

WHITE PAPER

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# **The Value Shift: VBID After the Sunset**

## How the End of VBID Reshapes Part D and Supplemental Benefits

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## SUMMARY

This paper is part three of “The Value Shift” series in which Wakely examines how market forces, benefit design, and competitive dynamics are redefining value across Medicare Advantage (MA). Leveraging Wakely’s Medicare Advantage Competitive Analysis Tool (WMACAT) and Strategic Market Analysis and Ranking Tool (SMART), this analysis focuses specifically on how plans have responded to the Value-Based Insurance Design (VBID) sunset at the end of 2025.

The Centers for Medicare & Medicaid Services (CMS) announced the termination of the MA VBID Model effective at the end of calendar year 2025, citing substantial and unmitigable costs to the Medicare Trust Funds, driven largely by risk score growth and increased Part D expenditures. Although VBID as a formal model is ending, many of the benefit design concepts it introduced, such as targeted cost sharing, non-medical supplemental benefits, and incentives tied to engagement, have already influenced broader MA policy and will likely continue to shape plan design going forward.

This paper examines how the sunset of VBID is reshaping MA plans in three key areas:

- Part D benefit design and cost sharing
- Supplemental and non-medical benefits
- Rewards and incentive programs

We conclude that the end of VBID represents more of a recalibration than a reversal in innovation. As plans enter 2026, they must operate with fewer targeted flexibilities while navigating concurrent policy pressures from the Inflation Reduction Act (IRA) and tightening margins.

## BACKGROUND

Launched in 2017 by the CMS Innovation Center, the MA-VBID Model allowed participating plans to deviate from traditional uniformity requirements to tailor benefit designs to specific populations based on chronic conditions, low-income status, social risk factors, or area deprivation index. Over time, MA plan participation in the VBID model expanded substantially with 62 MA organizations across 967 plans<sup>1</sup> participating.

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<sup>1</sup> Centers for Medicare & Medicaid Services. Medicare Advantage Value-Based Insurance Design Model Calendar Year 2025 Model Participation. September 27, 2024. Available at: <https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-value-based-insurance-design-model-calendar-year-2025-model-participation>.

Summary of VBID Offerings in 2025

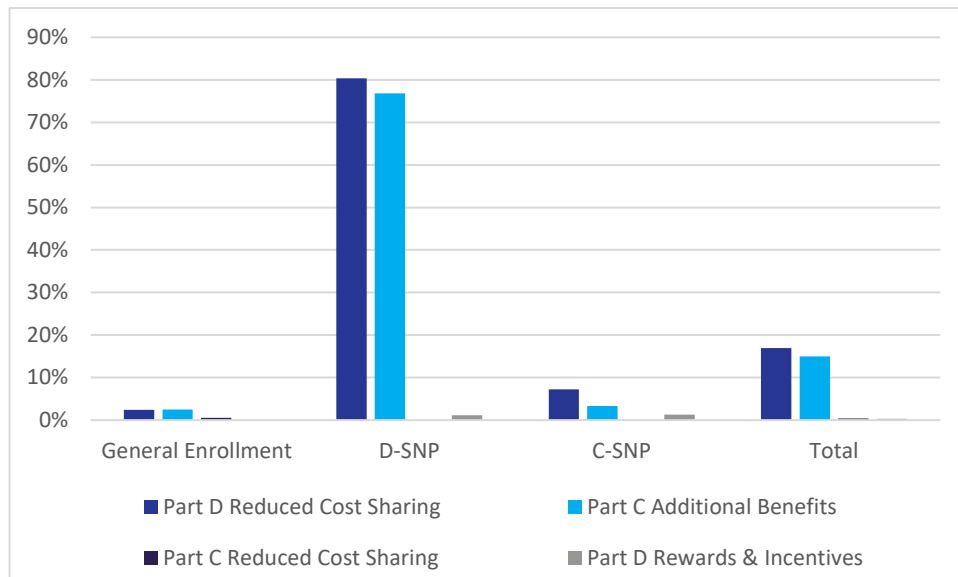
VBID participation in 2025 reflected the model's peak scale. Plans leveraged VBID primarily to offer:

