

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PART D PLANS GENERALLY
INCLUDE DRUGS COMMONLY
USED BY DUAL ELIGIBLES:
2017**



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Why OIG Did This Review

This report fulfills for 2017 the annual reporting mandate from the Patient Protection and Affordable Care Act (ACA). The ACA requires OIG to conduct a study of the extent to which formularies used by Medicare Part D plans include drugs commonly used by full-benefit dual-eligible individuals (i.e., individuals who are eligible for both Medicare and full Medicaid benefits). These individuals generally get drug coverage through Medicare Part D. Pursuant to the ACA, OIG must annually issue a report with recommendations as appropriate. This is the seventh report OIG has produced to meet this mandate.

How OIG Did This Review

For this report, we determined whether the 369 unique formularies used by the 3,014 Part D plans operating in 2017 cover the 200 drugs most commonly used by dual eligibles. We also determined the extent to which plan formularies applied utilization management tools to those commonly used drugs. To create the list of the 200 drugs most commonly used by dual eligibles, we used data from the 2012 Medicare Current Beneficiary Survey—the most recent data available at the time of our study. Of the top 200 drugs, 197 are eligible for Part D prescription drug coverage, 1 is excluded from coverage, and 1 is no longer prescribed in the form taken by beneficiaries. One additional drug is eligible for Part D prescription drug coverage. However, we did not include it in our analysis because we could not confidently project the use of this drug to the entire dual-eligible population.

Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2017

What OIG Found

Overall, we found that the rate of Part D plan formularies' inclusion of the 197 drugs commonly used by dual eligibles is high, with some variation. On average, Part D plan formularies include 97 percent of the 197 commonly used drugs. In addition, 70 percent of the commonly used drugs are included by all Part D plan formularies. These results are largely unchanged from OIG's findings for formularies reported in the mandated annual report from 2016, as well as our findings from 2011 through 2015.

We also found that the percentage of drugs to which plan formularies applied utilization management tools remained the same from 2016 to 2017. On average, formularies applied utilization management tools to 28 percent of the unique drugs we reviewed in 2017, the same percentage as in 2016.

What OIG Concludes

Inclusion rates for the 197 drugs commonly used by dual eligibles are largely unchanged compared with the inclusion rates listed in our previous reports. Part D formularies include roughly the same percentage of these commonly used drugs in 2017 as they did in 2016.

As mandated by the ACA, OIG will continue to monitor and produce annual reports on 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. OIG has no recommendations at this time.

Key Takeaway

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

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OBJECTIVES

1. To determine the extent to which Part D plan formularies cover the drugs commonly used by dual eligibles.
2. To determine the extent to which Part D plan formularies applied utilization management tools to the drugs commonly used by dual eligibles.

BACKGROUND

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 prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs), hereinafter referred to collectively as Part D plans.¹

For beneficiaries who are eligible for both 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. 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 are allowed to control drug utilization through utilization management tools.² These tools include prior authorization, quantity limits, and step therapy.³

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.

¹ MMA, P.L. No. 108-173 § 101, Social Security Act, § 1860D-1(a).

² 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).

³ 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 drug therapy that is the most cost-effective or safest and progressing if necessary to more costly or risky drug therapy.

The Medicare Prescription Drug Benefit

Beginning in 2006, the MMA made comprehensive prescription drug coverage under Medicare Part D available to all Medicare beneficiaries.⁴ 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.⁵ As of January 2017, approximately 42.3 million of the 57.7 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. In 2017, plan sponsors offer 3,014 unique Part D plans, with many plan sponsors offering multiple Part D plans.

Dual Eligibles Under Medicare Part D

Approximately 11.4 million Medicare beneficiaries are dual eligibles. For about 8.2 million dual eligibles, referred to as “full-benefit dual eligibles,” Medicaid provides full Medicaid benefits, including Medicaid-covered services, and may also assist beneficiaries with premiums and cost-sharing for Medicare fee-for-service or Medicare managed care.⁶ For other dual eligibles, Medicaid does not provide Medicaid-covered services, but provides assistance with beneficiaries’ 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. 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.⁷ 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

⁴ MMA, P.L. No. 108-173 § 101, Social Security Act, § 1860D-1(a).

⁵ CMS, *PDBM*, ch. 1, § 10.1.

⁶ Kaiser Family Foundation, *Medicare’s Role for Dual Eligible Beneficiaries*. Accessed at <http://www.kff.org/medicare/upload/8138-02.pdf> on April 13, 2017.

⁷ *Ibid.*

covering outpatient prescription drugs for dual eligibles through Part D plans.⁸

Medicare covers Part D plan premiums for dual eligibles up to a set benchmark. The benchmark is a statutorily defined amount that is based on the average premium amounts for Part D plans for each region.^{9, 10} 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.¹¹

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.¹² The PDPs to which CMS assigns dual eligibles must meet certain requirements, such as having a premium at or below the regional benchmark amount and offering basic prescription drug coverage (or equivalent).¹³ 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 Part D plans at any time to find plans that cover the prescription drugs they require.¹⁴ When dual eligibles change plans, their prescription drug coverage under the new Part D plan 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.¹⁵ For dual eligibles who were randomly assigned to their

⁸ MMA, P.L. No. 108-173 § 101, Social Security Act, § 1860D-1(a).

⁹ Social Security Act, § 1860D-14(b); 42 CFR § 423.780(b)(2)(i)

¹⁰ Dual eligibles residing in territories are not eligible to receive cost-sharing assistance from Medicare. With this being the case, there are no benchmarks for Part D plans offered in the territories. Social Security Act, § 1860D-14(a)(3)(F).

¹¹ 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. Patient Protection and Affordable Care Act (ACA), P.L. No. 111-148 § 3303, Social Security Act, § 1860D-14(a)(5). For 2017, CMS set the de minimis amount at \$2 above the regional benchmark.

