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[UNH, HUM, ALHC, AGL, PRVA, MD]: Trump's Unorthodox CMS Pick Reinforces Already Anticipated Support for Medicare Advantage and Physicians

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President Trump's surprise and unorthodox nomination of Dr. Mehmet Oz to be CMS administrator, whom we presume will likely be confirmed, affords somewhat of a blank slate for others in the administration to fill in the details on most Medicare, Medicaid and Obamacare policies with a bias towards more the free market and previously espoused GOP views of smaller government programs.

His known embrace of **Medicare Advantage (MA)** and his medical background suggest he would push for additional flexibilities, reimbursement increases, and removal of regulatory barriers, thereby putting the finger on the scale in favor of **MA insurers** [**UNH, HUM, CVS, ELV, ALHC**] and **physicians/physician management firms** [**AGL, PRVA, MD, RDNT**], though we note more full-scale overhauls like default automatic enrollment, material revisions to MA benchmark rate-setting, and major Medicare physician payment redesign all require legislation and are unlikely next year, given Congress' prioritization of tax cut extensions. This would dovetail with earlier – and widespread – expectations for a Trump administration, regardless of who was to be picked as CMS administrator.

While some have speculated that his experience as a cardiothoracic surgeon could benefit reimbursement for related device products – with investors most focused on transcatheter aortic valve replacement (TAVR) [**EW**, **MDT**] and mitral valve repair (TMVR) [**ABT**, **EW**] – we view the ratesetting processes as wholly insulated from the CMS administrator. This experience could potentially lead to more accommodative views on *coverage*, but with CMS already evaluating newer tricuspid valve products from these companies, any benefits would likely be incremental. We also think he is unlikely to meaningfully accelerate the timing of a National Coverage Determination (NCD) on renal denervation [**MDT**], which we would not expect until ~mid-2025, in light of the current backlog of pending requests and coming turnover in administration personnel.

However, Oz's limited record leaves us with few concrete changes about how he would oversee this sprawling agency or carry out its mandates on key initiatives like Medicare drug price negotiation, and the bulk of providers regulated and reimbursed by CMS. As such, the selection suggests he is likely to be more amenable to the politicos and right-leaning think tanks (Paragon Health Institute, America First, Heritage's Project 2025). We think this is more likely than Oz deferring to current policies and biases at Biden's CMS.

Should Oz be confirmed – and as mentioned above, we assume he will become CMS Administrator, especially when nominees for other Cabinet positions may be viewed as more controversial – he would still be constrained by statute. He would have at his disposal the same tools available for every other CMS head: promulgating rules, approving Medicaid and ACA state waivers, and testing out Medicare demonstration projects.

UnitedHealth Group Incorporated (UNH)

Price:	$577.00
52-Week High:	$630.73
52-Week Low:	$436.38

Humana Inc (HUM)

Price:	$277.78
52-Week High:	$527.18
52-Week Low:	$213.31

Alignment Healthcare LLC (ALHC)

Price:	$11.09
52-Week High:	$14.25
52-Week Low:	$4.46

agilon health Inc (AGL)

Price:	$1.59
52-Week High:	$13.76
52-Week Low:	$1.50

Privia Health Group Inc (PRVA)

Price:	$21.11
52-Week High:	$24.30
52-Week Low:	$15.92

Mednax Inc (MD)

Price:	$14.61
52-Week High:	$16.41
52-Week Low:	$6.62

Medtronic PLC (MDT)

Price:	$85.00
52-Week High:	$92.68
52-Week Low:	$74.66

Medicare Advantage

MA is one of the few areas where Oz has a bit more of a record. In 2020 he called for a Medicare Advantage-for-all in an opinion piece in Forbes that he co-wrote with the former CEO of Kaiser. Specifically, they advocated for enrolling uninsured individuals into Medicare Advantage plans, which would be paid for by a 20% payroll tax. This idea, which could only be carried out via legislation, has little chance of passing next Congress, but it does suggest Oz's bias in favor of MA as affording good value and care vs. traditional Medicare or Medicaid for the basis of a potential single-payer system.

Using his past proposal as a premise, we expect him to support regulatory policies to boost MA at the expense of traditional Medicare and make it easier for plans to compete. To us, this potentially translates to a regulatory pause of the phased-in MA risk adjustment model's final year for CY26. We intuit that he would also support: 1) scrapping for CY27 the final policy to use the MA star ratings' reward factor to fund a health equity index; 2) providing greater flexibility to MA plans to offer more supplemental benefits like exercise, hospice, and home care; and 3) giving more financial room in bid design by allowing MA plans to use local dialysis costs, instead a statewide averages. It also likely means that despite any potential support by Oz, efforts to automatically enroll seniors into MA, reform the MA benchmarks or adopt competitive bidding in MA are likely *not* to progress unless Congress changes the law, which is unlikely to be a priority next year.

CMS tools

Below are how we expect a Trump CMS to use the existing regulatory tools for changes in Medicare, Medicaid, and individual insurance markets based on either what was pursued during the first Trump term, advice from the aforementioned right-leaning groups or in line with more free-market ideology.

Promulgation of rules that:

- Reinterpret various reimbursement methodologies (e.g. expand what is included in annual provider cost reports like MA negotiated payment amounts for future incorporation into rate-setting, use existing power to deem certain procedures in need of volume control and subject them to lower site-neutral rates, revise the independent dispute resolution payment paradigm under surprise medical billing rules, reimburse telehealth more broadly).
- Redefine terms (e.g., broaden what connotes a small business to be eligible to participate in an association health plan, expand the market for short-term medical plans, rewrite the composition of qualifying payment arrangement in the surprise medical billing rules).
- Tweak benefit and service categories (e.g., distinguish between various therapeutics for drug price negotiation, expand coverage for exercise or alternative care).
- Allow more procedures to be done in cheaper settings (e.g., eliminate the inpatient only list and the ambulatory surgery center covered procedures list).
- Eliminate barriers to care (allow for more procedures and care to be done via telehealth, expand restrictions on use of prior authorization in Medicare Advantage).

Approval of state waivers that:

- Enable states to remake their Medicaid programs by adopting work or other community engagement requirements, impose premiums, tailor benefits, and/or reconfigure the program based on per-capita caps or block grants.
- Continue to permit states with Medicaid managed care programs to carry out state-directed payment programs that allow the drawing down of federal Medicaid dollars to help boost certain Medicaid providers' overall payment amounts in pursuit of certain objectives.
- Allow states to have more control over their insurance markets and get exemptions from ACA requirements to create state reinsurance pools for high-risk individuals or to allow short-term medical plans, health reimbursement arrangements, direct primary care coverage, etc. as an ACA subsidy-eligible exchange option.

Pursuit of Medicare demonstration projects that:

- Test direct primary contracting models or bundled payment models based on treating/preventing the progression of chronic diseases.
- Allow for coverage of alternative therapies/treatments to medical care.
- Push the existing ACO (Accountable Care Organization) REACH model further to entice more providers to take on full risk and perhaps revert to the original design under the first Trump term.

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