- Access to targeted supplemental benefits (e.g., food, utilities, rent, transportation, caregiver supports) for enrollees meeting defined clinical or socioeconomic criteria, typically through an allowance
- Reduced or \$0 prescription drug (Part D) cost sharing for low-income members
- Part D rewards and incentives linked to medication adherence or engagement in care management activities
- Reduced or \$0 cost sharing tied to specific chronic conditions such as diabetes, congestive heart failure, or chronic obstructive pulmonary disease

These flexibilities enabled MA organizations to differentiate benefit designs and address health-related social needs in ways that standard MA uniformity rules do not allow.

Before the VBID sunset, 14% of plans participated in VBID flexibilities, primarily in the Dual Special Needs Plan (D-SNP) market. Some beneficiaries participated in the Chronic Condition Special Needs (C-SNP) market, with little participation in the general enrollment market. **Figure 1** shows the prevalence of plans by enrollment type offering the various flexibilities permitted under the VBID program.

**Figure 1. Percentage of Plans Offering Benefits Under VBID in 2025**



VBID participation was concentrated among D-SNPs, with Part D reduced cost sharing and Part C additional benefits the most common offerings. Although some plans used VBID to vary Part C cost sharing (e.g., by provider) or to offer rewards and incentives tied to prescription drugs, these approaches were relatively uncommon.

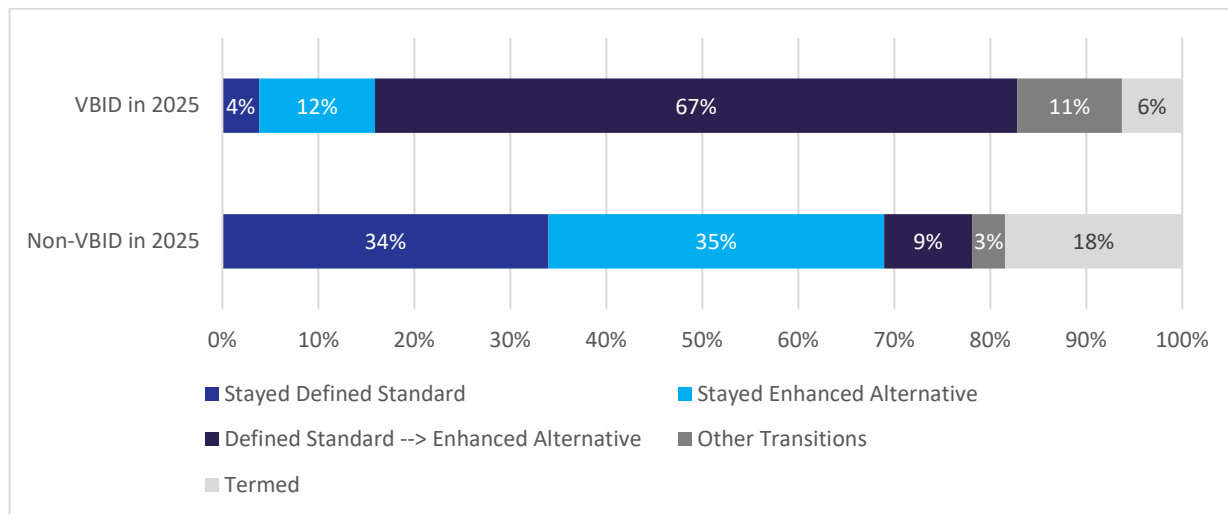
**IMPACT ON PART D BENEFIT DESIGN**

Under VBID, MA plans could offer targeted Part D cost-sharing reductions and financial rewards tied directly to prescription drug use for defined populations. These flexibilities enabled benefit designs such as \$0 copays for select drug classes or adherence-based incentives – approaches that were otherwise prohibited under standard Part D rules.

