



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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/s/

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SUBJECT: Memorandum Report: *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2014*, OEI-05-14-00170

This memorandum report fulfills the annual reporting mandate from the Patient Protection and Affordable Care Act of 2010 (ACA) for 2014. The ACA requires that the Office of Inspector General (OIG) conduct a study of the extent to which formularies used by stand-alone prescription drug plans (PDP) and Medicare Advantage prescription drug plans (MA-PD) under Medicare Part D include drugs commonly used by full-benefit dual-eligible individuals (i.e., individuals who are eligible for both Medicare and Medicaid and who receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing).¹ Pursuant to the ACA, OIG must annually issue a report, with recommendations as appropriate. This is the fourth report that OIG has produced to meet this mandate. For the relevant text of the ACA, see Appendix A.

SUMMARY

Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), comprehensive prescription drug coverage under Medicare Part D is available to all Medicare beneficiaries through PDPs and MA-PDs (hereinafter referred to collectively as Part D plans).²

For beneficiaries who are eligible for Medicare and Medicaid (hereinafter referred to as dual eligibles), Medicare covers Part D plan premiums, deductibles, and other cost-sharing up to a determined premium benchmark that varies by region.

¹ ACA, P.L. No. 111-148 § 3313(a), 42 U.S.C. § 1395w-101 note.

² MMA, P.L. No. 108-173 § 101, Social Security Act, § 1860D-1(a), 42 U.S.C. § 1395w-101(a).

If dual eligibles enroll in Part D plans with premiums higher than the regional benchmark, they are responsible for paying the premium amounts above that benchmark.

To control costs and ensure the safe use of drugs, Part D plans are allowed to establish formularies from which they may omit drugs from prescription coverage and control drug utilization through utilization management tools.³ These tools include prior authorization, quantity limits, and step therapy.⁴

The Centers for Medicare & Medicaid Services (CMS) annually reviews Part D plan formularies to ensure that they include a range of drugs in a broad distribution of therapeutic categories or classes. CMS also assesses the utilization management tools present in each formulary.

For this memorandum report, we determined whether the 329 unique formularies used by the 3,309 Part D plans operating in 2014 cover the 200 drugs most commonly used by dual eligibles. We also determined the extent to which those commonly used drugs are subject to utilization management tools.

Overall, we found that the rate of Part D plan formularies' inclusion of the drugs commonly used by dual eligibles is high, with some variation. On average, Part D plan formularies include 96 percent of the commonly used drugs. In addition, 64 percent of the commonly used drugs are included by all Part D plan formularies.

We also found that from 2013 to 2014, the proportion of unique drugs subject to utilization management tools remained the same. On average, formularies applied utilization management tools to 28 percent of the unique drugs we reviewed in both 2013 and 2014.

The results of our analysis for 2014 are largely unchanged from OIG's findings in 2011, 2012, and 2013.^{5, 6 7}

³ A formulary is a list of drugs covered by a Part D plan. Part D plans can exclude drugs from their formularies and can control utilization for formulary-included drugs within certain parameters. Social Security Act § 1860D-4(b) and (c), 42 U.S.C. § 1395w-104(b) and (c).

⁴ Prior authorization—often required for very expensive drugs—requires that physicians obtain approval from Part D plans to prescribe a specific drug. Quantity limits are intended to ensure that beneficiaries receive the proper dose and recommended duration of drug therapy. Step therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective or safest drug therapy and progressing if necessary to more costly or risky drug therapy.

⁵ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles*, OEI-05-10-00390, April 2011.

⁶ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2012*, OEI-05-12-00060, June 2012.

⁷ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2013*, OEI-15-13-00090, June 2013.

BACKGROUND

The Medicare Prescription Drug Benefit

Beginning in 2006, the MMA made comprehensive prescription drug coverage under Medicare Part D available to all Medicare beneficiaries.⁸ Medicare beneficiaries generally have the option to enroll in a PDP and receive all other Medicare benefits on a fee-for-service basis, or to enroll in an MA-PD and receive all of their Medicare benefits, including prescription drug coverage, through managed care. As of March 2014, approximately 37.3 million of the 50.8 million Medicare beneficiaries were enrolled in a Part D plan.

Part D plans are administered by private companies, known as plan sponsors, that contract with CMS to offer prescription drug coverage in one or more PDP or MA-PD regions. CMS has designated 34 PDP regions and 26 MA-PD regions.⁹ In 2014, plan sponsors offer 3,309 unique Part D plans, with many plan sponsors offering multiple Part D plans.

Dual Eligibles Under Medicare Part D

Approximately 9.7 million Medicare beneficiaries are dual eligibles. About 7 million dual eligibles, referred to as “full-benefit dual eligibles,” receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing.¹⁰ Other dual eligibles receive assistance with only their Medicare premiums or cost-sharing, depending on their level of income and assets.

Dual eligibles are a particularly vulnerable population. Overall, most dual eligibles have very low incomes: 86 percent have annual incomes below 150 percent of the Federal poverty level, compared with 22 percent of all other Medicare beneficiaries.¹¹ Additionally, dual eligibles are in worse health than the average Medicare beneficiary: half are in fair or poor health, more than twice the rate of others in Medicare.¹² Because of their self-reported health needs, dual eligibles may use more prescription drugs and health care services in general than other Medicare beneficiaries.

Until December 31, 2005, dual eligibles received outpatient prescription drug benefits through Medicaid. In January 2006, Medicare began covering outpatient prescription drugs for dual eligibles through Part D plans.¹³

⁸ MMA, P.L. No. 108-173 § 101, Social Security Act, § 1860D-1(a), 42 U.S.C. § 1395w-101(a).

⁹ CMS, *Prescription Drug Benefit Manual (PDBM)*, Pub. 100-18, ch. 5, Appendixes 2 and 3. Accessed at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html> on October 19, 2012.

¹⁰ Kaiser Family Foundation, *Dual Eligibles: Medicaid's Role for Dual Eligible*. Accessed at <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/7846-04-medicoids-role-for-dual-eligible-beneficiaries.pdf> on April 21, 2014.

¹¹ Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries*. Accessed at <http://www.kff.org/medicare/upload/8138-02.pdf> on November 20, 2012.

¹² Ibid.

¹³ MMA, P.L. No. 108-173 § 101.

Medicare covers Part D plan premiums, deductibles, and other cost-sharing for dual eligibles up to a determined premium benchmark. The benchmark is a statutorily defined amount that is based on the average premium amounts for Part D plans for each region.^{14, 15} If dual eligibles enroll in Part D plans with premiums higher than the regional benchmark, they are responsible for paying the premium amounts above that benchmark.¹⁶

Dual eligibles' assignment to Part D plans. When individuals become eligible for both Medicare and Medicaid, CMS randomly assigns those individuals to PDPs unless they have elected a specific Part D plan or have opted out of Part D prescription drug coverage.¹⁷ CMS assigns dual eligibles to PDPs that meet certain requirements, such as having a premium at or below the regional benchmark amount and offering basic prescription drug coverage (or equivalent).¹⁸ Basic prescription drug coverage is defined in terms of benefit structure (initial coverage, coverage gap, and catastrophic coverage) and costs (initial deductible and coinsurance).

Some dual eligibles may be randomly assigned to PDPs that do not cover the specific drugs they use. However, unlike the general Medicare population, dual eligibles can switch plans at any time to find Part D plans that cover the prescription drugs they require.¹⁹ When dual eligibles change plans, their prescription drug coverage under their new Part D plans becomes effective at the beginning of the following month.

CMS annually reassigns some dual eligibles to new PDPs if their current PDPs will have premiums above the regional benchmark premium for the following year.²⁰ CMS reassigns dual eligibles who were randomly assigned to their current PDPs to new PDPs that will have premiums at or below the regional benchmark premium.²¹ In addition, CMS notifies dual eligibles who elected their current Part D plans that their plans will have premiums above the regional benchmark premium. For 2014, CMS reported reassigning approximately 370,000 Medicare beneficiaries, including but not exclusively dual eligibles, because of premium increases.