¹² CMS, *PDBM*, ch. 3, § 40.1.4.

¹³ *Ibid.*

¹⁴ *Ibid.*, § 30.3.2. In general, Medicare beneficiaries can switch Part D plans only once a year during a defined enrollment period.

¹⁵ *Ibid.*, § 40.1.5.

current PDPs, CMS chooses new PDPs that will have premiums at or below the regional benchmark premium.¹⁶ For dual eligibles who elected their current Part D plans, CMS notifies them that their plans will have premiums above the regional benchmark premium. For 2017, CMS reported reassigning approximately 277,000 Medicare beneficiaries, including but not exclusively dual eligibles, because of premium increases.

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 plan sponsors' needs to contain costs. Generally, a formulary must include at least two drugs in each therapeutic category or class.^{17, 18} In addition, Part D plans must include Part D-covered drugs in certain categories and classes.¹⁹

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 that Part D plans make regarding individual formularies, certain categories of drugs are excluded from Medicare Part D prescription drug coverage as mandated by the MMA.²⁰ For example, prescription vitamins, prescription mineral products, and nonprescription drugs are excluded from Part D prescription drug coverage.²¹

Until 2013, barbiturates and benzodiazepines were excluded from Part D prescription drug coverage. However, the ACA reversed this exclusion,

¹⁶ CMS, *PDBM*, § 40.1.5.

¹⁷ *Ibid.*, ch. 6, § 30.2.1.

¹⁸ 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.

¹⁹ Social Security Act, § 1860D-4(b)(3)(G).

²⁰ MMA, P.L. No. 108-173 § 101, Social Security Act, § 1860D-2(e).

²¹ Social Security Act § 1860D-2(e)(2), 1927(d)(2).

removing these two drug types from the list of drug classes ineligible for such coverage.^{22, 23}

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, as well as all drugs in specified therapeutic categories or classes.²⁴ 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 (i.e., 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.²⁵

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.^{26, 27, 28}

Exceptions and appeals process. CMS has implemented an exceptions and appeals process whereby beneficiaries can request coverage of nonformulary drugs or an exception to a utilization management tool that applies to a formulary drug. When a Part D plan receives a prescriber's statement supporting an exception request, the plan must notify the beneficiary of its determination within 72 hours or, for expedited requests, within 24 hours.²⁹ If the beneficiary's plan makes an adverse determination, the beneficiary has the right to appeal.³⁰ If the plan continues to deny the beneficiary's request, the beneficiary has additional appeal rights and may continue to appeal until those rights are exhausted. Alternatively, the beneficiary can work with his or her prescriber to

²² ACA, P.L. No. 111-148 § 2502, Social Security Act, § 1927(d).

²³ 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 April 13, 2017.

²⁴ CMS, *PDBM*, ch. 6, § 30.2.7.

²⁵ *Ibid.*

²⁶ *Ibid.*, § 30.2.2.

²⁷ *Ibid.*, § 30.2.7.

²⁸ 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.

²⁹ CMS, *PDBM*, ch. 18, §§ 30.1 and 30.2.

³⁰ *Ibid.*, § 60.1.

determine whether there is an appropriate therapeutically equivalent alternative drug on the plan's formulary.

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.³¹ 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.³²

In 2011, OIG issued the first annual mandated report examining dual eligibles' access to drugs under Medicare Part D.³³ We have released an annual mandated report each year since then.^{34, 35, 36, 37, 38} The current report is the seventh report released.

³¹ CMS, *PDBM*, ch. 6, § 30.4.4.

³² OIG, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, January 2006.

³³ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2011*, OEI-05-10-00390, April 2011.

³⁴ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2012*, OEI-05-12-00060, June 2012.

³⁵ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2013*, OEI-15-13-00090, June 2013.

³⁶ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2014*, OEI-05-14-00170, June 2014.

³⁷ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2015*, OEI-05-15-00120, June 2015.

³⁸ OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2016*, OEI-05-16-00090, June 2016.

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 2017. As part of our assessment, we included dual eligibles' enrollment data from March 2017, the most recent enrollment data available from CMS at the time of our study. We also compared the results of our 2017 study with those of our 2016 study.³⁹

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 Medicare Current Beneficiary Survey (MCBS)—i.e., the 2012 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 that we identified using the MCBS, 197 are eligible for coverage under Part D. In this report, we refer to these 197 Part D-eligible high utilization drugs as “commonly used drugs.”

The list of 200 drugs with the highest utilization by dual eligibles referenced in this 2017 report is the same list of drugs referenced in the 2016 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 the 2013, 2014, 2015, 2016, and 2017 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: 2016*, OEI-05-16-00090, June 2016.

Data Sources

MCBS. We used the 2012 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 2012 MCBS Cost and Use data were the most recent data available at the time of our study and were also used for this analysis in the 2016 report. Historically, the list of the 200 drugs with the highest utilization by dual eligibles has remained largely unchanged between one year and the next. The list for 2016 overlapped by 91 percent with the list for 2015, which in turn overlapped by 93 percent with the list for 2014.⁴⁰

The MCBS is a continuous, multipurpose survey that CMS conducts of a representative national sample of the Medicare population, including dual eligibles. Sampled Medicare beneficiaries were interviewed three times per year and asked what drugs they were taking and whether they had started taking any new drugs since the previous interview. The MCBS also includes Part D prescription drug events for surveyed Medicare beneficiaries. In 2012, the MCBS surveyed 11,299 Medicare beneficiaries, of whom 2,244 were dual eligibles who had used prescription drugs during the year (out of 2,484 dual-eligible survey respondents).