With the termination of VBID, these targeted Part D mechanisms are no longer available. Plans must instead rely on traditional Part D levers, such as formulary design, tier placement, and cost sharing reductions applied uniformly to manage affordability and adherence.

**Figure 1** indicates that D-SNPs most often had reduced Part D cost sharing based on socioeconomic factors. **Figure 2** shows how D-SNPs shifted their Part D benefit type in 2025 and 2026.

**Figure 2. Plan Design Crosswalk from 2025 to 2026**



Examining how D-SNPs shifted their Part D benefit types from 2025 to 2026 provides clear insights into how VBID-participating D-SNPs responded to the sunset and how that differed from D-SNPs that did not participate in VBID in 2025.

**D-SNPs that participated in VBID disproportionately transitioned from Defined Standard (DS) in 2025 to Enhanced Alternative (EA) in 2026.**

Approximately 67% of VBID plans transitioned from DS to EA, compared with only 9% of non-VBID plans, which suggests that VBID participation in 2025 is directly associated with significant plan redesign, particularly a shift toward EA in 2026.

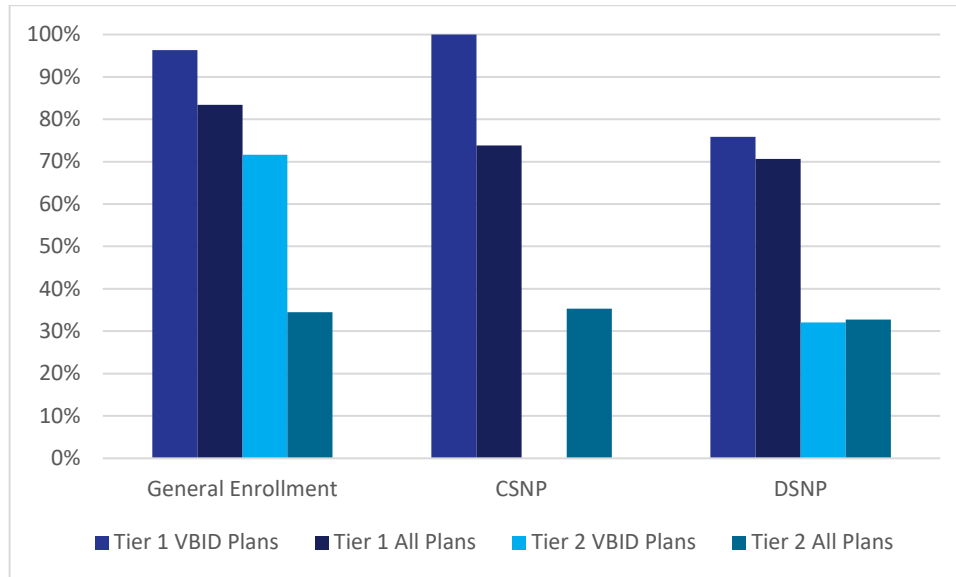
**Non-participating VBID D-SNPs have demonstrated much more “stickiness” in the Part D benefit type.**

Among non-VBID D-SNPs, 34% remained DS, and 35% remained EA, meaning 69% were unchanged overall from 2025 to 2026. Conversely, only 4% of D-SNPs that participated in VBID in 2025 stayed DS from 2025 to 2026.

**“Other transitions” represent a secondary, yet notable, trend.**

In all, 11% of VBID-participating D-SNPs and 3% of non-VBID-participating D-SNPs fall into this category. While the DS to EA transition is the dominant pattern, meaningful shifts are occurring outside the primary pathways. For D-SNPs that participated in VBID in 2025, most of the “Other transitions” cohort is composed of plans switching from DS to Basic Alternative (BA).