¹⁴ 42 CFR § 423.780(b)(2)(i).

¹⁵ Social Security Act, § 1860D-14(a)(3)(f), 42 U.S.C. § 1395w-114(a)(3)(f). Dual eligibles residing in territories are not eligible to receive cost-sharing assistance from Medicare. As such, there are no benchmarks for Part D plans offered in the territories.

¹⁶ Patient Protection and Affordable Care Act (ACA), P.L. No. 111-148 § 3303, Social Security Act, § 1860D 14(a)(5), 42 U.S.C. § 1395w-114(a)(5). The ACA established a “de minimis” premium policy, whereby a Part D plan may elect to charge dual eligibles the benchmark premium amount if the Part D plan’s basic premium exceeds the regional benchmark by a de minimis amount. For 2013, CMS set the de minimis amount at \$2 above the regional benchmark.

¹⁷ CMS, *PDBM*, ch. 3, § 40.1.4.

¹⁸ *Ibid.*

¹⁹ *Ibid.*, § 30.3.2. In general, Medicare beneficiaries can switch Part D plans only once a year during a defined enrollment period.

²⁰ *Ibid.*, § 40.1.5.

²¹ *Ibid.*, § 40.1.5.

Part D Prescription Drug Coverage

Under Part D, plans can establish formularies from which they may exclude drugs and control drug utilization within certain parameters. These parameters are intended to balance Medicare beneficiaries' needs for adequate prescription drug coverage with Part D plans' needs to contain costs. Generally, a formulary must include at least two drugs in each therapeutic category or class.^{22, 23} In addition, Part D plans must include Part D-covered drugs in certain categories and classes.²⁴

Part D plans may also control drug utilization by applying utilization management tools. These tools include requiring prior authorization to obtain drugs that are on plan formularies, establishing quantity limits, and requiring step therapy. Utilization management tools can help Part D plans and the Part D program limit the cost of prescription drug coverage by placing restrictions on the use of certain drugs.

In addition to these drug coverage decisions made regarding individual formularies, certain categories of drugs are excluded from Medicare Part D prescription drug coverage as mandated by the MMA.²⁵ For example, prescription vitamins, prescription mineral products, and nonprescription drugs are excluded from Part D prescription drug coverage.²⁶

Until 2013, barbiturates and benzodiazepines were excluded from Part D prescription drug coverage. However, the ACA reversed this exclusion, removing these two drug types from the list of drug classes ineligible for Part D prescription drug coverage.^{27, 28}

CMS Efforts To Ensure Prescription Drug Coverage

Formulary review. CMS annually reviews Part D plan formularies to ensure that they include a range of drugs in a broad distribution of therapeutic categories or classes and include all drugs in specified therapeutic categories or classes.²⁹ During this review, CMS analyzes formularies' coverage of the drug classes most commonly prescribed for the Medicare population. CMS intends for Part D plans to cover the most widely used medications, or therapeutically alternative medications (e.g., drugs from the same therapeutic category or class), for the most common conditions. CMS uses Part D prescription drug data to identify the most commonly prescribed classes of drugs.³⁰

²² CMS, *PDBM*, ch. 6, § 30.2.1.

²³ Therapeutic categories or classes classify drugs according to their most common intended uses. For example, cardiovascular agents compose a therapeutic class intended to affect the rate or intensity of cardiac contraction, blood vessel diameter, or blood volume.

²⁴ ACA, P.L. No. 111-148 § 3307, Social Security Act, § 1860D 4(b)(3)(G), 42 U.S.C. § 1395w-104(b)(3)(G).

²⁵ MMA, P.L. No. 108-173 § 101, Social Security Act, § 1860D-2(e), 42 U.S.C. § 1395w-102(e).

²⁶ Social Security Act § 1860D-2(e)(2), 1927(d)(2), 42 U.S.C. § 1395w-102(e)(2), 1396r-8(d)(2).

²⁷ ACA, P.L. No. 111-148 § 2502, Social Security Act, § 1397r-8(d).

²⁸ CMS, *Transition to Part D Coverage of Benzodiazepines and Barbiturates Beginning in 2013*. Accessed at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/BenzoandBarbituratesin2013.pdf> on January 17, 2013.

²⁹ CMS, *PDBM*, ch. 6, §§ 30.2.1 and 30.2.5.

³⁰ *Ibid.*, § 30.2.7.

CMS also assesses each formulary's utilization management tools to ensure consistency with current industry standards and with standards that are widely used with drugs for the elderly and people with disabilities.^{31, 32, 33}

Exceptions and appeals process. CMS has implemented an exceptions and appeals process whereby beneficiaries can request coverage of nonformulary drugs. Beneficiaries apply to their Part D plans for exceptions to obtain coverage of nonformulary drugs. Generally, Part D plans must make determinations within 72 hours or, for expedited requests, within 24 hours.³⁴ If their plans make negative determinations, beneficiaries have the right to appeal.³⁵ If their plans deny their appeals, beneficiaries would need to get prescriptions from their physicians for therapeutically alternative drugs that are covered by their plans.

Transitioning new enrollees to Part D. CMS requires that Part D plans establish a transition process for new enrollees (including dual eligibles) who are transitioning to their respective Part D plans either from different Part D plans or from other prescription drug coverage. During Medicare beneficiaries' first 90 days under a new Part D plan, the new plan must provide one temporary refill of a prescription when beneficiaries request either a drug that is not in the plan's formulary or a drug that requires prior authorization or step therapy under the formulary's utilization management tools.³⁶ The temporary fill accommodates beneficiaries' immediate drug needs the first time they attempt to fill a prescription. The transition period also allows beneficiaries time to work with their prescribing physicians to obtain prescriptions for therapeutically alternative drugs or to request formulary exceptions from Part D plans.

Related OIG Work

In 2006, OIG published a report assessing the extent to which PDP formularies included drugs commonly used by dual eligibles under Medicaid. The study found that PDP formularies included between 76 and 100 percent of the 178 drugs commonly used by dual eligibles under Medicaid prior to the implementation of Part D. Approximately half of the 178 commonly used drugs were covered by all formularies.³⁷

In 2011, OIG issued the first annual mandated memorandum report examining dual eligibles' access to drugs under Medicare Part D.³⁸ In 2012, OIG issued the second annual mandated memorandum report examining dual eligibles' access to drugs under

³¹ CMS, *PDBM*, ch. 6, § 30.2.2.

³² *Ibid.*, § 30.2.7.

³³ CMS looks to appropriate guidelines from expert organizations such as the National Committee for Quality Assurance, the Academy of Managed Care Pharmacy, and the National Association of Insurance Commissioners.

³⁴ CMS, *PDBM*, ch. 18, §§ 130.1 and 130.2.

³⁵ *Ibid.*, § 60.1.

³⁶ *Ibid.*, ch. 6, § 30.4.4.

³⁷ OIG, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, January 2006.

³⁸ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles*.

Medicare Part D.³⁹ In 2013, OIG issued the third annual mandated memorandum report examining dual eligibles' access to drug under Medicare Part D.⁴⁰ In the current memorandum report, we compare the results from 2013 and 2014.