First DataBank National Drug Data File. We used the April 2017 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 that contains information—such as drug name, therapeutic category or class, and the unique combination of active ingredients—for each drug as defined by a National Drug Code (NDC).⁴¹

Part D plan data. In March 2017, we collected from CMS the formulary data and the plan data for Part D plans operating in 2017. The formulary data includes Part D plans' formularies and utilization management tools for plans operating in 2017. In 2017, there are 369 unique formularies offered by 3,014 Part D plans. The plan data provides 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.

⁴⁰ In 2015, we used the 2011 data and in 2014, we used the 2010 data.

⁴¹ An NDC is a three-part universal identifier that specifies the drug manufacturer's name, the drug form and strength, and the package size.

We also collected 2017 enrollment data for Part D plans. These data provide the number of dual eligibles enrolled in each Part D plan as of March 2017.

Determining the Most Commonly Used Drugs

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

1. We created a list of all drugs reported by dual eligibles surveyed in the 2012 MCBS. We excluded respondents from territories because they are not eligible to receive cost-sharing assistance under Part D. The MCBS listed 167,848 drug events for 2,244 dual eligibles who did not reside in territories.⁴²
2. We 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 brand-name drug Prozac) has only one entry on our list, covering all strengths of both the brand-name drug Prozac and the available generic versions of fluoxetine hydrochloride. 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 167,848 drug events associated with 868 drugs.
3. We ranked the 868 drugs by frequency of utilization, weighting the drug-event information from MCBS by sample weight.
4. We selected the 200 drugs with the highest utilization by dual eligibles. For a full list of the top 200 drugs, see Appendix B.
5. We removed all drugs not covered under Part D. Of the 200 drugs with the highest utilization, 197 are eligible under Part D. One fell into a drug category excluded under Part D, and one is no longer prescribed in the form taken by beneficiaries surveyed in the 2012 MCBS. One additional drug is eligible for Part D prescription drug coverage. However, we did not include it in our analysis because we could not confidently project the use of this drug to the entire dual-eligible population. For details on the two drugs excluded under Part D, see Appendix C.

⁴² For the purposes of this report, a drug event is an MCBS survey response indicating that the responding beneficiary took a specific drug at least once in 2012. For example, 1 MCBS survey respondent reported taking rosuvastatin calcium (Crestor) 12 times in 2012. We counted this beneficiary/drug combination as 12 drug events.

Formulary Analysis

We analyzed the 369 unique Part D plan formularies to determine their rates of inclusion of the 197 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 197 commonly used drugs had low rates of inclusion by formularies by counting how many of the 369 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 197 commonly used drugs were included by 75 percent or less of formularies.

Utilization management tools. We determined the extent to which Part D plans apply utilization management tools to the 197 drugs that we reviewed. The tools that we reviewed are prior authorization, quantity limits, and step therapy.

To determine the extent to which Part D plan formularies applied utilization management tools to the 197 commonly used drugs, 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 197 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 analysis of utilization management tools by both

dual-eligible enrollment and Medicare enrollment. To do this, we applied enrollment data from March 2017 to Part D plans available in 2017.

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 2012 account for 88 percent of all prescriptions dispensed to the dual-eligible respondents in the 2012 MCBS.

Standards

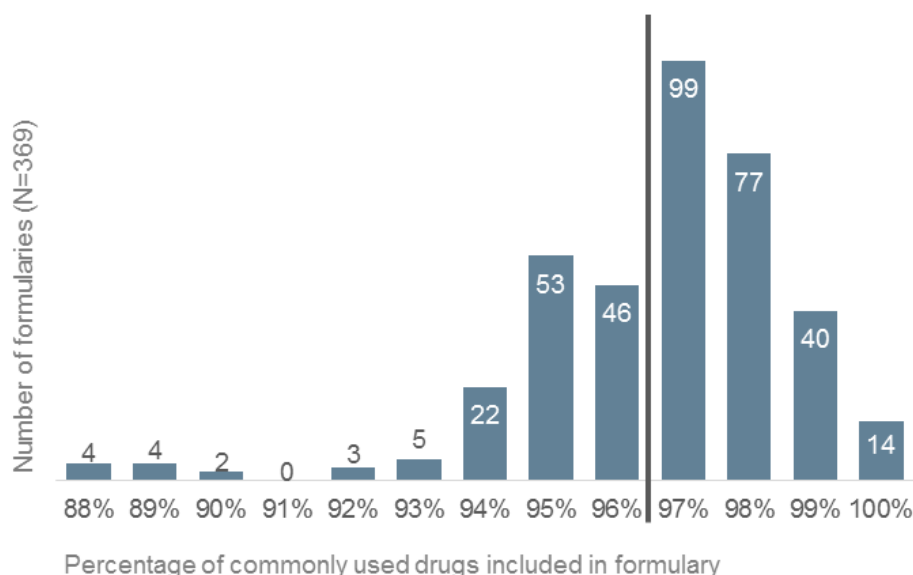
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Part D Plan Formularies Include Between 88 and 100 Percent of the Drugs Commonly Used by Dual Eligibles

On average, Part D plan formularies include 97 percent of the drugs commonly used by dual eligibles. Of the 369 unique formularies used by Part D plans in 2017, 14 formularies include 100 percent of the commonly used drugs. At the other end of the inclusion range, four formularies include 88 percent of the commonly used drugs. Exhibit 1 provides a breakdown of the formularies' inclusion rates for the drugs most commonly used by dual eligibles. 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.

Exhibit 1: Nearly two-thirds of Part D plan formularies cover at least 97 percent of the drugs commonly used by dual eligibles.



Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2017.

Part D plan formularies' rate of inclusion of the drugs commonly used by dual eligibles in 2017 is similar to that of 2016. The average rate of inclusion increased slightly between 2016 and 2017, from 96 percent to 97 percent. The range of inclusion rates in 2016 and 2017 are the same—88 to 100 percent of the drugs commonly used by dual eligibles.