VBID allowed plans to reduce Part D cost sharing non-uniformly, commonly based on low-income status. Without VBID, if plans elect to continue to reduce cost sharing, they must do so on a uniform basis for drugs within the same tier. All else being equal, this approach would result in an increase in plan liability, as plans would lose a portion of their low-income cost sharing subsidies. **Figure 3** (next page) shows the prevalence of plans offering \$0 cost sharing on Tiers 1 and 2 for plans that participated in VBID in 2025 compared with all plans in 2026.

**Figure 3. Zero-Dollar Cost Share Prevalence for 2026**

For Tier 1 drugs, plans that participated in VBID were more likely to offer \$0 cost sharing, suggesting that these plans prioritized preserving reduced cost sharing for preferred generic medications despite the VBID sunset. For D-SNPs that had a DS Part D benefit type and participated in VBID in 2025, this change is especially significant, given the financial implication of the reduction in low-income cost sharing subsidies from CMS.

Tier 2 also remained a common target for \$0 cost sharing among plans that participated in VBID, whereas Tiers 3–5 are rarely offered at \$0 cost sharing in 2026.

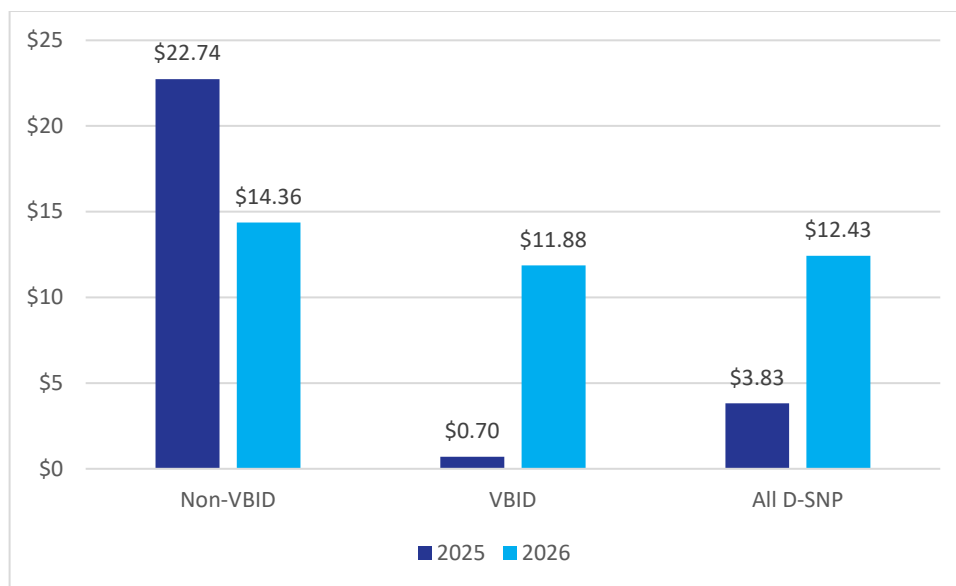
Taken together, these patterns suggest that, following the end of the Part D VBID model, plans concentrated \$0 cost-sharing strategies in lower drug tiers, where actuarial predictability and utilization controls are strongest. The near-elimination of \$0 cost sharing in mid- and upper-tier drugs underscores the role VBID previously played in enabling broader cost sharing reductions and highlights the constraints plans faced in maintaining such designs under standard Part D rules in 2026.