METHODOLOGY

Scope

As mandated in the ACA, this study assessed the extent to which drugs commonly used by dual eligibles are included by Part D plan formularies. To make this assessment, we evaluated formularies for Part D plans operating in 2014. As part of our assessment, we included dual eligibles' enrollment data from March 2014, the most recent enrollment data available from CMS at the time of our study. We also compared the results of our 2014 study with those of our 2013 study.⁴¹

The ACA did not define which drugs commonly used by dual eligibles we should review. We defined drugs commonly used by dual eligibles as the 200 drugs with the highest utilization by dual eligibles as reported in the latest Medicare Current Beneficiary Survey (MCBS). We used the MCBS because it contains drugs that dual eligibles received through multiple sources (e.g., Part D, Medicaid, and the Department of Veterans Affairs) and, as such, it provides a comprehensive picture of drug utilization. Of the 200 highest utilization drugs identified using the MCBS, 195 are eligible for coverage under Part D. In this report, we refer to these 195 Part D-eligible high-utilization drugs as “commonly used drugs.”

The 200 drugs with the highest utilization by dual eligibles referenced in this 2014 memorandum report are similar but not identical to the list of drugs referenced in the 2013 memorandum report. Specifically, 182 (91 percent) of the 200 drugs listed in the 2013 report are also listed in this 2014 report.

For each study, OIG went beyond the ACA's mandate by reviewing drug coverage for all dual eligibles under Medicare Part D, rather than only for full-benefit dual eligibles. With the data available for this study, we could not confidently identify and segregate full-benefit dual eligibles—and thus the drugs they used—from the total population of dual eligibles.

We also went beyond the ACA's mandate in both the 2013 and 2014 reports by examining the utilization management tools that Part D plan formularies apply to the drugs commonly used by dual eligibles. These tools may affect dual eligibles' access even in cases where formularies include the commonly used drugs. Analyzing the extent to which Part D plan formularies apply these tools to drugs commonly used by dual eligibles allows us to provide a comprehensive picture of Part D plan formularies' coverage of, and dual eligibles' access to, those drugs.

³⁹ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2012*.

⁴⁰ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2013*.

⁴¹ *Ibid.*

Data Sources

MCBS. We used 2010 MCBS Cost and Use data to create a list of the 200 drugs with the highest utilization by dual eligibles. The MCBS Cost and Use data contain information on hospitals, physicians, and prescription drug costs and utilization. The 2010 MCBS Cost and Use data are the most recent data available.

The MCBS is a CMS-conducted continuous, multipurpose survey of a representative national sample of the Medicare population, including dual eligibles. Sampled Medicare beneficiaries are interviewed three times per year and asked what drugs they are taking and whether they have started taking any new drugs since the previous interview. The MCBS also includes Part D prescription drug events for surveyed Medicare beneficiaries. In 2010, the MCBS surveyed 10,741 Medicare beneficiaries, of which 2,046 were dual eligibles who had used prescription drugs during the year (out of 2,274 dual-eligible survey respondents).

First Databank National Drug Data File. We used the November 2012 and December 2013 First DataBank National Drug Data File to identify the drug product information for the 200 drugs with the highest utilization by dual eligibles. The National Drug Data File is a database containing information—such as drug name, therapeutic category or class, and the unique combination of active ingredients—for each drug defined by the Food and Drug Administration’s National Drug Code (NDC).⁴²

Part D plan data. In November 2013 and January 2014, we collected from CMS formulary data and plan data for Part D plans operating in 2014. The November 2013 Part D formulary data include Part D plans’ formularies and utilization management tools for plans operating in 2014. In 2014, there are 329 unique formularies offered by 3,309 Part D plans. The January 2014 Part D plan data provide information such as the State in which a Part D plan is offered, whether the Part D plan is a PDP or an MA-PD, and whether the Part D plan premium is below the regional benchmark.

We also collected 2014 Part D plan enrollment data. These data provide the number of dual eligibles enrolled in each Part D plan as of March 2014.

Determining the Most Commonly Used Drugs

To determine the drugs most commonly used by dual eligibles, we took the following steps:

1. Created a list of all drugs reported by dual eligibles surveyed in the MCBS. We excluded respondents from territories because they are not eligible to receive cost-sharing assistance under Part D. There were 150,106 drug events listed for 2,046 MCBS-surveyed dual eligibles who did not reside in territories.⁴³

⁴² An NDC is a three-part universal identifier that specifies the drug manufacturer’s name, the drug form and strength, and the package size.

⁴³ For the purposes of this report, a drug event is a MCBS survey response indicating that the responding beneficiary took a specific drug at least once in 2010. For example, one MCBS survey respondent reported taking atenolol 8 times in 2010. We counted this beneficiary/drug combination as 8 drug events.

2. Collapsed this list to a list of drugs based on their active ingredients, using the Ingredient List Identifier located in First DataBank’s National Drug Data File. For example, a multiple-source drug such as fluoxetine hydrochloride (the active ingredient for the multiple-source brand-name drug Prozac) has only one entry on our list, covering all strengths of both the brand-name drug Prozac and the generic versions of fluoxetine hydrochloride available. From this point forward, unless otherwise stated, we will use the term “drug” to refer to any drug in the same Ingredient List Identifier category, and the term “unique drug” to refer to an NDC corresponding to a drug, as a given drug can have multiple NDCs. This process left 150,106 drug events associated with 901 drugs.
3. Ranked the 901 drugs by frequency of utilization, weighting the drug-event information from MCBS by sample weight.
4. Selected the 200 drugs with the highest utilization by dual eligibles. For a full list of the top 200 drugs, see Appendix B.
5. Removed all drugs not covered under Part D. Of the 200 drugs with the highest utilization, 195 are eligible under Part D, 3 fell into drug categories excluded under Part D, 1 is no longer prescribed in the form taken by beneficiaries surveyed in the 2010 MCBS, and 1 is no longer available in the United States. For details on the five drugs excluded under Part D, see Appendix C.

Formulary Analysis

We analyzed the 329 unique Part D plan formularies to determine their rates of inclusion of the 195 drugs commonly used by dual eligibles. We counted a drug as included in a Part D plan’s formulary if the formulary included the active ingredient. When a drug included multiple ingredients that could be dispensed separately and combined by the patient to the same effect as the combined drug, we treated the drug as included if the ingredients were included in the formulary either separately or in combination.

Low rates of inclusion by formularies. We determined which of the 195 commonly used drugs had low rates of inclusion by formularies by counting how many of the 329 formularies covered each drug. We considered a drug to have a low rate of inclusion if it was included by 75 percent or less of formularies. For such drugs, we counted the number of drugs (if any) that each formulary covered in the same therapeutic category or class.

We conducted this analysis to ensure that dual eligibles have access to therapeutically similar drugs. We also conducted additional research to identify potential reasons why some of the 195 commonly used drugs were included by less than 75 percent of formularies.

Utilization management tools. We determined the extent to which Part D plans apply utilization management tools to the 195 drugs that we reviewed. The tools that we reviewed are prior authorization, quantity limits, and step therapy.

To determine the extent to which the 195 commonly used drugs are subject to utilization management tools, we conducted an analysis of the NDCs that correspond to the commonly used drugs. Part D plan formularies do not apply utilization management tools at the active ingredient level. Rather, Part D plan formularies apply utilization management tools at a more specific level that identifies whether a drug is brand-name or generic and its dosage form, strength, and route of administration, irrespective of package size. To conduct this analysis, we determined the NDCs (unique drugs) associated with each of the 195 commonly used drugs that are on each Part D formulary. We then calculated the percentage of unique drugs to which each Part D plan formulary applies utilization management tools.

Enrollment Analysis

We weighted the formulary analysis by dual-eligible enrollment and weighted the utilization management tool analysis by both dual-eligible enrollment and Medicare enrollment. To do this, we applied March 2013 enrollment data to 2013 Part D plans.

Data Limitations

We did not assess individual dual eligibles' prescription drug use or whether individual dual eligibles are enrolled in Part D plans that include the specific drugs that each individual uses. Because we relied on a sample of dual eligibles responding to the MCBS to develop our list of commonly used drugs, a particular dual eligible might not use any of the drugs on our list. However, the drugs most commonly used by dual-eligible MCBS survey participants in 2010 account for 87 percent of all prescriptions dispensed to the dual-eligible respondents in the 2010 MCBS.