Nationally, PDP and MA-PD formularies have similar rates of inclusion of the drugs commonly used by dual eligibles, averaging 95 percent and

97 percent, respectively. For PDP and MA-PD formularies, the rates of inclusion ranged from 88 to 100 percent. Eleven formularies—3 percent of the 369 unique formularies used by Part D plans in 2017—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 includes at least 98 percent of these drugs. Appendix D provides a breakdown of formularies' rates of inclusion of the drugs by PDP and MA-PD region.

On average, formularies for Part D plans with premiums below the regional benchmark include 96 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, such plans. For drugs commonly used by dual eligibles, formularies for such plans have rates of inclusion that range from 88 percent to 100 percent. Approximately 85 percent of dual eligibles are enrolled in Part D plans with premiums below the regional benchmark.

Most 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 9.9 million dual eligibles enrolled in Part D plans, approximately 96 percent are enrolled in Part D plans that use formularies that include at least 90 percent of the commonly used drugs. Four percent of dual eligibles are enrolled in Part D plans that use formularies that include less than 90 percent of these drugs. Exhibit 2 provides a breakdown of dual eligibles' enrollment in Part D plans by the rates at which the plans' formularies include the commonly used drugs.

Exhibit 2: Enrollment of Dual Eligibles in Part D Plans, by Formularies' 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	249,598	3%
95% to 99% of commonly used drugs	5,340,291	54%
90% to 94% of commonly used drugs	3,891,989	39%
85% to 89% of commonly used drugs	405,474	4%
Total	9,887,352	100%

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles and dual eligibles' enrollment, 2017.

The percentage of dual eligibles enrolled in Part D plans that include at least 90 percent of the drugs commonly used by dual eligibles decreased from nearly 100 percent in 2016 to 96 percent in 2017.

Seventy 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 can be confident that regardless of the Part D plan in which they are enrolled, the plan's formulary will include many of these drugs. By drug, inclusion in formularies ranges from 46 percent to 100 percent. At one end of the range, there is a drug that is included in 46 percent of Part D plan formularies, and at the other end, 138 drugs are included in all plan formularies. The average rate of inclusion in formularies is 97 percent. Exhibit 3 shows the rates at which formularies include the 197 drugs. Appendix B lists the 197 drugs and the rates at which formularies include them.

Exhibit 3: Formularies' Rates of Inclusion of Commonly Used Drugs

Percentage of the 369 Formularies	Percentage of the 197 Commonly Used Drugs Included in Formularies
100%	70% (138 drugs)
85% to 99%	22% (43 drugs)
76% to 84%	3% (6 drugs)
46% to 75%	5% (10 drugs)
Total	100% (197 drugs)

Source: OIG analysis of State Medicaid claims data, 2007.

The rates at which formularies include the drugs commonly used by dual eligibles in 2017 are similar to those in 2016. The percentage of commonly used drugs included in all formularies increased slightly between 2016 and 2017, from 68 percent to 70 percent.

Part D plan formularies include certain drugs less frequently than others

Of the commonly used drugs, 5 percent (10 drugs) are included by 75 percent or less of Part D plan formularies. Exhibit 4 provides the percentage of formularies covering each of these 10 drugs.

The drugs that make up this group include both brand-name and generic drugs and are used to treat a variety of primary indications. Five of the 10 drugs are brand-name drugs, which are typically more costly than generic drugs. As for the primary indications, 3 of the 10 drugs are used for diabetes therapy, 2 are muscle relaxants, 2 are used for gastrointestinal conditions, and the remaining drugs treat a variety of conditions.

Exhibit 4: Drugs Included by 75 Percent or Less of Part D Plan Formularies

Generic Name of Drug	Primary Indication(s)	Rate of Inclusion by Formularies
Risedronate sodium	Osteoporosis, Paget's disease of bone	75%
Insulin aspart	Diabetes	74%
Budesonide/formoterol fumarate	Inflammation, bronchodilator	73%
Solifenacin succinate	Overactive bladder, incontinence	73%
Esomeprazole magnesium	Dyspepsia, peptic ulcer disease, gastroesophageal reflux disease, Zollinger-Ellison syndrome	63%
Methocarbamol	Musculoskeletal pain	60%
Insulin lispro	Diabetes	59%
Dexlansoprazole	Gastroesophageal reflux disease	51%
Glyburide	Diabetes	48%
Carisoprodol	Musculoskeletal pain	46%

Source: OIG analysis of formularies' inclusion of drugs commonly used by dual eligibles, 2017.

The drugs in the shaded rows also had low rates of inclusion by formularies in 2016.

Although Part D formularies frequently omit these 10 drugs, they all cover other drugs in the same respective therapeutic classes. For each of these 10 drugs, 100 percent of formularies cover at least 1 drug in the same therapeutic class that is also on the list of 197 drugs commonly used by dual eligibles.

The number of drugs included by 75 percent or less of formularies increased from 9 in 2016 to 10 in 2017. There are seven drugs with low inclusion rates in 2017 that were also on the list of commonly used drugs with low inclusion rates in our 2016 report; we note these seven drugs above in Exhibit 4. Five of these seven drugs were also on the list of drugs with low inclusion rates in our 2015 report.