### Part D Benefit Design Plan Value-Add

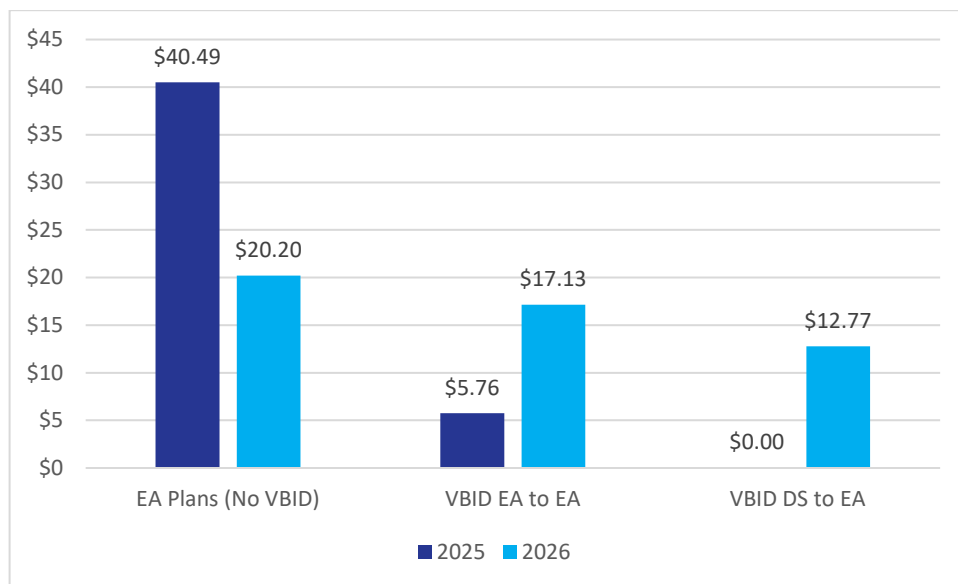
Wakely evaluated the benefit richness, or plan value-add,<sup>2</sup> for EA Part D plans using the 2026 CMS Out-of-Pocket Cost model, which calculates member cost sharing under a DS benefit design relative to the plan's benefit design. DS, Actuarially Equivalent (AE), and BA Part D benefit types are assigned a \$0 value-add.

**Figure 4** summarizes the average value-add among D-SNPs 2025 and 2026. **Figure 5** (next page) compares the D-SNP plan value-add by 2025 VBID status and Part D benefit type.

**Figure 4. D-SNP Part D Plan Value-Add by 2025 VBID Status, 2025 to 2026**



<sup>2</sup> Marino D, Nelessen A. The Value Shift: How Medicare Advantage Benefits Are Evolving for 2026 2026 Enrollment Updates. Wakely. February 2026. Available at: [The-Value-Shift-How-Medicare-Advantage-Benefits-Are-Evolving-for-2026.pdf](#).

**Figure 5. D-SNP Value-Add by Part D Benefit Type and 2025 VBID Status, 2025 to 2026**

**Figures 4 and 5** provide complementary perspectives on how D-SNP benefit designs evolved following the sunset of VBID. Key findings include:

- Because **Figure 4** reflects all D-SNPs, the average Part D value-add is diluted by the inclusion of DS, AE, and BA benefit types, which carry a \$0 value-add. The observed increase in the VBID Part D value-add is primarily driven by the migration of VBID-participating D-SNPs to EA designs in 2026, enabling continued low-income cost sharing reductions.
- D-SNPs that participated in VBID in 2025 show a lower average value-add than non-VBID, indicating a less rich plan design overall.
- As shown in **Figure 5**, EA D-SNPs that did not participate in VBID in 2025 reduced Part D benefit richness from 2025 to 2026. Nonetheless, these plans remain richer than EA plans formed through VBID transitions in 2026, suggesting that former VBID D-SNPs are partially offsetting the loss of VBID flexibility through EA benefit design.

## IMPACT ON REWARDS AND INCENTIVES PROGRAMS

VBID uniquely enabled certain financial rewards and incentives tied to Part D utilization, such as medication adherence or disease-specific engagement. These incentives functioned as

cash-equivalent benefits and were particularly prevalent in plans serving low-income populations. With the termination of VBID, Part D-linked incentives are no longer permitted.

Importantly, CMS regulations continue to allow rewards and incentives under Part C for activities such as completing preventive visits or health assessments. As a result, plans may shift toward these allowable incentive structures, though they may be less targeted and less directly linked to prescription drug behavior.