Because the lists of commonly used drugs in the 2013 and 2014 memorandum reports are not identical, changes in rates of inclusion by formularies and in application of utilization management tools between 2013 and 2014 may reflect changes as to which specific drugs were included in the lists, rather than changes regarding any specific drug. However, the two lists largely overlap; 91 percent of the drugs reviewed in the 2013 report are the same as those reviewed in this 2014 report.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

Part D Plan Formularies Include Between 86 and 100 Percent of the Drugs Commonly Used by Dual Eligibles

On average, Part D plan formularies include 96 percent of the drugs commonly used by dual eligibles. Of the 329 unique formularies used by Part D plans in 2014, 18 formularies include 100 percent of the commonly used drugs. At the other end of the inclusion range, three formularies include 86 percent of the commonly used drugs. CMS generally requires Part D plan formularies to include at least two drugs, rather than all drugs, in each therapeutic category or class. Therefore, Part D plan formularies may still

meet CMS's formulary requirements even if they do not include all of the drugs we identified as commonly used by dual eligibles.

Part D plan formularies' inclusion of the drugs commonly used by dual eligibles in 2014 is nearly identical to that of 2013. The average rate of inclusion—96 percent—was unchanged between 2013 and 2014. The ranges of inclusion in 2013 and 2014 are almost the same—in 2013, the rates of inclusion ranged from 85 to 100 percent of the drugs commonly used by dual eligibles, and in 2014, they ranged from 86 to 100 percent.

Nationally, PDP and MA-PD formularies include a similar average of the drugs commonly used by dual eligibles: 94 percent and 96 percent, respectively. PDP formularies' rates of inclusion of the commonly used drugs ranged from 86 to 100 percent and MA-PD formularies' rates ranged from 87 to 100 percent. Twenty-one formularies—6 percent of the 329 unique formularies used by Part D plans in 2014—are offered by both PDPs and MA-PDs.

Regionally, all dual eligibles have the choice of a Part D plan that includes at least 98 percent of the commonly used drugs. Every PDP region has a plan that includes at least 99 percent of the commonly used drugs, and every MA-PD region has a plan that covers at least 98 percent of these drugs. Appendix D provides a breakdown of formulary inclusion by PDP and MA-PD region.

On average, formularies for Part D plans with premiums below the regional benchmark include 95 percent of the drugs commonly used by dual eligibles. The percentage of drugs included by Part D plans with premiums below the regional benchmark is important because dual eligibles are automatically enrolled in, or annually reassigned to, these plans. For drugs commonly used by dual eligibles, formularies for Part D plans with premiums below the regional benchmark have a rate of inclusion that ranges from 86 percent to 100 percent. Approximately 83 percent of dual eligibles are enrolled in Part D plans with premiums below the regional benchmark.

Ninety-nine percent of dual eligibles are enrolled in Part D plans that include at least 90 percent of the drugs commonly used by dual eligibles. Of the approximately 9.5 million dual eligibles enrolled in Part D plans, 99 percent are enrolled in Part D plans that use formularies that include at least 90 percent of the commonly used drugs. Only 1 percent of dual eligibles are enrolled in Part D plans that use formularies that include less than 90 percent of these drugs. Table 1 provides a breakdown of dual eligibles' enrollment in Part D plans by the plans' formulary inclusion rates.

Table 1: Enrollment of Dual Eligibles in Part D Plans and Formulary Inclusion of Commonly Used Drugs

Part D Plans With Formularies That Include:	Number of Dual Eligibles Enrolled*	Percentage of Dual Eligibles Enrolled
100% of commonly used drugs	172,000	2%
95% to 99% of commonly used drugs	3,453,000	36%
90% to 94% of commonly used drugs	5,745,000	61%
85% to 89% of commonly used drugs	120,000	1%
Total	9,490,000	100%

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles and dual eligibles' enrollment, 2014.

*Rounded to the nearest 1,000.

The percentage of dual eligibles enrolled in Part D plans that include at least 90 percent of the drugs commonly used by dual eligibles stayed consistent between 2013 and 2014 at 99 percent.

Sixty-Four Percent of the Drugs Commonly Used by Dual Eligibles Are Included in All Part D Plan Formularies

Because most of the commonly used drugs are included in a large percentage of formularies, dual eligibles are guaranteed that, regardless of the Part D plan in which they are enrolled, the plan's formulary will include many of these drugs. By drug, formulary inclusion ranges from 45 percent to 100 percent. In other words, one drug commonly used by dual eligibles is included in as few as 45 percent of Part D plan formularies, and 125 drugs are included in all plan formularies. The average rate of inclusion by formularies is 96 percent. Table 2 provides a summary of rates of inclusion by formularies. Appendix B provides rates of inclusion by formularies for each of the commonly used drugs.

Table 2: Formularies' Rates of Inclusion of Commonly Used Drugs

Percentage of the 329 Formularies	Percentage of the 195 Commonly Used Drugs Included in Formularies
100%	64% (125 drugs)
85% to 99%	25% (48 drugs)
75% to 84%	6% (11 drugs)
45% to 74%	6% (11 drugs)
Total	100%* (195 drugs)

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2014.

* Percentages do not add to 100 percent because of rounding.

The rates of formulary inclusion of the drugs commonly used by dual eligibles in 2014 are similar to those in 2013. The percentage of commonly used drugs included in all formularies remained the same between 2013 and 2014, at 64 percent.

Part D plan formularies include certain drugs less frequently than others. Of the commonly used drugs, 6 percent (11 drugs) are included by less than 75 percent of Part D plan formularies. Table 3 provides the percentage of formularies covering each of these 11 drugs.

The drugs that make up this group include both brand and generic drugs, and are used to treat a variety of primary indications. Five of the eleven drugs are brand-name drugs, which are typically more costly than generic drugs. In terms of primary indications, 3 of the 11 drugs are muscle relaxants, and the remaining drugs treat a variety of conditions including high cholesterol, anxiety, and insomnia.

Table 3: Drugs Included by Less Than 75 Percent of Part D Plan Formularies

Generic Name of Drug	Primary Indication(s)	Rate of Inclusion by Formularies
Promethazine HCL	Allergies	71%
Valsartan*	Hypertension (high blood pressure)	71%
Temazepam*	Insomnia	65%
Ezetimibe/simvastatin*	Hyperlipidemia (high cholesterol)	64%
Methocarbamol*	Muscle relaxant	64%
Esomeprazole magnesium*	Dyspepsia, peptic ulcer disease, gastroesophageal reflux disease, Zollinger-Ellison syndrome	62%
Cyclobenzaprine HCL*	Muscle relaxant	59%
Hydroxyzine pamoate	Anxiety	54%
Hydrocortisone acetate	Hemorrhoids	51%
Carisoprodol*	Muscle relaxant	47%
Darifenacin hydrobromide	Overactive bladder	45%

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2014.

* These drugs also had low formulary inclusion rates in 2013.

Although Part D formularies frequently omit these 11 drugs, they all cover other drugs in the same therapeutic classes. For these 11 drugs, 100 percent of formularies cover at least 1 drug in the same therapeutic class that is also on the list of 195 drugs commonly used by dual eligibles.

The number of drugs included by less than 75 percent of formularies decreased from 16 in 2013 to 11 in 2014. There are seven drugs with low inclusion rates in 2014 that were also on the list of commonly used drugs with low inclusion rates in our 2013 report; these drugs are noted in Table 3. Three of the low-inclusion drugs were also listed as low-inclusion drugs in our 2012 report.

There are many potential reasons why a commonly used drug might be included by less than 75 percent of formularies:

- Seven of these drugs—carisoprodol, cyclobenzaprine HCL, darifenacin hydrobromide, hydroxyzine pamoate, methocarbamol, promethazine HCL, temazepam—are listed as being potentially inappropriate for older adults.

