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Emerging Trends in Part D Formulary Design Following Implementation of the IRA

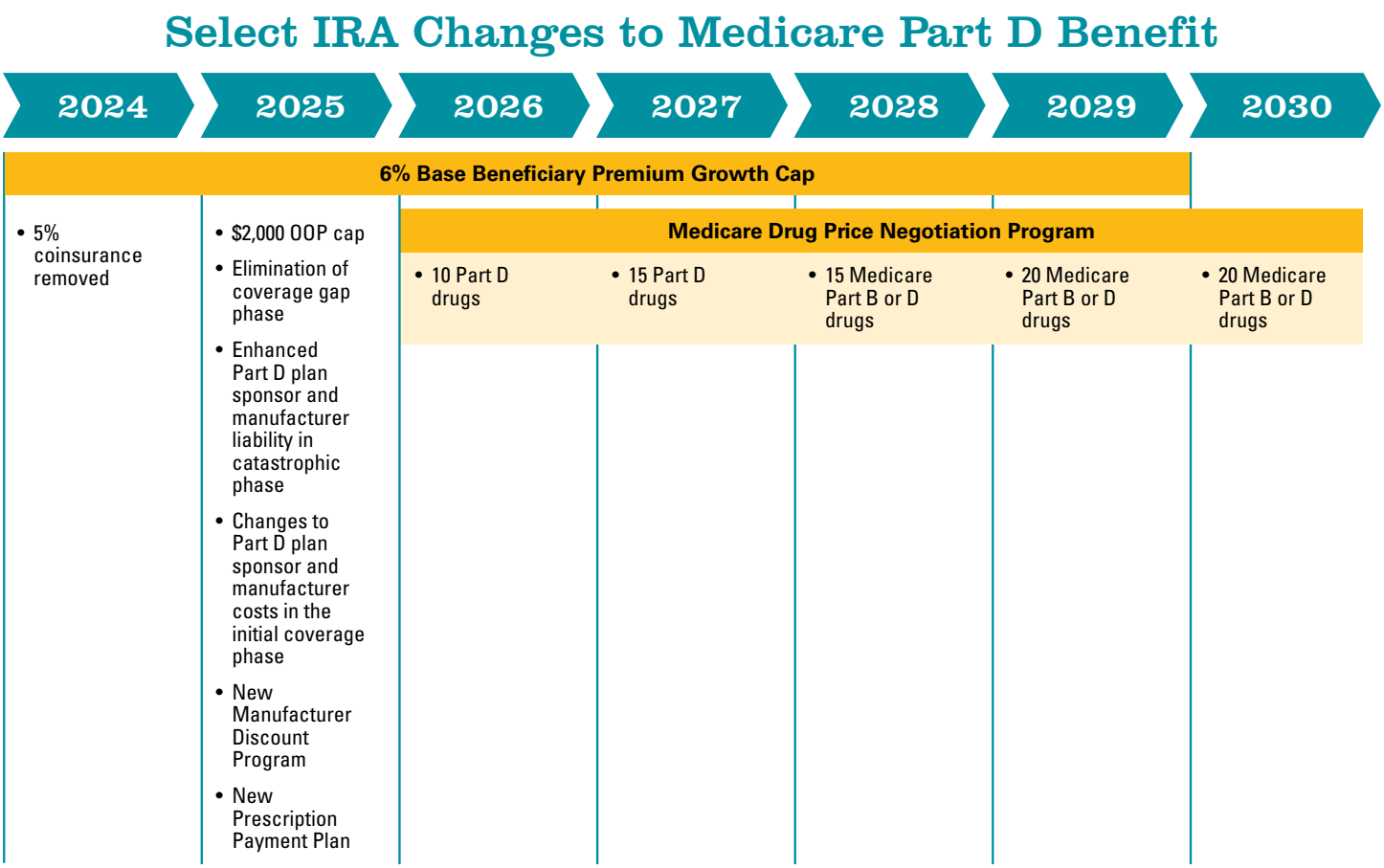
Introduction to Part D Redesign and the Medicare Drug Price Negotiation Program

The Inflation Reduction Act (IRA) of 2022 makes significant changes to the Medicare Part D prescription drug benefit intended to lower prescription drug costs for Part D enrollees. Key provisions include:

- Capping enrollee out-of-pocket drug spending at $2,000
- Requiring Part D plans and drug manufacturers to pay a greater share of costs for Part D enrollees, and
- Implementing a drug price negotiation program for high-spend drugs.

