Advancing Medication Adherence: Does Waiving Drug Copays Improve Medication Accessibility for Medicare Advantage Members?

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Background

The Center for Medicare & Medicaid Innovation (CMMI) was established under the Affordable Care Act (ACA) with the objective of testing innovative models that focus on improving the quality of care, enhancing patient outcomes, and reducing costs in Medicare and other government programs. One of the models that CMMI is credited with establishing is the Value-Based Insurance Design (VBID) model. Though it has since been announced that the VBID model will be sunsetting come Calendar Year (CY) 2026, lessons learned from this program and subsequent impacts of the implemented benefits will guide future priority interventions and member care going forward.

The VBID model provided an opportunity for Medicare Advantage (MA) plans to offer supplemental benefits or reduced cost sharing to a subset of enrollees. The targeted enrollees under this model were identified based on an individual's socioeconomic status (SES) by using eligibility for the Part D Low Income Subsidy (LIS) and/or chronic health condition(s) to address that individual's unique medical and health-related social needs focused on the services that are of highest clinical value to them. This model began in 2017 and continued to grow in participation and evolve in its design over the years. For CY 2025, the VBID Model has 62 participating Medicare Advantage Organizations (MAOs) testing the model in 48 states, D.C., and Puerto Rico through 967 plan benefit packages (PBPs).[1] This is in comparison to 9 MAOs that participated in the inaugural year.

In 2021, the VBID model expanded to include the option for several new flexibilities. One benefit adopted by a majority of eligible plans was the option to waive low income (LI) cost share for certain individuals. This paper focuses on the adaptation of that benefit and the resulting alignment with CMMI VBID objectives.

In the 2024 coverage year, more than 85% of all D-SNP members were enrolled in a plan that waived all Part D copay amounts.

While there were different variations of offering this benefit, such as restricting applicable drugs to essential medications for defined chronic conditions or tiered benefits based on income level within the LIS

[1] https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-value-based-insurance-design-model-calendar-year-2025-model-participation#:~:text=For%20CY%202025%2C%20the%20VBID,plan%20benefit%20packages%20(PBPs).

bracket, the majority of MAOs offered the benefit to all dual eligible members in Dual Special Needs Plans, or D-SNPs. D-SNP members who were eligible for the enhanced benefit had $0 copays on all covered drugs, through all phases of coverage. In the 2024 coverage year, more than 85% of all D-SNP members were enrolled in a plan that waived all Part D copay amounts.

To assess the impact of this benefit on medication accessibility, Wakely used Part D claims data from eight (8) Medicare Advantage Organizations. The study analyzed changes in the Medication Adherence Stars measures before and after the removal of Part D copays on the organizations' D-SNP plans. Measures included Medication Adherence for Diabetes Medications, Hypertension (RAS Antagonists), and Cholesterol (Statins)[2]. Within the CMS Stars program, these three measures are weighted at 3 points each and represent almost 10% of each contract's Overall Star Rating.

The discussion that follows is a summary of the key findings and takeaways from the analysis. Note that the results below specifically focus on normalizing adherence changes for members that were responsible for a copay prior to the benefit change. Some members in D-SNP plans did not have copays prior to the benefit change; these members are excluded from the changes presented below.

Key Findings

In the first year of waiving LI cost share, every plan demonstrated improvement in at least one medication adherence measure. Five out of the eight MAOs observed improvements in all three adherence measures. Two others showed progress in two of the measures, while the remaining plan improved in just one measure. These findings strongly suggest that eliminating copay barriers for low-income individuals enhances their ability and willingness to consistently fill their prescribed medications.

All but one plan showed improvement in at least two of the medication adherence measures.

The normalized improvement observed in medication adherence was significant in all three measures: 2.2% improvement for Diabetes, 2.5% improvement for Hypertension, and 1.2% for Cholesterol. Further, we reviewed results by each individual measure and calculated the 25th, 50th (median), and 75th percentile change in adherence. Table 1 summarizes these results.