- Further, two of these drugs—cyclobenzaprine HCl and methocarbamol—are on CMS’s list of high-risk Part D medications, which may explain the low inclusion rates for these drugs.⁴⁴
- Another drug—temazepam—is a benzodiazepine, a category of drugs that was excluded from Part D coverage until 2013. Temazepam was also on the list of drugs with low inclusion by formularies in 2013 report. The low inclusion rates for temazepam may be explained by CMS’s change in Part D coverage guidelines.

Low rates of inclusion by formularies may require dual eligibles to obtain a nonformulary drug. There are several means by which dual eligibles can obtain a nonformulary drug, all of which require them to take additional action. Obtaining therapeutically alternative drugs requires that dual eligibles get new prescriptions from their doctors. Dual eligibles may also submit statements of medical necessity from their physicians as part of appeals to obtain coverage of nonformulary drugs.⁴⁵ Finally, dual eligibles may switch to Part D plans that include their drugs, with the new coverage becoming effective the following month.⁴⁶

The Percentage of Commonly Used Drugs Subject to Utilization Management Tools by Plan Formularies Remained the Same Between 2013 and 2014

For the unique drugs that compose the list of commonly used drugs, the percentage subject to utilization management tools by Part D plan formularies remained the same with an average of 28 percent in both 2013 and 2014. Formularies for plans with premiums below the regional benchmarks and for plans with premiums above the benchmarks had the same percentage of drugs—28 percent—that were subject to utilization management tools. See Table 4 for a breakdown of the percentage of unique drugs to which Part D plan formularies apply utilization management tools in 2013 and 2014.

⁴⁴ This list—“Use of High-Risk Medications in the Elderly: High-Risk Medications”—is part of the Healthcare Effectiveness and Information Set national drug code measures published by the National Committee for Quality Assurance. A high-risk medication is a drug with a high risk of serious side effects in the elderly. CMS uses this medication list to calculate the percentage of Medicare beneficiaries who received at least one high-risk medication in the past year. CMS publishes this percentage and other Part D patient safety measures so that Medicare beneficiaries can make informed decision in choosing a Part D plan for their prescription drug coverage. National Committee on Quality Assurance, *HEDIS 2012 NDC List*. Accessed at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2012/HEDIS2012FinalNDCLists.aspx> on January 14, 2013 and at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Technical-Notes-2013-.pdf> on March 25, 2013.

⁴⁵ CMS, *PDBM*, ch. 18, § 30.2.2.

⁴⁶ CMS, *PDBM*, ch. 3, § 30.3.2.

Table 4: Part D Plan Formularies' Application of Utilization Management Tools to Commonly Used Drugs, 2013 to 2014

Percentage of Unique Drugs to Which Utilization Management Tools Are Applied	Number of 2013 Part D Plan Formularies	Percentage of 2013 Part D Plan Formularies	Number of 2014 Part D Plan Formularies	Percentage of 2014 Part D Plan Formularies
Greater than 40%	41	13%	30	9%
30% to 39%	116	38%	136	41%
20% to 29%	74	25%	65	20%
10% to 19%	34	11%	75	23%
Less than 10%	37	12%	23	7%
Totals	302	100%*	329	100%

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2014.

* Percentages do not add to 100 percent because of rounding.

In 2014, the percentage of drugs subject to quantity limits remained essentially the same while there was a slight decrease in the percentage of drugs subject to prior authorization or step therapy. Formularies applied quantity limits to 24 percent of unique drugs in both 2013 and 2014. Formularies decreased the use of prior authorization from 5 percent to 3 percent and decreased the use of step therapy from 3 percent to 2 percent.

The rate at which plan formularies apply specific utilization management tools varies widely. In 2014, some formularies applied utilization management tools to none of the unique drugs, whereas at the other end of the range, some applied tools to 45 percent of the unique drugs. More specifically, formularies apply quantity limits to 0–43 percent of unique drugs, prior authorization to 0–9 percent, and step therapy to 0–16 percent.

Looking at enrollment across plans provides a slightly different picture than looking only at plans themselves. On average, plan formularies in 2014 apply utilization management tools to 28 percent of unique drugs. However, dual eligibles—and the Medicare population as a whole—tend to be enrolled in plans with formularies that apply these tools at a higher rate. When plans are weighted by dual-eligible enrollment, the median plan applies such tools to 34 percent of unique drugs, a slight decrease from the 2013 rate of 35 percent. Similarly, when plans are weighted by overall Medicare enrollment, the median plan applies these tools to 33 percent of unique drugs in 2014, a slight increase from 32 percent in 2013.

Both dual eligibles and Medicare beneficiaries overall tend to be enrolled in plans with formularies that apply utilization management tools to between 30 and 45 percent of unique drugs. In 2013, 68 percent of dual eligibles and 58 percent of Medicare beneficiaries overall were enrolled in plans with formularies in this range. Table 5 provides a breakdown of dual eligibles and Medicare beneficiaries' enrollment in Part D plans by the percentage range of unique drugs to which formularies apply utilization management tools.

Table 5: Beneficiary Enrollment in Part D Plans by Application of Utilization Management Tools to Commonly Used Drugs, 2013 to 2014

Percentage of Unique Drugs to Which Plan Formularies Apply Utilization Management Tools	Percentage of Dual Eligibles Enrolled, 2013	Percentage of Medicare Beneficiaries Enrolled, 2013	Percentage of Dual Eligibles Enrolled, 2014	Percentage of Medicare Beneficiaries Enrolled, 2014
Greater than 40%	18%	20%	5%	14%
30% to 39%	44%	34%	63%	44%
20% to 29%	16%	12%	7%	6%
10% to 19%	6%	5%	24%	32%
Less than 10%	17%	29%	2%	4%
Totals	100%*	100%	100%*	100%

Source: OIG analysis of dual-eligible enrollment and Medicaid beneficiary enrollment by rates of utilization management tool application to drugs commonly used by dual eligibles, 2014.

*Percentages do not add to 100 percent because of rounding.

Further, although utilization management tools control access to drugs, they are important tools for managing costs in Medicare and ensuring appropriate utilization of drugs. For example, oxycodone HCl/acetaminophen drugs saw more than a 30-percent increase in formulary application of utilization management controls in 2013. Such limits may be intended to ensure appropriate utilization, as CMS's Part D 2013 guidance to Part D sponsors set forth expectations for opioid overutilization reviews to help ensure that opioids are prescribed and used correctly.⁴⁷

CONCLUSION

When establishing formularies and applying utilization management tools, Part D plans need to balance Medicare beneficiaries' needs for adequate prescription drug coverage with the need to contain costs for themselves and for the Part D program. By law, Part D plan formularies do not have to include every available drug. Rather, to meet CMS's formulary requirements, they must include at least two drugs in each therapeutic category or class. For example, for each of the 11 drugs that this memorandum report identifies as being included by less than 75 percent of Part D plan formularies, all Part D plan formularies cover at least one therapeutically alternative drug. Part D plan formularies may also institute utilization management tools to ensure appropriate utilization as well as to control costs.

For the drugs commonly used by dual eligibles, we found that the rate of formulary inclusion is high with some variation. On average, Part D plan formularies include 96 percent of the commonly used drugs. Part D plan formularies' inclusion of the commonly used drugs ranges from 86 percent to 100 percent. Formulary inclusion rates are similar for PDPs and MA-PDs. Further, formularies for Part D plans with premiums below the regional benchmark include the commonly used drugs at a rate similar to that of Part D plan formularies overall.

⁴⁷ CMS, *Supplemental Guidance Related to Improving Drug Utilization Review Controls in Part D*. Accessed at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/HPMSSupplementalGuidanceRelated-toImprovingDURcontrols.pdf> on January 16, 2013.