Figure 1 below provides an overview of when the IRA's various Part D provisions go into effect. While many of these provisions may lower prescription drug costs for Part D enrollees, they are likely to increase costs for Part D plans and manufacturers. In October 2024, the Congressional Budget Office (CBO) released a new fiscal analysis estimating that increased costs among Part D plans due to the IRA's Part D provisions would result in an increase in federal spending of $10–$20 billion in 2025 compared to earlier CBO fiscal projections.[1] Other recent analyses have revealed increases in loss ratios among both Medicare Advantage prescription drug (MA-PD) plans and standalone prescription drug plans (PDPs) from 2023 to 2024.[2]

Figure 1: Timeline of IRA Part D Provisions



Some have argued that the IRA's drug price negotiation program, in particular, will lead plans towards formulary changes for drugs selected for negotiation (e.g., increased use of utilization management, tightening formularies, and movement of drugs across formulary tiers). Under the program, because of the new Maximum Fair Prices (MFPs) for selected drugs, Part D plans will no longer receive the same level of manufacturer rebates for negotiated drugs, which may lead plans to implement cost-saving strategies that could have unintended negative effects on formularies and beneficiary cost sharing for these drugs.[3]

Stakeholders are understandably interested in assessing the extent to which the IRA will drive changes to formulary design. The multi-policy reforms associated with the IRA (e.g., redesign and drug price negotiation) make uncovering the root causes of these formulary dynamics challenging, as multiple provisions with overlapping goals are being implemented in tandem. To better understand this dynamic, we used publicly available Part D formulary and enrollment data to assess trends in cost sharing requirements and formulary placement from 2024–2025 of drugs in PDP and MA-PD plans. We then examined the same trends among the 10 drugs selected for negotiation for initial price applicability year (IPAY) 2026.

Cost Sharing Trends Show Broad Shifts in the Part D Market

Across both the PDP and MA-PD plans, many made shifts from copayment to coinsurance cost sharing for tier 3 and 4 drugs between 2024 and 2025. Figures 2 and 3 below summarize the percent of MA-PD and PDP enrollees, respectively, that faced coinsurance requirements by formulary tier in each year. For example, the share of MA-PD

enrollees with coinsurance requirements for tier 3 drugs increased from 12% to 28%, while the percent with coinsurance for tier 4 drugs more than tripled, from 17% to 55%. These trends were more stark among MA-PD enrollees because most enrollees in standalone PDPs already had coinsurance requirements in place for tier 3 and 4 drugs in 2024.

Figure 2: Percent of MA-PD Enrollees With Coinsurance by Formulary Tier, 2024–2025