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

- Two of these drugs—carisoprodol and methocarbamol—are on CMS’s list of Part D medications that are high-risk for the elderly.⁴³
- The two drugs above and a third drug—glyburide—are listed by the American Geriatrics Society as being potentially inappropriate for older adults.⁴⁴
- The American Geriatrics Society also cautions against certain uses of proton pump inhibitor drugs (PPIs) and drugs with strong anticholinergic properties. Dexlansoprazole and esomeprazole magnesium are PPIs, and solifenacin succinate has strong anticholinergic properties.⁴⁵

If a particular drug has a low rate of inclusion by formularies, a dual eligible may need 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. If dual eligibles wish to obtain therapeutically equivalent alternative drugs that are included by their plans’ formularies, they would need to get new prescriptions from their doctors. Dual eligibles may also go through an appeals process to obtain coverage of nonformulary drugs by submitting statements of medical necessity from their physicians.⁴⁶ Finally, dual eligibles may switch to Part D plans with formularies that include their drugs, with the new coverage becoming effective the following month.⁴⁷

⁴³ 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 drug that is listed as being high risk for the elderly is one that has a high risk of serious side effects in that population. CMS uses its prescription data and 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 measures of Part D patient safety so that Medicare beneficiaries can make informed decisions in choosing Part D plans for their prescription drug coverage. National Committee on Quality Assurance, *HEDIS 2012 NDC List*. Accessed at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPatientSafetyMeasures_071610.pdf on April 13, 2017.

⁴⁴ The American Geriatrics Society, *American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*, 2015.

⁴⁵ *Ibid.*

⁴⁶ CMS, *PDBM*, ch. 18, § 30.2.2.

⁴⁷ *Ibid.*, ch. 3, § 30.3.2.

The Percentage of Commonly Used Drugs To Which Plan Formularies Applied Utilization Management Tools Stayed the Same Between 2016 and 2017

For the unique drugs that compose the list of commonly used drugs, the percentage to which Part D plan formularies applied utilization management tools remained unchanged, at an average of 28 percent in 2016 and 2017. There was not much of a difference between plans with premiums below the regional benchmarks and those with premiums above those benchmarks; formularies for the two groups of plans used utilization management tools for 25 percent and 29 percent, respectively, of their drugs. See Exhibit 5 for a breakdown of the percentage of unique drugs to which Part D plan formularies apply utilization management tools in 2016 and 2017.

Exhibit 5: Part D Plan Formularies' Application of Utilization Management Tools to Commonly Used Drugs, 2016 and 2017

Percentage of Unique Drugs to Which Utilization Management Tools Are Applied	Number of 2016 Part D Plan Formularies	Percentage of 2016 Part D Plan Formularies	Number of 2017 Part D Plan Formularies	Percentage of 2017 Part D Plan Formularies
Greater than 40%	22	6%	60	16%
30% to 39%	189	50%	85	23%
20% to 29%	59	16%	140	38%
10% to 19%	74	20%	66	18%
Less than 10%	30	8%	18	5%
Totals	374	100%	369	100%

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2017.

Although utilization management tools can restrict beneficiaries' access to drugs, they are important tools for managing costs in Medicare and ensuring appropriate utilization of drugs. For example, in 2013, CMS set forth expectations for reviews of opioid overutilization to help ensure that opioids are appropriately prescribed and used. As a result, formularies' application of utilization management controls to oxycodone HCl/acetaminophen drugs increased by 30 percent in 2013.⁴⁸

The percentage of drugs for which formularies applied the utilization management tools of quantity limits, prior authorization, or step therapy⁴⁹ stayed the same from 2016 to 2017. Formularies applied quantity limits to 24 percent of drugs, required prior authorization for 4 percent of drugs, and required step therapy for 1 percent of unique drugs.

⁴⁸ CMS, *Supplemental Guidance Related to Improving Drug Utilization Review Controls in Part D*, September 6, 2012. Accessed at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/HPMSSupplementalGuidanceRelated-toImprovingDURcontrols.pdf> on April 13, 2017.

⁴⁹ See footnote 3 for explanations of quantity limits, prior authorization, and step therapy.

The rate at which plan formularies apply specific utilization management tools varies widely. In 2017, some formularies applied utilization management tools to none of the unique drugs, whereas at the other end of the range, some applied tools to 44 percent of the unique drugs. More specifically, formularies apply quantity limits to between 0 and 42 percent of unique drugs, require prior authorization for between 0 and 14 percent, and require step therapy for between 0 and 8 percent.

Looking at enrollment across plans provides a slightly different picture than looking only at plans themselves. On average, plan formularies in 2017 apply utilization management tools to 28 percent of unique drugs. However, dual eligibles tend to be enrolled in plans with formularies that apply these tools at a slightly higher rate. In 2017, the median plan weighted by dual-eligible enrollment applies such tools to 29 percent of unique drugs; in 2016, the figure was 32 percent. Similarly, the median plan weighted by overall Medicare enrollment applies these tools to 30 percent of unique drugs in 2017; in 2016, the figure was 31 percent.

Both dual eligibles and Medicare beneficiaries overall tend to be enrolled in plans with formularies that apply utilization management tools to between 20 and 39 percent of unique drugs. In 2017, 87 percent of dual eligibles and 79 percent of Medicare beneficiaries overall were enrolled in plans with formularies in this range. Exhibit 6 shows enrollment in Part D plans by dual eligibles and Medicare beneficiaries, as broken down by the percentages at which the plans' formularies' apply utilization management tools.

Exhibit 6: Beneficiary Enrollment in Part D Plans by Application of Utilization Management Tools to Commonly Used Drugs, 2016 and 2017

Percentage of Unique Drugs to Which Plan Formularies Apply Utilization Management Tools	Percentage of Dual Eligibles Enrolled, 2016	Percentage of Medicare Beneficiaries Enrolled, 2016	Percentage of Dual Eligibles Enrolled, 2017	Percentage of Medicare Beneficiaries Enrolled, 2017
Greater than 40%	1%	1%	8%	13%
30% to 39%	79%	72%	37%	39%
20% to 29%	14%	18%	50%	40%
10% to 19%	3%	5%	3%	4%
Less than 10%	2%	4%	2%	3%
Totals	100%*	100%	100%	100%*

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2017.

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

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 plan sponsors 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 10 drugs that this report identifies as being included by 75 percent or less of Part D plan formularies, all Part D plan formularies cover at least 1 therapeutically equivalent 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 97 percent of the commonly used drugs. Part D plan formularies' inclusion of the commonly used drugs ranges from 88 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.