Inclusion rates for the 195 drugs commonly used by dual eligibles are largely unchanged compared with those from OIG's 2013 memorandum report. Part D plan formularies include roughly the same percentage of these commonly used drugs in 2014 as they did in 2013. Enrollment in plans that cover at least 90 percent of unique drugs stayed consistent, with 99 percent of dual eligibles enrolled in such plans.

Because some variation exists in Part D plan formularies' inclusion of the commonly used drugs and in their application of utilization management tools to these drugs, some dual eligibles may need to use alternative methods to access the drugs they take. They could appeal prescription drug coverage decisions, switch prescription drugs, or switch Part D plans. These scenarios require additional effort by dual eligibles and may result in administrative barriers to accessing certain prescription drugs.

As mandated by the ACA, OIG will continue to monitor the extent to which Part D plan formularies cover drugs that dual eligibles commonly use. In addition, OIG will continue to monitor Part D plan formularies' application of utilization management tools to these drugs.

This memorandum report is being issued directly in final form because it contains no recommendations. We have included the list of the 200 drugs with the highest utilization by dual eligibles. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-05-14-000170 in all correspondence.

APPENDIX A

Section 3313 of the Patient Protection and Affordable Care Act of 2010

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

(1) **STUDY.**—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used by prescription drug plans and MA-PD plans under Part D include drugs commonly used by full benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

(2) **ANNUAL REPORTS.**—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

APPENDIX B**Commonly Used Drugs and Rates of Formulary Inclusion****Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles**

Generic Name	Sample Size*	Projected Number of Scripts*	95-Percent Confidence Interval*	Number of Formularies Including	Percentage of Formularies Including
Lisinopril	4,049	17,526,086	15,331,765–19,720,406	329	100%
Simvastatin	3,908	16,947,357	15,003,278–18,891,435	328	100%
Furosemide	3,706	14,685,813	13,216,521–16,155,104	329	100%
Hydrocodone Bit/Acetaminophen	4,001	14,666,041	13,199,673–16,132,409	329	100%
Omeprazole	3,671	14,385,881	12,805,024–15,966,738	329	100%
Levothyroxine sodium	3,342	13,657,429	12,044,455–15,270,403	329	100%
Potassium chloride	2,890	11,003,461	9,736,337–12,270,585	329	100%
Amlodipine besylate	2,592	10,969,140	9,475,674–12,462,606	329	100%
Metformin HCl	2,483	10,431,797	8,979,265–11,884,328	329	100%
Warfarin sodium	2,508	10,037,136	8,168,682–11,905,591	329	100%
Metoprolol tartrate	2,142	8,581,675	7,404,396–9,758,953	329	100%
Atorvastatin calcium	1,713	6,979,616	5,816,224–8,143,007	329	100%
Atenolol	1,576	6,864,054	5,736,872–7,991,236	329	100%
Clopidogrel bisulfate	1,506	6,522,574	5,481,166–7,563,982	329	100%
Esomeprazole magnesium	1,485	6,343,762	5,215,704–7,471,819	203	62%
Hydrochlorothiazide	1,431	6,307,800	5,263,081–7,352,520	329	100%
Gabapentin	1,622	6,059,703	4,960,876–7,158,530	329	100%
Albuterol sulfate	1,341	5,303,805	4,497,290–6,110,319	329	100%
Carvedilol	1,174	5,049,410	4,177,612–5,921,208	327	99%
Zolpidem tartrate	1,224	4,983,444	4,152,091–5,814,797	325	99%
Glipizide	1,146	4,822,133	3,980,482–5,663,783	329	100%
Citalopram hydrobromide	1,310	4,783,877	3,913,182–5,654,572	329	100%
Alendronate sodium	948	4,614,027	3,660,653–5,567,401	329	100%
Sertraline HCl	1,261	4,559,228	3,801,869–5,316,588	329	100%
Ranitidine HCl	1,262	4,455,550	3,592,488–5,318,613	329	100%
Trazodone HCl	1,174	4,391,732	3,430,134–5,353,330	329	100%
Oxycodone HCl/acetaminophen	1,267	4,276,243	3,399,359–5,153,128	329	100%
Metoprolol succinate	941	4,184,076	3,375,498–4,992,654	324	98%
Quetiapine fumarate	1,523	4,095,070	3,274,770–4,915,371	329	100%
Rosuvastatin calcium	852	3,974,567	3,044,103–4,905,030	290	88%
Fluticasone/salmeterol	878	3,949,321	3,178,846–4,719,796	317	96%
Risperidone	1,209	3,932,051	3,058,980–4,805,122	329	100%
Tramadol HCl	1,112	3,877,159	3,152,198–4,602,120	329	100%
Donepezil HCl	1,138	3,759,718	3,126,212–4,393,224	329	100%

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Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Number of Scripts *	95-Percent Confidence Interval*	Number of Formularies Including	Percentage of Formularies Including
Insulin glargine,hum.rec.anlog	851	3,659,644	3,012,309–4,306,978	314	95%
Fluticasone propionate	865	3,597,277	2,821,480–4,373,073	329	100%
Divalproex sodium	1,020	3,542,033	2,061,502–5,022,565	329	100%
Pioglitazone HCl	804	3,437,272	2,640,553–4,233,992	329	100%
Isosorbide mononitrate	816	3,388,631	2,674,554–4,102,707	329	100%
Valsartan	766	3,383,711	2,649,128–4,118,294	232	71%
Prednisone	888	3,364,367	2,692,772–4,035,963	329	100%
Montelukast sodium	824	3,340,768	2,506,496–4,175,041	329	100%
Cyclobenzaprine HCl	784	3,338,445	2,715,574–3,961,316	195	59%
Diltiazem HCl	763	3,301,378	2,498,884–4,103,872	329	100%
Duloxetine HCl	586	3,260,018	533,248–5,986,789	329	100%
Pravastatin sodium	738	3,245,987	2,495,652–3,996,321	329	100%
Escitalopram oxalate	980	3,108,921	2,491,993–3,725,848	328	100%
Lovastatin	645	2,874,074	2,214,791–3,533,357	326	99%
Tamsulosin HCl	696	2,800,208	2,150,801–3,449,615	329	100%
Tiotropium bromide	577	2,784,574	2,210,013–3,359,135	322	98%
Clonidine HCl	726	2,733,778	2,159,082–3,308,475	329	100%
Digoxin	736	2,733,625	2,033,296–3,433,954	329	100%
Ibuprofen	764	2,718,286	2,101,309–3,335,262	329	100%
Glimepiride	538	2,659,533	2,062,079–3,256,986	329	100%
Paroxetine HCl	600	2,646,915	1,947,365–3,346,465	329	100%
Allopurinol	682	2,601,275	1,988,900–3,213,650	329	100%
Lisinopril/hydrochlorothiazide	564	2,555,824	1,889,101–3,222,547	328	100%
Azithromycin	668	2,525,071	2,168,823–2,881,320	329	100%
Enalapril maleate	633	2,514,748	1,861,670–3,167,826	329	100%
Pantoprazole sodium	583	2,457,619	1,811,725–3,103,513	328	100%
Clonazepam	651	2,382,146	1,730,502–3,033,790	329	100%
Mirtazapine	721	2,367,499	1,887,649–2,847,349	329	100%
Memantine HCl	719	2,362,226	1,788,232–2,936,221	329	100%
Venlafaxine HCl	595	2,326,346	1,433,293–3,219,400	329	100%
Meloxicam	511	2,291,140	1,806,516–2,775,764	328	100%
Naproxen	606	2,254,503	1,719,298–2,789,707	329	100%
Famotidine	565	2,194,121	1,620,576–2,767,667	327	99%
Nifedipine	533	2,193,852	1,585,621–2,802,083	327	99%
Alprazolam	651	2,190,069	1,753,385–2,626,753	248	75%
Carbamazepine	621	2,169,900	1,475,462–2,864,338	329	100%
Spironolactone	472	2,143,185	1,622,925–2,663,444	329	100%