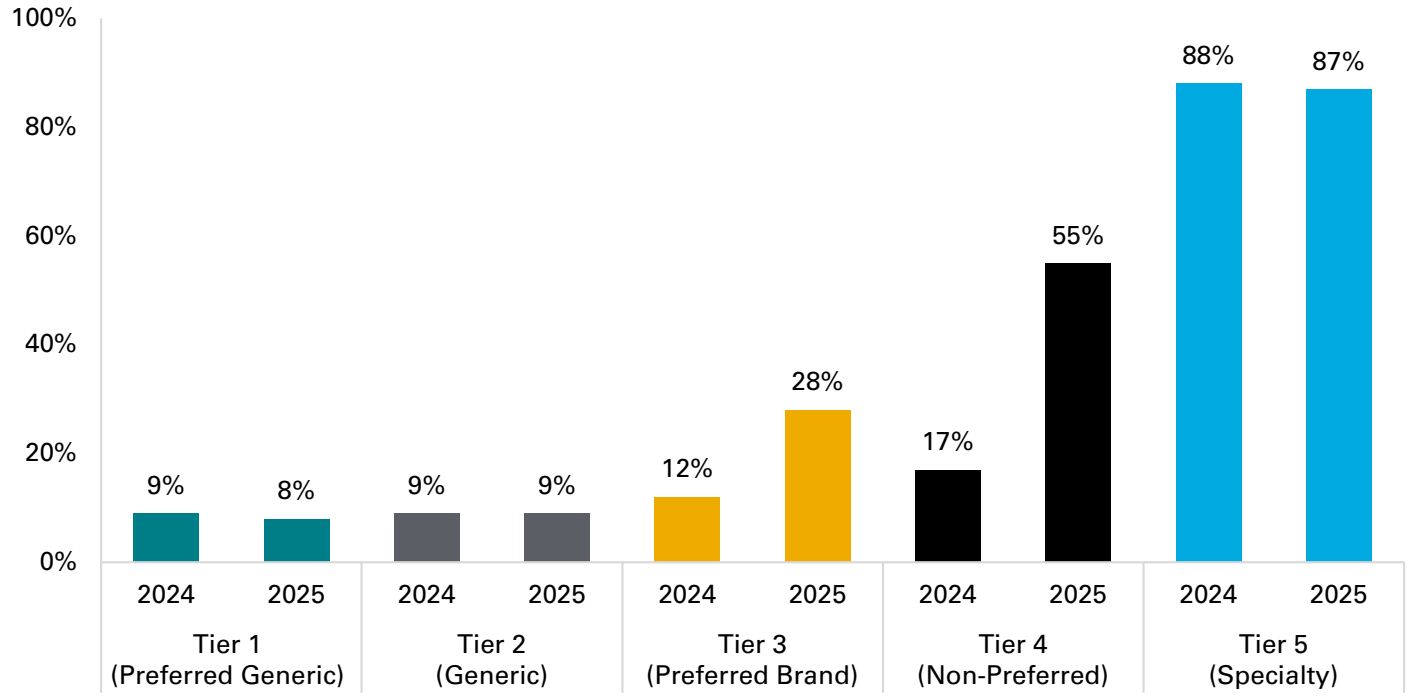
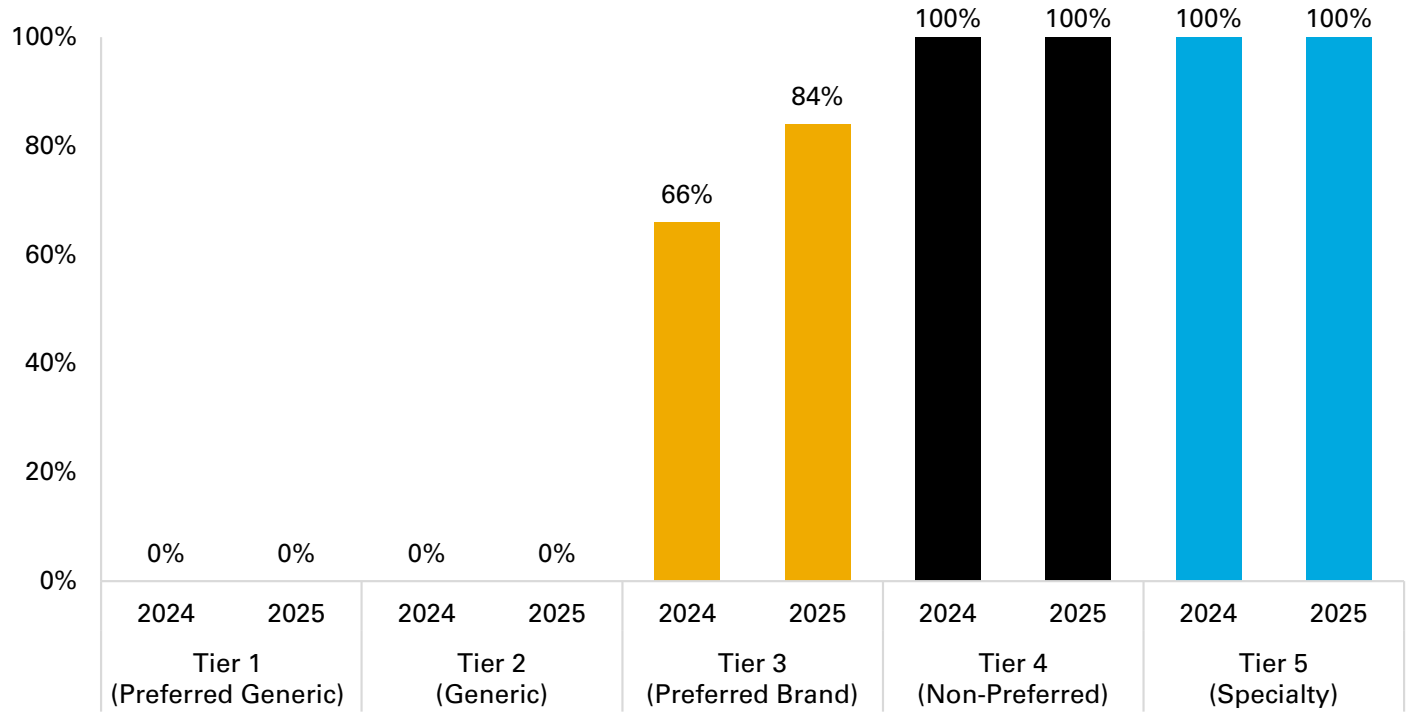


