (1) deriving the MA base rate solely from the costs of beneficiaries with both Medicare Parts A and B; (2) default enrollment into MA rather than FFS; and/or (3) converting MA into a competitive bidding program. Were Congress to dig into these ideas, they may be accompanied by major changes and funding reductions to risk adjustment and the quality bonus ratings, based on past recommendations of right-leaning think tanks.

HARRIS WIN. The knee-jerk reaction of a Harris victory would be status quo. While legislative change is highly unlikely in a split Congress, we expect ongoing regulatory efforts to further squeeze and restrain the perceived unnecessary spending flowing to MA insurers. Even then, actions are likely to be incremental.

- **Regulatory Policies.** Harris' CMS is likely to continue Biden administration efforts, such as proceeding with the finalized risk adjustment changes, forcing MA plans to work harder to secure/maintain higher quality ratings, redirecting a portion of the quality bonus rewards towards plans with disproportionately higher enrollments of poorer and disadvantaged individuals, and scrutinizing supplemental benefits. This would suggest a relatively flat YoY rate environment in the near term. Longer term, her CMS could take more aggressive actions to rein in risk adjustment spending if the current redesign did not go far enough to dampen the extra spending plans receive. We also think there

is risk of further changes to medical loss ratio (MLR) requirements by limiting how MA treats medical expenses charged by affiliated providers and vendors, as well as limitations on supplemental benefits.

- **Legislative Policies.** We are dubious that Congress would take up material MA policies, even ones that would garner sizable savings or cut down on perceived unnecessary MA spending. Unless Harris has a Democrat-controlled Congress, her proposal to add an in-home care benefit and narrow vision / hearing aid benefits is unlikely to go anywhere, and challenges remain even in a Dem sweep scenario.

PBM (CI, CVS, UNH, ELV)

Lame duck. PBM "reforms" are likely to receive ongoing attention and efforts for inclusion in a FY25 spending bill remain high due to the associated savings and bipartisan frustration at these businesses, though we are not confident of the changes being successfully enacted during the lame duck. These policies include expanded transparency disclosures by PBMs to their payer / employer customers about fees/rebates/conflicts of interests/ownership, a ban on Medicaid spread pricing, limits on Medicaid pharmacy payments, and flat fixed fees, instead of price- or volume-based drug rebates, in Medicare Part D. While these policies would pressure some PBM behaviors and impair profitability, we doubt this would be meaningful. For the past year, the target on PBMs has widened, especially with the FTC's antitrust administrative complaint against the largest actors. While potential legislative action wouldn't necessarily kill the FTC's case, it may undercut the punitive bite.

Even if the above are *not* included in the FY25 spending bill, we expect them to carry over into 2025, irrespective of White House / Congressional control after the November elections.

TRUMP WIN. We are skeptical that interest in PBM business practice is reduced given ongoing concerns over drug pricing, high out-of-pocket costs, an opaque business model, and alleged double-dealing that federal and state policymakers decry. We think Trump would let both the regulatory and legislative threats unfold so he can extract sufficient PBM concessions that would ultimately dissipate the overhang, but this will take time.

- **Regulatory Policies.** We expect the Trump administration to proceed with the regulatory scrutiny and negative policies that have persisted since his time in office and continued under Biden. This could include a reformed efforts to declare PBM rebate arrangements illegal under the Anti-Kickback Statute unless based on a fixed dollar amount (unrelated to drug price / volume) and savings reflected in pharmacy acquisition costs. On the antitrust front, we suspect Trump's appointments to the FTC will maintain the agency's focus on the sector, at least until behavioral concessions can be secured to allow the administration to claim it had helped lower drug costs. Should the PBMs fight the FTC complaint, it would likely take years for the courts to adjudicated, and a judge may challenge the scope / legality of the actual allegations and the agency's underlying authority.

HARRIS WIN. This also maintains the focus on PBMs, especially since Harris has cited PBM reforms as a potential offset for campaign promises associated with expanded Medicare benefits. Her CMS is likely to pursue greater transparency within Medicare Part D and overall ownership of and by PBMs of the vendors providing supportive services. The FTC in her administration is likely to proceed with its current strategy and legal case against the PBMs, without any involvement by Harris.

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