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Trump Return Signals Move to More Flexibility in Value-Based Care

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The Affordable Care Act, in effect for more than a decade now, is often lauded for expanding insurance coverage, but it also aims to reduce health-care costs and improve quality. The incoming Trump administration will continue the trend toward cost savings when it takes over reimbursement reform, but likely will emphasize different approaches than the Biden White House.

The ACA created the CMS Innovation Center, which focuses on transitioning from fee-for-service reimbursement models to paying for value and quality—value-based payment—creating a need for industry consolidation.

This transformation, now entering its 15th year, has been fueled by policy initiatives seeking to curb escalating health-care costs and improve health-care quality in the US. In 2023, Americans spent $4.9 trillion on health care ($14,570 per person and 17.6% of the gross domestic product), according to research by the Centers for Medicare and Medicaid Services. Medicare, the largest single payor, accounted for 21% of national health-care expenditures, or $1 trillion, an increase of 8.1%.

While traditional fee-for-service payment models encourage overuse without considering outcomes, value-based payment models tie reimbursement to achieving quality metrics, cost savings, and patient outcomes. For example, in 2023, the Medicare Shared Savings Program resulted in $2.1 billion in net savings to Medicare.

It’s worth taking a comprehensive look at the next phase of the ACA as it relates to reimbursement reform under a second Trump administration.

Impact on Medicare

In 2024, there were about 13.7 million people in Medicare Parts A and B, known as original Medicare, that were partnered with an accountable care organization—meaning that ACOs serve nearly half of original Medicare beneficiaries. While different administrations have released different value-based payment models over the past 10 years, the goals to reform payment incentives, manage costs, and coordinate care remain consistent, irrespective of politics.

A Trump administration likely will emphasize choice of coverage and care, including reinstating the Global and Professional Direct Contracting Model that was rebranded and revised under Biden as the Accountable Care Organization Realizing Equity, Access, and Community Health Model.

Key differences between the two entities center on governance (lower voting right percentages held by providers for GPDC) and ACO REACH's focus on health equity. The Trump administration could revise ACO REACH to align with prior GPDC goals for performance years 2025-2026.

More than half of Medicare participants are enrolled in Medicare Advantage organizations, which often use quality bonuses and two-sided risk arrangements to encourage high-value services. CMS projects that at least 35.7 million Medicare beneficiaries will enroll in a Medicare Advantage organization for plan year 2025, which represents more than half of all individuals eligible for Medicare.

Payments to Medicare Advantage organizations in 2024 surpassed—by an estimated 122%—what Medicare expects it would have spent if the individuals were in Original Medicare. The Medicare Payment Advisory Commission projects 2024 risk scores for Medicare Advantage organizations to be 20% higher than scores for similar fee-for-service beneficiaries (risk scores effectively provide Medicare Advantage organizations with increased premiums for sicker individuals).

Despite this, a Trump administration may encourage greater competition between Medicare Advantage and private plans and strengthen the Medicare Advantage program. This includes the possibility of making Medicare beneficiaries opt-in to Original Medicare, thus making Medicare Advantage the default option.

The Trump administration also may reverse policies that provide greater oversight over Medicare Advantage organizations; remove required benefits and services giving plans and beneficiaries more options and flexibility; and reconfigure the current risk adjustment model and premium setting process. These kinds of measures would likely encourage expanded Medicare Advantage enrollment and increase overall value-based payment.

Expansion Across Products

Value-based payment models are expected to drive value by aligning payment models across Medicare, Medicaid, and commercial products. CMS' goal for 2030 is for all Medicare and a vast majority of Medicaid beneficiaries to enroll in an ACO relationship. It is unknown if this goal will continue under the incoming Trump administration. However, multi-payer alignment models have demonstrated promise at reducing costs—Vermont's all-payer ACO model, which includes Medicare, Medicaid, and commercial insurers, reported a spending reduction.

Since the ACA was enacted, the number of lives covered by self-insured plans has grown. From 2019 to 2020, the number of self-insured plans grew more rapidly than other kinds of plans. This market will likely continue to grow under a Trump administration.

To the extent alternative payment models can drive down health-care costs and improve quality, alternative payment models across all products will likely grow. The key will be keeping these models simple enough to be scalable.

Consolidation Efforts

Achieving savings in value-based payment requires scale, and the ACA has driven integration and consolidation among providers and intermediaries. This has helped providers and provider networks perform and compete on quality measures and share in the total cost of care for certain attributed lives.

In recent years, state and federal regulators have grown weary of the perceived negative consequences of this market trend on competition, and they've enacted regulations to increase transparency and oversight of health-care transactions.

Under a Trump administration, federal scrutiny of provider consolidation likely will ease but continue in certain states, creating regulatory hurdles for covered transactions that span multiple jurisdictions. This could drive value-based payment growth in states with less regulation and be a rationale for regulators to permit consolidation in states requiring regulatory approval.

Other Effects

There has been a focus over the past few years on embedding health equity into all value-based payment models through demographic and social determinants data reporting. This focus will likely diminish at the federal policy level under Trump.

The past several years also have focused on advocating for price transparency for care, including the disparity in care costs across health-care settings such as inpatient, outpatient, and physician offices. Policies to advance these objectives will likely maintain support under President-elect Trump.

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