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Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Number of Scripts *	95-Percent Confidence Interval*	Number of Formularies Including	Percentage of Formularies Including
Fluoxetine HCl	553	2,094,592	1,455,602–2,733,581	329	100%
Pregabalin	636	2,086,857	1,581,685–2,592,029	329	100%
Fexofenadine HCl	580	2,082,626	1,545,892–2,619,361		
Propoxyphene napsylate /acetaminophen	604	2,082,433	1,694,904–2,469,963		
Valsartan/ hydrochlorothiazide	481	2,069,464	1,412,189–2,726,738	316	96%
Promethazine HCl	607	2,021,571	1,703,772–2,339,370	234	71%
Oxycodone HCl	617	2,008,292	1,342,448–2,674,137	328	100%
Glyburide	483	1,975,413	1,447,101–2,503,725	280	85%
Aripiprazole	731	1,970,998	1,465,975–2,476,021	329	100%
Morphine sulfate	599	1,931,038	1,160,369–2,701,707	329	100%
Nitroglycerin	496	1,900,437	1,411,056–2,389,818	329	100%
Amitriptyline HCl	538	1,882,663	1,338,773–2,426,552	329	100%
Ipratropium/albuterol sulfate	438	1,876,353	1,357,155–2,395,551	321	98%
Sitagliptin phosphate	404	1,867,218	1,297,783–2,436,654	316	96%
Lorazepam	514	1,852,994	1,283,303–2,422,684	311	95%
Ciprofloxacin HCl	511	1,847,320	1,555,668–2,138,973	329	100%
Cephalexin	527	1,808,242	1,481,756–2,134,727	329	100%
Meclizine HCl	462	1,801,969	1,312,952–2,290,986	319	97%
Bupropion HCl	509	1,793,546	1,281,807–2,305,286	329	100%
Triamterene/ hydrochlorothiazid	391	1,776,758	1,253,001–2,300,515	329	100%
Fenofibrate nanocrystallized	404	1,775,090	1,214,001–2,336,179	313	95%
Sulfamethoxazole/ trimethoprim	523	1,764,454	1,458,882–2,070,025	329	100%
Losartan potassium	380	1,764,440	1,222,143–2,306,737	329	100%
Oxybutynin chloride	480	1,740,865	1,345,634–2,136,096	329	100%
Verapamil HCl	346	1,703,733	1,230,338–2,177,127	329	100%
Lansoprazole	380	1,683,504	1,211,129–2,155,880	263	80%
Diclofenac sodium	405	1,648,570	1,164,686–2,132,454	329	100%
Lidocaine	466	1,636,160	1,177,128–2,095,192	329	100%
Latanoprost	404	1,628,021	1,152,893–2,103,149	329	100%
Amoxicillin	418	1,606,735	1,358,388–1,855,083	329	100%
Ezetimibe	364	1,592,702	1,118,147–2,067,257	329	100%
Benzotropine mesylate	549	1,590,165	1,078,761–2,101,568	325	99%
Fentanyl	423	1,590,156	872,009–2,308,303	329	100%
Levofloxacin	431	1,561,579	1,233,302–1,889,856	329	100%
Insulin aspart	400	1,521,854	1,143,825–1,899,883	277	84%
Tolterodine tartrate	393	1,517,053	1,097,902–1,936,203	312	95%

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Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Number of Scripts*	95-Percent Confidence Interval*	Number of Formularies Including	Percentage of Formularies Including
Carisoprodol	416	1,501,274	968,766–2,033,783	153	47%
Insulin regular, human	389	1,494,291	1,031,644–1,956,937	329	100%
Levetiracetam	502	1,473,031	998,050–1,948,011	329	100%
Albuterol	396	1,472,047	792,776–2,151,318		
Olanzapine	505	1,432,551	981,491–1,883,610	329	100%
Mometasone furoate	377	1,422,774	980,063–1,865,484	328	100%
Doxazosin mesylate	307	1,421,563	963,227–1,879,900	329	100%
Celecoxib	312	1,420,857	997,347–1,844,367	291	88%
Ezetimibe/simvastatin	285	1,398,142	894,058–1,902,227	210	64%
Amlodipine besylate/benazepril	278	1,384,176	971,890–1,796,462	317	96%
Lactulose	408	1,380,890	932,973–1,828,808	329	100%
Phenytoin sodium extended	427	1,375,442	973,570–1,777,314	329	100%
Benazepril HCl	312	1,367,757	857,318–1,878,195	328	100%
Ramipril	293	1,362,475	759,558–1,965,391	325	99%
Finasteride	287	1,352,674	966,773–1,738,576	329	100%
Triamcinolone acetonide	363	1,338,148	1,015,094–1,661,201	329	100%
Hum Insulin Nph/Reg Insulin Hm	374	1,328,419	979,059–1,677,779	329	100%
Hydroxyzine HCl	333	1,322,202	755,736–1,888,668	273	83%
Ropinirole HCl	298	1,287,497	760,643–1,814,352	329	100%
Hydralazine HCl	336	1,251,590	863,416–1,639,764	329	100%
Polyethylene glycol 3350	404	1,248,600	909,737–1,587,464	322	98%
Buspirone HCl	334	1,240,126	793,876–1,686,376	329	100%
Estrogens, conjugated	291	1,235,655	832,319–1,638,991	325	99%
Terazosin HCl	297	1,208,995	812,220–1,605,771	329	100%
Metoclopramide HCl	309	1,193,673	805,030–1,582,317	329	100%
Brimonidine tartrate	263	1,173,338	775,450–1,571,225	329	100%
Carbidopa/levodopa	366	1,155,427	730,656–1,580,198	329	100%
Lamotrigine	436	1,129,854	795,906–1,463,802	329	100%
Baclofen	381	1,128,460	756,368–1,500,552	329	100%
Propranolol HCl	312	1,109,568	774,300–1,444,835	329	100%
Ziprasidone HCl	502	1,107,688	705,145–1,510,231	329	100%
Diazepam	317	1,092,935	670,955–1,514,914	329	100%
Risedronate sodium	269	1,087,393	730,392–1,444,394	247	75%
Omega-3 acid ethyl esters	243	1,072,683	510,179–1,635,187	306	93%
Topiramate	426	1,030,993	649,834–1,412,152	329	100%
Methocarbamol	269	1,017,362	505,495–1,529,228	210	64%
Clotrimazole/betamethasone dip	282	1,010,615	635,191–1,386,040	288	88%
Methylprednisolone	244	993,034	659,511–1,326,556	329	100%