Table 1 – Plan Distribution of Medication Adherence Changes

Percentile	Diabetes	Hypertension (RASA)	Cholesterol (Statins)
Average	2.5%	2.2%	1.2%
25th %	0.5%	1.2%	0.3%
50th % (Median)	1.9%	2.9%	1.1%
75th %	6.0%	4.2%	1.6%

As shown in the table above, the median performance for all three measures is greater than zero, indicating an overall positive impact to the medication adherence rates. The median ranges from 1.1%

[2] For more information on these measures, refer to the Medicare 2025 Part C & D Star Rating Technical Notes.

to 2.9% by measure, with the largest average impact on Hypertension medication adherence. For all three measures, the 75th percentile is above 1.5% with the highest impact on the diabetes measure. These findings indicate high, consistent improvements in medication adherence for these three conditions resulting from the removal of Part D copays.

While the consistency of improvements across plans in this study implies the removal of copays had a positive impact on medication adherence, there are other factors that likely drive the fluctuation observed in this study. These factors include year-over-year changes in pharmacy networks, formularies, and care management programs, or simply, normal fluctuations. Wakely's analysis attempted to normalize the impact of other year-over-year factors – this normalization method is described in more detail below.

Methodology

For this study, Wakely analyzed performance differences of Part D Medication Adherence measures, calculated using the 2024 Measure Manual specifications published by the Pharmacy Quality Alliance (PQA). This study examined eight D-SNP plans that began waiving Part D copays for LI members in 2023 by quantifying the impact of the benefit change on plan-level medication adherence.

The study was limited to members with the Part D low-income indicator and those continuously enrolled in the same plan for two consecutive years (CY 2022 and 2023). Members were categorized using the "Low-Income Copay Level ID" available through the CMS Low-Income Subsidy History Data (CMS LISHIST) files. Members were segmented using the LI copay level ID (referred to as LI category below) to determine their copay status for the Part D benefit prior to cost share waiver implementation. The copayment category definitions specify different copayment amounts for low-income beneficiaries. Category 1 is the highest copay level for low-income beneficiaries, category 2 is the lower co-pay level among the two that vary each year. Category 3 beneficiaries have no copay, this applies to individuals with the highest level of subsidy assistance. And finally, category 4 is assigned to beneficiaries that pay 15% coinsurance and generally qualify for partial subsidies rather than full. The dataset used for this study did not have any members in category 4.

Medication Adherence rates vary from year to year, depending on the number of members eligible for the measures and the drug lists for the specific measurement year. To normalize for year-over-year fluctuation from external factors, we observed the difference in medication adherence rate changes between category 1 + 2 members and category 3 members. Identifying category 3 as a control group allowed us to effectively isolate the impact of the copay change because, as previously defined, these beneficiaries had zero-dollar copays regardless of the LI cost share waiver implementation. Wakely used this segment's performance as the baseline of this study. The impact of the benefit change was then measured as the difference in the change of medication adherence rates in category 1+2 relative to category 3 between the calendar year prior to the benefit change (CY 2022) and the calendar year that the benefit change was implemented (CY 2023).

Wakely focused on three measures for this study: Medication Adherence for Diabetes Medications, Hypertension (RAS Antagonists), and Cholesterol (Statins).

Conclusion

Overall, we observed that implementing the LI cost share waiver benefit for low-income Medicare Advantage members leads to an overall positive improvement on all medication adherence measures. The highest impact is observed on diabetes medications, with slightly lower positive impacts on hypertension and cholesterol medications.

The medication adherence measures observed in this study a very important and impactful subset of the Star Rating calculation and resulting plan revenue each year. Improving medication adherence can also have additional benefits for an MA plan. Bettering members' health outcomes can lead to controlling the cost of chronic illnesses and reduce the frequency of complications stemming from these illnesses. Increased adherence to these necessary medications can reduce emergency department visits and inpatient readmits. All of the aforementioned advantages can play into member satisfaction and cause for improved member retention and help an MAO better manage the overall health of its population.

As previously noted, CMS announced in December 2024 that the VBID model will be terminated at the end of 2025 due to unprecedented and unmanageable costs, with no viable policy solutions to mitigate these costs. Many interventions established over the course of the VBID program have laid a foundation for future benefit designs, and several can be seamlessly integrated into other MA benefit flexibility programs. However, the waiving of LI cost sharing lacks a straightforward transition path. This raises significant questions about how plans will pivot, realign benefit structures, and whether future regulations will successfully adjust part D cost sharing reductions for LI members. Eliminating copay barriers for LI members remains a top priority, as emphasized throughout this paper. More insights and strategic considerations from Wakely on the VBID model termination will follow as organizations gear up for 2026.

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