Figure 3: Percent of PDP Enrollees With Coinsurance by Formulary Tier, 2024–2025



Trends in Cost Sharing Requirements for Negotiated Drugs Reflect Larger Part D Market Dynamics

Mirroring the trends observed above across all drugs, CMS Part D formulary data show that many Part D enrollees face new coinsurance requirements for IPAY 2026 negotiated drugs in 2025, as summarized in Figures 4 and 5 below. For example, the percent of MA-PD enrollees that have coinsurance requirements for Farxiga and Novolog more than tripled from 2024 to 2025, while the percent with coinsurance for Eliquis, Entresto, Januvia, Jardiance, and Xarelto doubled over this time period. Many PDP enrollees also face new coinsurance requirements for most of the IPAY 2026 negotiated drugs, but trends among PDP enrollees are again less stark than those among MA-PD enrollees because most PDP enrollees already had coinsurance requirements for these drugs in place in 2024. Overall, the shift to coinsurance for the IPAY 2026 drugs was not unique within the full context of the Part D market, but rather reflective of broader programmatic shifts that were already underway.

Figure 4: Percent of MA-PD Enrollees With Coinsurance for IPAY 2026 Negotiated Drugs, 2024–2025

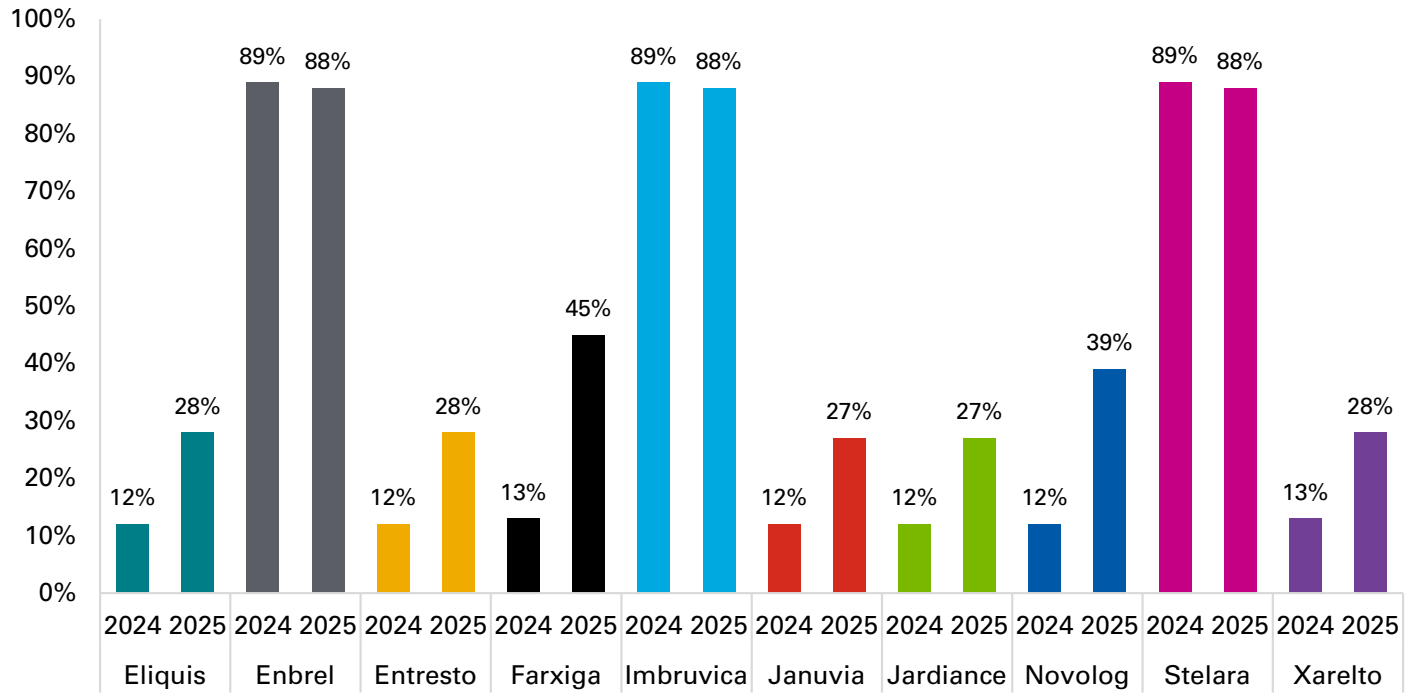
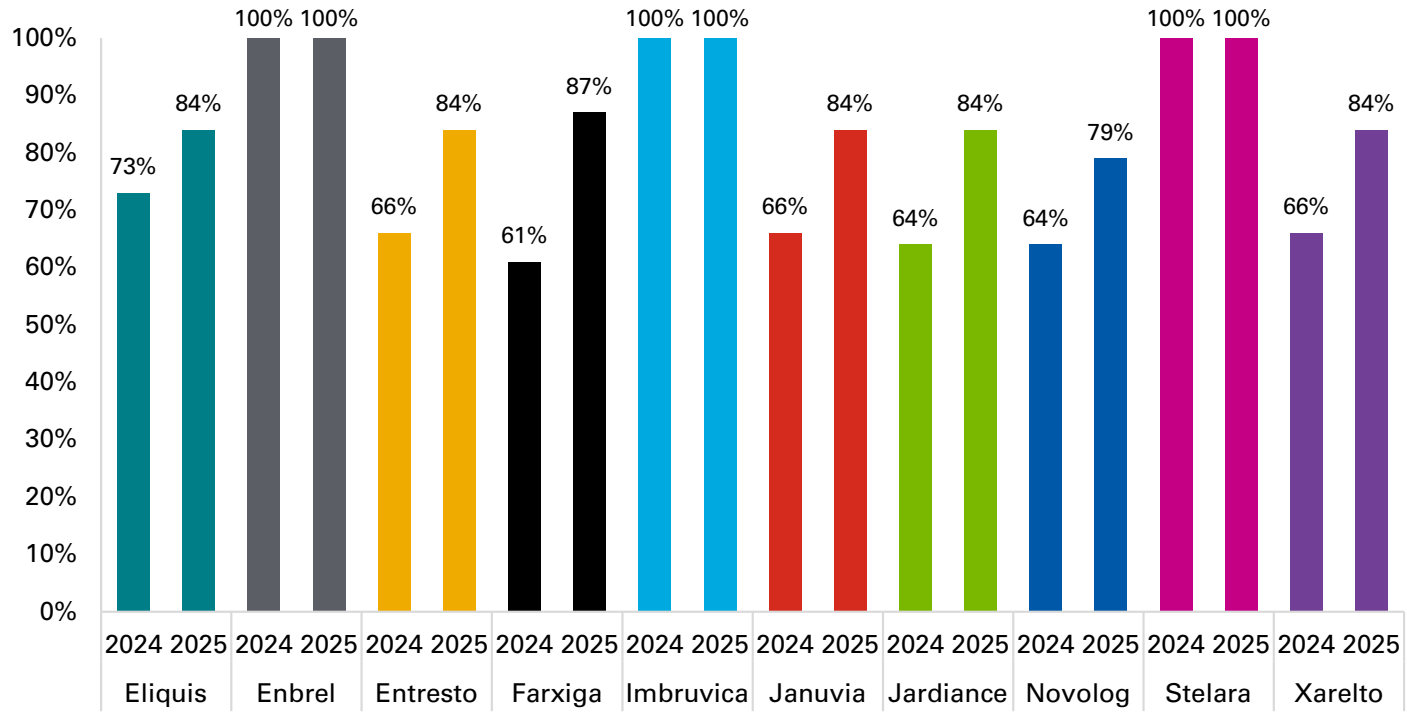


Figure 5: Percent of PDP Enrollees With Coinsurance for IPAY 2026 Negotiated Drugs, 2024–2025



Analyses of CMS Part D formulary data also reflect that most plans did not shift IPAY 2026 drugs to different formulary tiers between 2024 and 2025. Table 1 below summarizes the most common formulary tier for each IPAY 2026 negotiated drug in 2024 and 2025 among MA-PD and PDP plans, and shows that all of these drugs tended to have the same formulary tier placement in both years. In other words, the driver of increased coinsurance requirements for IPAY 2026 drugs is generally not a change to the tier on which these drugs sit, but rather a more global change to cost-sharing requirements on tiers across formulary products. Broad analyses of formulary treatment across all Part D drugs suggest that these trends are not isolated to IPAY 2026 products, and are reflective of broader trends among Part D plans.