A total of 136 plans offered some variation of a Part D reward and incentive in 2024. This figure declined to 16 in 2025, which suggests that plans may have already deprioritized these designs even while they remained permissible, perhaps because of operational complexity or lower return relative to other Part D benefit strategies.

### **IMPACT ON PART C BENEFITS**

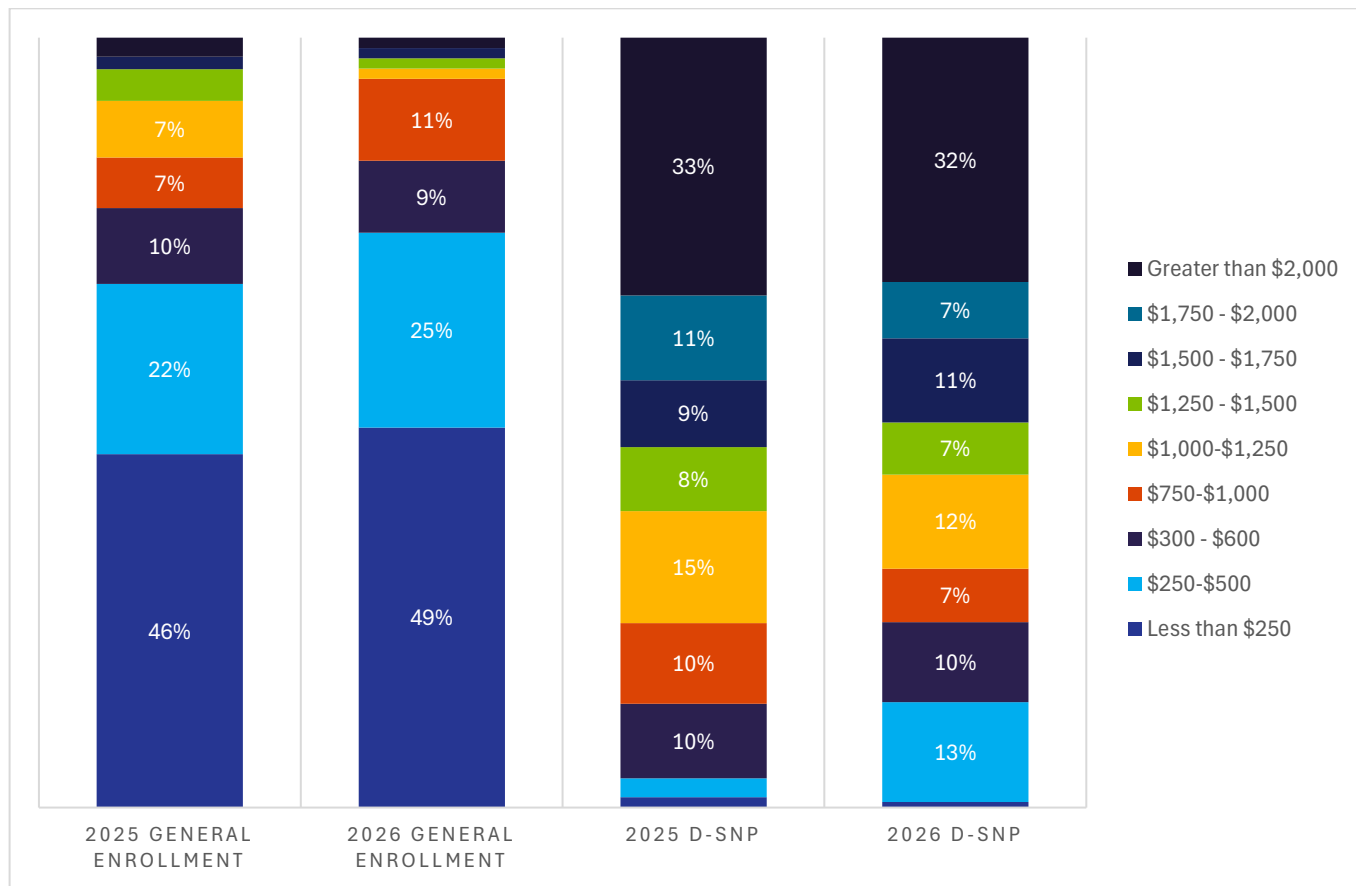
VBID played a central role in expanding non-medical benefits addressing health-related social needs, including food, transportation, housing stability, and utilities. While the VBID was sunset at the end of 2025, CMS continues to allow many of these benefits under the Special Supplemental Benefits for the Chronically Ill (SSBCI) framework, albeit with stricter eligibility and documentation requirements.