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Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Number of Scripts*	95-Percent Confidence Interval*	Number of Formularies Including	Percentage of Formularies Including
Ipratropium bromide	247	975,326	594,837–1,355,814	329	100%
Gemfibrozil	316	962,455	615,723–1,309,188	329	100%
Glyburide/metformin HCl	205	950,386	625,458–1,275,314	276	84%
Acetaminophen with codeine	265	948,099	720,858–1,175,340	329	100%
Nystatin	280	946,856	694,658–1,199,055	329	100%
Amoxicillin/potassium clavulanate	266	906,325	713,848–1,098,802	329	100%
Ketoconazole	236	893,572	517,129–1,270,015	329	100%
Amiodarone HCl	221	882,707	532,845–1,232,568	329	100%
Folic acid	215	870,744	580,327–1,161,162		
Temazepam	209	870,741	536,789–1,204,692	214	65%
Doxycycline hyclate	266	863,594	671,393–1,055,796	329	100%
Niacin	221	854,672	490,113–1,219,231	329	100%
Sucralfate	217	854,101	511,084–1,197,117	329	100%
Pramipexole Di-HCl	187	850,734	436,128–1,265,340	329	100%
Neutrap protamine hagedorn, human insulin isophane	207	841,706	553,217–1,130,196	329	100%
Insulin detemir	181	838,194	523,273–1,153,115	320	97%
Oxcarbazepine	285	822,165	477,951–1,166,378	329	100%
Nitrofurantoin monohydrate/macrocrystals	204	806,300	541,167–1,071,433	309	94%
Solifenacin succinate	171	795,224	428,361–1,162,087	271	82%
Hydroxyzine pamoate	212	794,850	378,738–1,210,961	177	54%
Dicyclomine HCl	205	761,078	474,731–1,047,425	267	81%
Metolazone	200	754,643	489,775–1,019,510	321	98%
Budesonide/formoterol fumarate	182	739,927	503,057–976,797	292	89%
Darifenacin hydrobromide	178	729,078	418,090–1,040,066	149	45%
Bimatoprost	140	726,619	422,202–1,031,037	290	88%
Hydrocortisone acetate	141	722,972	361,614–1,084,330	167	51%
Ergocalciferol (Vitamin D2)	199	722,170	452,905–991,434		
Nabumetone	171	720,777	453,343–988,210	321	98%
Isosorbide dinitrate	147	719,742	323,296–1,116,188	329	100%
Torsemide	165	710,217	291,404–1,129,030	321	98%
Olopatadine HCl	186	707,858	417,593–998,124	284	86%
Lithium carbonate	221	705,974	384,907–1,027,041	329	100%
Timolol maleate	203	703,462	452,117–954,807	329	100%
Tizanidine HCl	284	702,405	440,132–964,678	329	100%
Irbesartan/hydrochlorothiazide	128	692,517	322,754–1,062,280	282	86%
Dutasteride	134	690,427	364,954–1,015,900	299	91%

continued on next page

Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Number of Scripts*	95-Percent Confidence Interval*	Number of Formularies Including	Percentage of Formularies Including
Fluconazole	204	681,807	532,325–831,289	329	100%
Travoprost	194	681,615	470,043–893,187	278	84%
Ibandronate sodium	130	681,499	339,583–1,023,415	317	96%
Estradiol	121	680,842	341,234–1,020,449	329	100%
Losartan/hydrochlorothiazide	146	661,914	362,115–961,712	328	100%
Cinacalcet HCl	171	661,514	343,657–979,372	329	100%
Haloperidol	257	652,766	427,602–877,930	329	100%
Aspirin/dipyridamole	162	651,442	334,771–968,114	328	100%
Raloxifene HCl	138	650,060	267,583–1,032,537	329	100%
Medroxyprogesterone acetate	131	646,445	316,771–976,120	329	100%
Megestrol acetate	161	611,738	387,587–835,890	329	100%
Labetalol HCl	146	603,265	292,698–913,832	329	100%
Fenofibrate	131	597,584	365,922–829,245	328	100%
Calcitriol	135	587,342	316,836–857,847	329	100%
Metronidazole	157	585,344	407,663–763,025	329	100%
Clozapine	181	582,542	145,263–1,019,820	329	100%
Insulin lispro	160	579,111	334,382–823,840	264	80%
Diphenoxylate HCl/atropine	132	573,335	241,642–905,028	250	76%
Sotalol HCl	130	550,800	174,131–927,469	329	100%

Source: OIG analysis of drugs commonly used by dual eligibles, 2014.

*Sample is from the 2010 Medicare Current Beneficiary Survey. Projections and confidence intervals are derived from its survey methodology.

APPENDIX C

Five Drugs Commonly Used by Dual Eligibles and Not Covered Under Part D

Generic Name	Reason Excluded Under Part D
Albuterol*	No longer prescribed without sulfate
Fexofenadine HCl*	Nonprescription drug
Folic acid*	Vitamin or mineral product
Propoxyphene napsylate/acetaminophen*	No longer available in the United States
Ergocalciferol (Vitamin D2)	Vitamin or mineral product

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2014.
* These drugs were also on the 2013 report's list of drugs commonly used by dual eligibles and not covered under Part D.

APPENDIX D**Inclusion of Commonly Used Drugs by Formularies in Stand-Alone Prescription Drug Plans* and in Medicare Advantage Prescription Drug Plans**, by Region****Table D-1: PDP Formularies' Inclusion of Commonly Used Drugs, by Region**

PDP Region	State(s)	Number of PDPs	Average Rate of Inclusion by Formularies	Minimum Rate	Maximum Rate
1	Maine, New Hampshire	30	95%	86%	99%
2	Connecticut, Massachusetts, Rhode Island, Vermont	31	95%	86%	99%
3	New York	29	95%	86%	99%
4	New Jersey	32	95%	86%	99%
5	Delaware, the District of Columbia, Maryland	34	96%	86%	100%
6	Pennsylvania, West Virginia	37	95%	86%	100%
7	Virginia	33	95%	86%	99%
8	North Carolina	32	95%	86%	99%
9	South Carolina	33	95%	86%	99%
10	Georgia	32	95%	86%	99%
11	Florida	33	95%	86%	99%
12	Alabama, Tennessee	33	95%	86%	99%
13	Michigan	34	95%	86%	99%
14	Ohio	35	95%	86%	99%
15	Indiana, Kentucky	33	95%	86%	99%
16	Wisconsin	31	94%	86%	99%
17	Illinois	36	94%	86%	99%
18	Missouri	33	95%	86%	99%
19	Arkansas	32	95%	86%	99%
20	Mississippi	31	95%	86%	99%
21	Louisiana	31	95%	86%	99%
22	Texas	34	95%	86%	99%
23	Oklahoma	34	95%	86%	99%
24	Kansas	31	94%	86%	99%
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	32	95%	86%	99%
26	New Mexico	34	95%	86%	99%
27	Colorado	32	95%	86%	99%
28	Arizona	32	95%	86%	99%
29	Nevada	32	95%	86%	99%
30	Oregon, Washington	33	95%	86%	99%
31	Idaho, Utah	35	95%	86%	99%
32	California	34	95%	86%	99%
33	Hawaii	27	95%	86%	99%
34	Alaska	26	95%	86%	99%

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2014.

*PDPs.

**MA-PDs.

Table D-2: MA-PD Formularies' Inclusion of Commonly Used Drugs, by Region

MA-PD Region***	State(s)	Number of MA-PDs	Average Rate of Inclusion by Formularies	Minimum Rate	Maximum Rate
1	Maine, New Hampshire	41	94%	90%	100%
2	Connecticut, Massachusetts, Rhode Island, Vermont	77	96%	90%	100%
3	New York	188	95%	89%	100%
4	New Jersey	30	96%	93%	98%
5	Delaware, the District of Columbia, Maryland	27	96%	93%	100%
6	Pennsylvania, West Virginia	159	97%	89%	100%
7	North Carolina, Virginia	111	96%	89%	100%
8	Georgia, South Carolina	80	96%	89%	100%
9	Florida	303	98%	87%	100%
10	Alabama, Tennessee	67	97%	93%	98%
11	Michigan	60	96%	92%	100%
12	Ohio	88	96%	89%	100%
13	Indiana, Kentucky	65	96%	89%	98%
14	Illinois, Wisconsin	122	96%	89%	100%
15	Arkansas, Missouri	82	96%	87%	99%
16	Louisiana, Mississippi	62	97%	93%	98%
17	Texas	132	96%	89%	99%
18	Kansas, Oklahoma	52	96%	93%	98%
19	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	85	97%	88%	100%
20	Colorado, New Mexico	71	97%	89%	100%
21	Arizona	68	96%	90%	100%
22	Nevada	25	95%	90%	98%
23	Idaho, Oregon, Utah, Washington	151	96%	89%	100%
24	California	261	96%	89%	100%
25	Hawaii	18	98%	96%	100%

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2014.

***Region 26, which covers Alaska, had no MA-PDs available for 2013.