Inclusion rates for the 197 drugs commonly used by dual eligibles are largely unchanged compared with those from OIG's 2016 report. Part D plan formularies include roughly the same percentage of these commonly used drugs in 2017 as they did in 2016. Enrollment in plans that cover at least 90 percent of unique drugs decreased, with 96 percent of dual eligibles enrolled in such plans in 2017 compared to nearly 100 percent of dual eligibles in 2016.

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 make additional efforts to access the drugs they take. They could appeal prescription drug coverage decisions, switch prescription drugs, or switch Part D plans. Because these scenarios require additional effort by dual eligibles, they may result in administrative barriers to accessing certain prescription drugs.

As mandated by the ACA, OIG will continue to monitor and produce annual reports on 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. OIG has no recommendations at this time.

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 Inclusion by Formularies

The 200 Drugs With the Highest Utilization by Dual Eligibles

*Sample is from the 2012 MCBS. Projections and confidence intervals are derived from its survey methodology.

Generic Name	Sample Size*	Projected Drug Events*	95-Percent Confidence Interval*	Number of Formularies Including Drug	Percentage of Formularies Including Drug
Simvastatin	4,085	20,275,845	18,246,788–22,304,903	369	100%
Lisinopril	4,146	20,105,037	17,883,005–22,327,069	369	100%
Omeprazole	4,277	17,651,028	15,907,564–19,394,492	369	100%
Levothyroxine Sodium	3,875	16,391,504	14,506,699–18,276,310	369	100%
Hydrocodone/Acetaminophen	4,335	15,724,258	13,700,633–17,747,884	369	100%
Furosemide	3,594	15,682,269	13,969,198–17,395,341	369	100%
Metformin HCl	3,053	15,402,973	13,342,093–17,463,852	369	100%
Amlodipine Besylate	3,084	14,334,829	12,552,775–16,116,883	369	100%
Potassium Chloride	2,535	9,847,651	8,425,381–11,269,921	369	100%
Gabapentin	2,195	9,659,579	7,744,867–11,574,290	369	100%
Atorvastatin Calcium	1,892	9,469,703	8,032,978–10,906,428	369	100%
Metoprolol Tartrate	2,161	9,465,474	8,198,827–10,732,121	369	100%
Hydrochlorothiazide	1,684	8,538,793	7,204,227–9,873,358	369	100%
Warfarin Sodium	2,143	8,176,792	6,782,635–9,570,949	369	100%
Albuterol Sulfate	1,809	8,051,430	6,601,089–9,501,772	369	100%
Esomeprazole Magnesium	1,623	7,345,547	5,669,748–9,021,345	233	63%
Tramadol HCl	1,814	7,033,265	5,908,206–8,158,324	369	100%
Citalopram Hydrobromide	1,743	7,028,557	5,999,840–8,057,274	369	100%
Clopidogrel Bisulfate	1,420	6,884,688	5,592,048–8,177,329	369	100%
Atenolol	1,341	6,622,365	5,452,738–7,791,992	369	100%
Zolpidem Tartrate	1,479	6,486,938	5,054,325–7,919,552	357	97%
Carvedilol	1,354	6,189,667	5,070,687–7,308,647	369	100%
Insulin Glargine,hum.Rec.Anlog	1,299	5,924,792	4,861,244–6,988,340	362	98%
Promethazine HCl	2,023	5,868,471	4,226,080–7,510,861	367	99%
Glipizide	1,064	5,847,097	4,635,210–7,058,983	369	100%
Fluticasone/Salmeterol	1,111	5,800,120	4,224,983–7,375,257	350	95%
Oxycodone HCl/ Acetaminophen	1,474	5,676,415	4,586,569–6,766,261	369	100%
Metoprolol Succinate	1,120	5,665,210	4,616,324–6,714,096	368	100%
Ranitidine HCl	1,409	5,482,639	4,145,862–6,819,416	369	100%
Losartan Potassium	1,153	5,482,241	4,424,476–6,540,005	369	100%
Trazodone HCl	1,285	5,420,884	4,236,837–6,604,931	369	100%
Clobetasol Propionate	1,232	5,343,963	3,259,867–7,428,059	305	83%
Sertraline HCl	1,329	5,328,104	4,285,112–6,371,097	369	100%

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The 200 Drugs With the Highest Utilization by Dual Eligibles, continued