SSBCI, however, does not fully replicate VBID flexibility. Benefits must meet a reasonable expectation of improving or maintaining health or function and cannot be based solely on socioeconomic status or area deprivation index.

The most common method of providing Part C reduced cost sharing and additional benefits through VBID was through an allowance benefit. In 2025, 73% of plans offering Part C VBID benefit enhancements offered an allowance through Combined Supplemental Benefit Packages or Reductions in Cost Sharing (Section D Flex).

Following the termination of the VBID program at the end of 2025, the availability of an allowance type benefit declined in 2026. Among plans that participated in VBID in 2025, 71% continued to offer some form of a stipend in 2026, indicating meaningful, though reduced, continuity. The share of plans offering an allowance benefit through a Section D Flex decreased to 53%, suggesting that many plans were unable or unwilling to sustain these benefits under standard uniform requirements.

**Figure 6. 2025 to 2026 Annualized Allowance Distribution for VBID Plans**



**Figure 6** illustrates the distribution of annualized allowances among MA plans that offered an allowance benefit through VBID in 2025, standardized for comparability across payment frequencies. In both 2025 and 2026, the most common allowance bucket was “less than \$250” for general enrollment plans and “greater than \$2,000” for D-SNPs; however, both segments shifted toward low allowance levels in 2026.

Plans that did not retain an allowance benefit under Section D Flex benefits predominantly shifted to Category 19 supplemental benefits, most commonly leveraging SSBCI to sustain allowance benefits. Among plans that previously included VBID benefits in their allowance

benefit, the 2026 average rises to 17.4 conditions, suggesting that plans expanded eligibility criteria to preserve reach under more restrictive rules.

## CONCLUSION

The sunset of the MA VBID Model at the end of 2025 represents a meaningful inflection point in benefit design – not a reversal of innovation, but rather a recalibration under a more restrictive regulatory framework. While VBID enabled highly targeted approaches to cost sharing, allowances, and incentives for specific populations, its termination has required plans to reassess which design elements are sustainable within standard Part C and Part D frameworks.

Plans that participated in Part D VBID flexibilities in 2025 responded decisively by shifting toward EA benefit designs in 2026, seeking to preserve affordability for low-income members through uniform cost-sharing reductions. These changes, however, only partially offset the loss of VBID flexibility, as reflected in lower overall value-add relative to non-VBID EA plans. The concentration of \$0 cost sharing in lower drug tiers further highlights the tradeoffs plans faced going into 2026.

The VBID sunset had perhaps the most significant impact on Part C allowances. Although many plans maintained some level of financial support in 2026, both availability and generosity of funds declined, with a clear shift toward lower annualized amounts. Plans increasingly relied on SSBCI authority, often expanding the number of eligible chronic conditions to sustain access, demonstrating both the adaptability and the limitations of post-VBID policy pathways.

These trends suggest that while the direction of benefit innovation remains intact, the tools available to deliver it have narrowed. As plans navigate concurrent pressures from the IRA, rising Part D costs, and margin compression, 2026 benefit designs reflect a more standardized, cost-disciplined approach to value. Success in the post-VBID environment will depend on balancing affordability, compliance, and competitive differentiation, with fewer targeted levers but greater precision.

## ACKNOWLEDGMENT

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Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

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