Table 1: Most Common Formulary Tiers Among IPAY 2026 Negotiated Drugs, 2024–2025

	MA-PD Plans		PDP Plans	
IPAY 2026 Negotiated Drugs	2024 Most Common Tier	2025 Most Common Tier	2024 Most Common Tier	2025 Most Common Tier
ELIQUIS	3	3	3	3
ENBREL	5	5	5	5
ENTRESTO	3	3	3	3
FARXIGA	3	3	3	3
IMBRUVICA	5	5	5	5
JANUVIA	3	3	3	3
JARDIANCE	3	3	3	3
NOVOLOG	3	3	3	3
STELARA	5	5	5	5
XARELTO	3	3	3	3

Conclusions

The IRA fundamentally changed the economics of the Part D marketplace. Early evidence suggests that plans have responded to increased costs driven by the IRA's Part D benefit redesign provisions by changing cost sharing requirements for Part D enrollees to recalibrate premiums and plan liabilities. Changes in coinsurance requirements among IPAY 2026 negotiated drugs reflect changes at the formulary tier-level associated with Part D redesign rather than being driven by the drug price negotiations themselves. Once formulary files for 2026 are released, further analyses should be conducted to understand the extent to which these trends remained constant or accelerated in the first year of negotiated prices.

Methods

These analyses are based off publicly available Part D formulary data from December 2023 and December 2024.[4] The December 2023/2024 files describe Part D coverage as of January 2024/2025, respectively. The Part D formulary data include general information on Part D plans (e.g., plan name, contract ID, service area) as well as information on each plan's formulary, including the drugs covered, utilization management criteria, and cost sharing details for preferred, non-preferred, and mail order network pharmacies.

Results presented here were enrollment weighted using publicly available CMS data on Part D enrollment.[5] These analyses were limited to only include plans that had 5 formulary tiers, as this represents the most common formulary structure among Part D plans. The percent of MA-PD/PDP enrollees with coinsurance for IPAY 2026 negotiated drugs was calculated by dividing the number of MA-PD/PDP enrollees with coinsurance requirements for these drugs by the total number of MA-PD/PDP enrollees in plans that covered these drugs. This analysis focused on cost sharing requirements at non-preferred retail pharmacies and characterized cost-sharing based on requirements for 30-day supply prescriptions where individuals were in the initial coverage phase.

These analyses were subject to several limitations. First, the Part D formulary data used for these analyses do not include data on several types of Part D plans, including national PACE plans, employer-sponsored plans, and demonstration plans. Second, the analysis of IPAY 2026 negotiated drugs was conducted using formulary data from 2025, which was the most recent data available at the time of the analysis. While plan behavior may already be driven by anticipated MFPs, additional research is needed to assess whether this behavior will continue or accelerate once MFPs take effect in 2026. CMS has also issued formulary review guidance to plans in anticipation of IPAY 2026, and this somewhat opaque formulary review process could also alter the formulary status of IPAY 2026 drugs.[6] Finally, these analyses only assessed whether individuals were subject to any coinsurance requirements in 2024 or 2025, and did not seek to assess changes in the total amount of cost sharing that Part D enrollees were subject to over this period.

1. Swagel, P. (2024). Re: Developments in Medicare's Prescription Drug Benefit. Congressional Budget Office. https://www.cbo.gov/system/files/2024-10/Arrington_et_al_Letter_PartD_0.pdf

2. Pierce, K., Cline, M., & Friedman, J. (2025). Emerging Medicare Advantage and Part D trends from 2024 financial statements. Milliman. https://www.milliman.com/en/insight/emerging-medicare-advantage-part-d-2024-financial

3. Jeremias, S. (2025). The IRA's Unintended Consequences for Drug Pricing and Coverage. AJMC. https://www.ajmc.com/view/the-ira-s-unintended-consequences-for-drug-pricing-and-coverage

4. Centers for Medicare & Medicaid Services. (2025a, June). Monthly Prescription Drug Plan Formulary and Pharmacy Network Information. https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/monthly-prescription-drug-plan-formulary-and-pharmacy-network-information

5. Centers for Medicare & Medicaid Services. (2025b, February 27). Medicare Advantage/Part D Contract and Enrollment Data. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data

6. Seshamani, M. (2024). Medicare Drug Price Negotiation Program: Final Guidance, Implementation of Sections 1191–1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

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