PARTNERSHIP TO advance cardiovascular health

REPORT

Evaluating Access to Negotiated Cardiovascular Drugs in 2026 Formularies

Introduction

In 2026, Maximum Fair Price (MFP) rules for ten selected treatments under the Medicare Drug Price Negotiation Program took effect. Of these medications, five are central to cardiovascular care, such as anticoagulants and heart failure treatments.

Because patients with cardiovascular disease account for nearly half of Medicare Part D beneficiaries, this first round of negotiated medicines carries particular significance for heart health. As negotiated pricing is implemented alongside broader Medicare Part D redesign, new market pressures have the potential to influence formulary placement, utilization management, patient out-of-pocket costs and access to care.

Recognizing these risks, the Partnership to Advance Cardiovascular Health (PACH), along with its partners, clinicians, and patient advocates, engaged early with regulators and Congress to help ensure that implementation of the Inflation Reduction Act would not inadvertently disadvantage patients who rely on cardiovascular therapies. To assess how these policy changes are beginning to materialize, PACH commissioned Avalere Health to analyze Medicare Part D formulary coverage, tiering, cost sharing and utilization management for selected anticoagulant and heart failure medications across the 2024–2026 plan years, including standalone Part D plans and Medicare Advantage Part D plans, as well as by geographic market. Data revealed that while there is limited use of utilization management for heart patients overall, Part D plans increasingly require coinsurance over copays compared to previous years. This may increase the out-of-pocket costs for patients.

> *While there is limited use of utilization management for heart patients overall, Part D plans increasingly require coinsurance over copays compared to previous years.*

Part D Plans and Heart Health

PACH's analysis of Medicare Part D formulary files found that several cardiovascular drugs subject to negotiation were increasingly placed on preferred tiers and generally faced limited utilization management requirements between 2024 and 2026.

This is welcome news for patients, clinicians and advocates who have long called for fewer barriers to care. However, the results also suggest emerging concerns related to affordability and access for certain patient populations, particularly rural beneficiaries, who face higher use of coinsurance.

Separate research has shown that interactions among negotiated prices, pharmacy benefit manager practices and Part D benefit design can produce outcomes that diverge from the Inflation Reduction Act's stated goal of reducing patient costs. These early findings underscore that, while initial advocacy efforts may have helped blunt some immediate risks, ongoing oversight and policy engagement will be critical to ensure that negotiated pricing translates into sustained affordability and access for Medicare beneficiaries living with cardiovascular disease.

Anticoagulants

For anticoagulants, Avalere examined two negotiated therapies—apixaban and rivaroxaban—alongside a non-negotiated alternative.

Today, apixaban and rivaroxaban are covered by all Part D plans and are almost universally placed on the preferred formulary tier, reflecting broad plan access. Utilization management remains limited, with most plans offering open access (i.e., no utilization management) to apixaban and only modest use of step therapy for rivaroxaban, driven largely by a single plan sponsor. Concurrently, plans have increasingly shifted toward coinsurance rather than flat copays, particularly for Medicare Advantage plans and in rural counties. This change may expose some patients to higher out-of-pocket costs even when coverage is maintained. Notably, the non-negotiated drug is effectively absent from Part D coverage.

Heart Failure Therapies

PACH's review of the analysis of heart failure medications—including three negotiated drugs and one non-negotiated drug—shows similarly strong coverage patterns.

By 2026, all four therapies are covered by Part D plans, with negotiated drugs almost always placed on preferred tiers. As with anticoagulants, however, cost sharing has shifted decisively toward coinsurance across plan types, with particularly high use among standalone Part D plans and in rural Medicare Advantage markets. While most negotiated heart failure therapies face little to no utilization management, the non-negotiated drug continues to be subject to prior authorization among a significant share of plans, especially among certain large sponsors, which may result in uneven access within the same therapeutic area.

Select Heart Failure and Anticoagulant Drugs:
Changes in Coinsurance Rates

Change in % with coinsurance, 2026 % with coinsurance

Plan Type	PDP	MA-PD
All heart failure drugs	↑ 41 pp, 97%	↑ 53 pp, 67%
ENTRESTO	↑ 23 pp, 97%	↑ 58 pp, 67%
FARXIGA	↑ 60 pp, 97%	↑ 53 pp, 66%
JARDIANCE	↑ 60 pp, 97%	↑ 55 pp, 66%
VERQUVO	↑ 21 pp, 97%	↑ 51 pp, 66%
Anticoagulants	↑ 21 pp, 97%	↑ 52 pp, 67%
ELIQUIS	↑ 18 pp, 97%	↑ 55 pp, 67%
XARELTO	↑ 23 pp, 97%	↑ 50 pp, 66%

Source: Information comissioned by the Partnership to Advance Cardiovascular Health

BY THE NUMBERS

Rural Americans and Medicare Part D

Under MFP, plans are required to cover negotiated drugs.

However, an increased use of coinsurance among plans may lead to changes to patients' out-of-pocket costs. The findings suggest that rural patients may face additional barriers compared to urban and suburban patients when accessing the five cardiovascular treatments under MFP.

On Average, Rural Americans:

- Have lower median incomes
- Are more likely to be on fixed incomes
- Are vulnerable to adherence issues if their out-of-pocket medical costs increase

Higher use of coinsurance means a great financial strain for rural patients.

Rural Americans on Medicare Part D plans require coinsurance more often than urban plans (**73% vs. 65% in 2026**). Coinsurance exposes patients to the full list price of drugs rather than a predictable cop

Preferred tier placement reduces, but does not eliminate, access barriers.

Select heart medications subject to government price setting are placed on preferred tiers. Placement on a preferred tier may not improve affordability for rural patients. Rural patients may technically have "better" tiering, but when coupled with greater use of coinsurance, they still face unpredictable and high out-of-pocket costs.

Utilization management remains stubbornly present in rural settings.

Some heart medications are still subject to UM practices, especially heart failure therapies. Prior authorization can delay therapy initiation or continuation and rural providers have less capacity to manage UM paperwork, increasing the risk of treatment gaps.

Coinsurance Requirements in MA-PD Plans (2026)

Source: Information comissioned by the Partnership to Advance Cardiovascular Health

CONCLUSION

Since this analysis represents an initial snapshot of plan behavior in the first year of MFPs taking effect, ahead of the 2027–2028 plan cycles, policymakers should remain vigilant and work to prevent access or affordability problems before they arise.

In particular, stakeholders should watch for sudden year-over-year shifts in preferred tier placement, evidence that plans are steering patients toward non-negotiated alternatives that carry more aggressive utilization management, increases in coinsurance concentrated in certain geographies or actions among specific plans sponsors, and widening differences in coverage and cost-sharing patterns between standalone PDPs and MA-Part D plans.

These findings also suggest early engagement by PACH, PACH's partners, clinicians, patients and others may have helped mitigate some of the access disruptions that stakeholders feared would accompany the Inflation Reduction Act's implementation. For many beneficiaries, these formulary signals represent an important safeguard during a period of significant policy change. However, the growing reliance on coinsurance and persistent geographic and plan-level variation point to ongoing affordability challenges that are not fully resolved by negotiated pricing alone.

As the Medicare Drug Price Negotiation Program and Part D redesign continue to evolve, these early signals underscore the importance of continued oversight to ensure that policy changes deliver meaningful affordability and access for people living with cardiovascular disease.