Generic Name	Sample Size*	Projected Drug Events*	95-Percent Confidence Interval*	Number of Formularies Including Drug	Percentage of Formularies Including Drug
Alendronate Sodium	1,134	5,059,020	4,027,978–6,090,062	369	100%
Valsartan	999	4,988,907	3,709,041–6,268,773	365	99%
Quetiapine Fumarate	1,580	4,695,543	3,580,822–5,810,265	369	100%
Pravastatin Sodium	1,055	4,497,382	3,599,813–5,394,952	369	100%
Fluticasone Propionate	1,031	4,475,369	3,782,797–5,167,942	369	100%
Montelukast Sodium	983	4,241,912	3,276,654–5,207,171	369	100%
Prednisone	987	4,140,130	3,299,891–4,980,370	369	100%
Rosuvastatin Calcium	862	4,079,698	3,143,992–5,015,404	345	93%
Donepezil HCl	1,067	3,945,615	3,220,946–4,670,284	369	100%
Risperidone	1,320	3,931,788	3,128,046–4,735,529	369	100%
Bupropion HCl	880	3,854,353	2,640,727–5,067,980	369	100%
Isosorbide Mononitrate	797	3,805,846	3,135,306–4,476,386	369	100%
Clonidine HCl	765	3,747,550	2,494,439–5,000,661	369	100%
Tamsulosin HCl	741	3,702,932	2,870,655–4,535,209	369	100%
Lovastatin	760	3,603,172	2,680,255–4,526,090	368	100%
Aripiprazole	915	3,588,383	2,471,105–4,705,661	369	100%
Cyclobenzaprine HCl	884	3,576,109	2,862,722–4,289,496	366	99%
Duloxetine HCl	829	3,455,834	2,612,026–4,299,643	369	100%
Pantoprazole Sodium	745	3,437,474	2,677,159–4,197,789	369	100%
Allopurinol	713	3,403,401	2,647,198–4,159,603	369	100%
Escitalopram Oxalate	881	3,387,426	2,551,390–4,223,461	369	100%
Ibuprofen	953	3,311,577	2,684,384–3,938,770	369	100%
Fluoxetine HCl	793	3,256,783	2,506,927–4,006,640	369	100%
Alprazolam	852	3,243,748	2,306,161–4,181,334	322	87%
Oxycodone HCl	923	3,211,833	2,344,856–4,078,811	369	100%
Diltiazem HCl	804	3,112,978	2,356,110–3,869,845	369	100%
Glimepiride	596	3,102,504	2,097,429–4,107,579	369	100%
Azithromycin	826	2,990,930	2,651,776–3,330,084	369	100%
Divalproex Sodium	1,147	2,956,347	2,371,699–3,540,994	369	100%
Memantine HCl	820	2,946,246	2,305,419–3,587,073	369	100%
Nystatin	778	2,877,573	1,728,167–4,026,980	369	100%
Pregabalin	620	2,874,390	1,945,883–3,802,897	369	100%
Olanzapine	826	2,743,691	1,746,975–3,740,406	369	100%
Famotidine	598	2,741,416	2,001,603–3,481,230	365	99%
Amitriptyline HCl	648	2,732,645	2,025,566–3,439,723	369	100%
Sitagliptin Phosphate	563	2,731,020	1,929,937–3,532,103	358	97%
Tiotropium Bromide	561	2,700,930	2,048,631–3,353,230	301	82%

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The 200 Drugs With the Highest Utilization by Dual Eligibles, continued

Generic Name	Sample Size*	Projected Drug Events*	95-Percent Confidence Interval*	Number of Formularies Including Drug	Percentage of Formularies Including Drug
Meloxicam	641	2,699,758	2,079,860–3,319,656	369	100%
Ketoconazole	778	2,678,585	1,642,081–3,715,089	369	100%
Mirtazapine	693	2,629,860	1,932,977–3,326,744	369	100%
Nifedipine	467	2,620,445	1,841,087–3,399,804	360	98%
Lisinopril/Hydrochlorothiazide	561	2,602,432	2,034,129–3,170,735	369	100%
Lamotrigine	812	2,568,810	1,524,901–3,612,719	369	100%
Levetiracetam	774	2,542,145	1,772,630–3,311,661	369	100%
Clonazepam	696	2,474,602	1,754,467–3,194,736	369	100%
Enalapril Maleate	551	2,442,608	1,834,260–3,050,956	369	100%
Triamterene/ Hydrochlorothiazide	484	2,409,224	1,777,659–3,040,789	369	100%
Paroxetine HCl	608	2,399,150	1,706,298–3,092,003	369	100%
Celecoxib	482	2,386,463	1,634,429–3,138,497	335	91%
Benzotropine Mesylate	796	2,344,725	1,666,426–3,023,025	368	100%
Carbamazepine	711	2,291,674	1,547,240–3,036,107	369	100%
Ciprofloxacin HCl	561	2,201,817	1,879,769–2,523,865	369	100%
Spironolactone	530	2,167,379	1,706,024–2,628,734	369	100%
Nitroglycerin	489	2,159,899	1,556,844–2,762,953	369	100%
Diclofenac Sodium	459	2,071,649	1,535,708–2,607,591	369	100%
Valsartan/ Hydrochlorothiazide	411	2,043,602	1,418,412–2,668,792	362	98%
Digoxin	563	2,017,627	1,397,347–2,637,908	369	100%
Latanoprost	451	1,941,504	1,429,872–2,453,136	369	100%
Topiramate	676	1,919,140	1,225,777–2,612,502	369	100%
Morphine Sulfate	482	1,917,895	1,323,903–2,511,887	369	100%
Fluocinonide	517	1,914,945	984,579–2,845,310	368	100%
Polyethylene Glycol 3350	563	1,911,548	1,456,516–2,366,580	369	100%
Sulfamethoxazole/ Trimethoprim	575	1,882,925	1,565,574–2,200,276	369	100%
Lorazepam	478	1,872,334	1,385,592–2,359,076	369	100%
Ipratropium/Albuterol Sulfate	475	1,863,411	1,265,089–2,461,734	362	98%
Carbidopa/Levodopa	469	1,847,813	1,150,958–2,544,668	369	100%
Fenofibrate Nanocrystallized	393	1,802,940	1,311,234–2,294,646	348	94%
Glyburide	333	1,800,905	1,292,057–2,309,754	178	48%
Levofloxacin	450	1,776,547	1,439,401–2,113,694	369	100%
Oxybutynin Chloride	465	1,772,254	1,130,986–2,413,522	369	100%
Venlafaxine HCl	565	1,769,289	1,293,093–2,245,485	369	100%
Verapamil HCl	386	1,768,870	1,232,568–2,305,172	369	100%
Pioglitazone HCl	350	1,765,584	1,267,958–2,263,210	369	100%

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The 200 Drugs With the Highest Utilization by Dual Eligibles, continued

Generic Name	Sample Size*	Projected Drug Events*	95-Percent Confidence Interval*	Number of Formularies Including Drug	Percentage of Formularies Including Drug
Naproxen	481	1,712,919	1,305,637–2,120,202	369	100%
Triamcinolone Acetonide	401	1,709,516	1,194,175–2,224,857	369	100%
Cephalexin	461	1,708,905	1,354,546–2,063,263	369	100%
Insulin Aspart	438	1,697,897	1,236,282–2,159,511	274	74%
Meclizine HCl	354	1,694,107	1,166,438–2,221,776	368	100%
Cinacalcet HCl	273	1,686,744	228,751–3,144,737	369	100%
Benazepril HCl	314	1,662,487	1,061,779–2,263,195	368	100%
Amoxicillin	449	1,645,349	1,440,430–1,850,269	369	100%
Ezetimibe	315	1,630,531	1,137,372–2,123,691	369	100%
Hydralazine HCl	352	1,626,562	1,040,354–2,212,770	369	100%
Losartan/Hydrochlorothiazide	323	1,616,723	1,126,209–2,107,237	369	100%
Methocarbamol	332	1,604,238	957,852–2,250,624	222	60%
Carisoprodol	468	1,569,542	1,069,916–2,069,169	168	46%
Lansoprazole	300	1,517,331	937,732–2,096,931	289	78%
Lidocaine	392	1,497,702	1,062,229–1,933,176	369	100%
Baclofen	432	1,496,342	901,759–2,090,925	369	100%
Propranolol HCl	441	1,466,579	989,903–1,943,256	369	100%
Tizanidine HCl	465	1,402,405	922,152–1,882,657	369	100%
Buspirone HCl	345	1,392,828	771,720–2,013,936	369	100%
Lactulose	352	1,376,489	858,083–1,894,894	369	100%
Brimonidine Tartrate	270	1,364,643	814,036–1,915,250	369	100%
Omega-3 Acid Ethyl Esters	337	1,340,484	863,754–1,817,215	323	88%
Methadone HCl	233	1,334,501	668,812–2,000,191	368	100%
Metoclopramide HCl	272	1,311,286	790,771–1,831,801	369	100%
Ropinirole HCl	318	1,304,881	795,681–1,814,080	369	100%
Phenytoin Sodium Extended	414	1,299,826	893,247–1,706,406	369	100%
Budesonide/ Formoterol Fumarate	297	1,282,394	897,195–1,667,593	270	73%
Timolol Maleate	251	1,278,484	801,832–1,755,136	369	100%
Hydrocortisone	279	1,276,518	768,357–1,784,678	369	100%
Travoprost	325	1,223,842	898,838–1,548,847	327	89%
Olopatadine HCl	288	1,210,924	776,919–1,644,928	353	96%
Hydroxyzine HCl	296	1,208,115	813,793–1,602,437	355	96%
Bimatoprost	206	1,206,009	747,306–1,664,713	352	95%
Insulin Detemir	325	1,203,894	807,216–1,600,572	303	82%
Ziprasidone HCl	331	1,183,365	639,947–1,726,783	369	100%
Doxazosin Mesylate	253	1,166,572	705,708–1,627,436	369	100%
Insulin Lispro	243	1,165,251	612,842–1,717,661	217	59%

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The 200 Drugs With the Highest Utilization by Dual Eligibles, continued

Generic Name	Sample Size*	Projected Drug Events*	95-Percent Confidence Interval*	Number of Formularies Including Drug	Percentage of Formularies Including Drug
Diazepam	336	1,163,773	805,788–1,521,758	369	100%
Pramipexole Di-HCl	269	1,163,159	716,859–1,609,460	369	100%
Dexlansoprazole	255	1,154,307	605,989–1,702,624	189	51%
Acetaminophen With Codeine	324	1,146,119	835,514–1,456,724	369	100%
Finasteride	193	1,142,207	645,801–1,638,614	369	100%
Metronidazole	277	1,082,251	740,294–1,424,207	369	100%
Estrogens, Conjugated	207	1,062,210	680,581–1,443,839	305	83%
Ramipril	216	1,044,656	618,660–1,470,651	366	99%
Mometasone Furoate	273	1,041,955	738,062–1,345,847	368	100%
Doxycycline Hyclate	306	1,039,974	803,052–1,276,896	369	100%
Gemfibrozil	317	1,002,452	655,398–1,349,505	369	100%
Insulin Regular, Human	321	997,047	448,381–1,545,713	369	100%
Clozapine	377	996,800	256,796–1,736,805	369	100%
Amoxicillin/Potassium Clav	296	992,326	798,742–1,185,910	369	100%
Fentanyl	283	950,958	630,440–1,271,475	369	100%
Fenofibrate	200	947,241	530,041–1,364,441	368	100%
Terazosin HCl	196	944,375	600,107–1,288,642	369	100%
Quinapril HCl	176	941,788	521,252–1,362,324	363	98%
Amlodipine Besylate/ Benazepril	210	938,298	638,282–1,238,313	352	95%
Tolterodine Tartrate	218	934,963	602,658–1,267,269	355	96%
Insulin Nph Hum/Reg Insulin Hm	223	926,025	503,322–1,348,729	369	100%
Fluconazole	268	906,521	631,479–1,181,562	369	100%
Sucralfate	252	899,714	608,736–1,190,692	369	100%
Niacin	249	884,662	476,245–1,293,079	364	99%
Colchicine	183	874,820	496,096–1,253,544	369	100%
Solifenacin Succinate	189	861,786	578,376–1,145,197	268	73%
Megestrol Acetate	226	860,045	569,049–1,151,041	369	100%
Ciclopirox Olamine	190	846,025	291,480–1,400,570	353	96%
Calcitriol	181	844,443	510,574–1,178,312	369	100%
Hydroxychloroquine Sulfate	227	843,974	546,086–1,141,862	369	100%
Dicyclomine HCl	258	835,905	510,720–1,161,090	369	100%
Sevelamer Carbonate	181	834,843	473,155–1,196,532	365	99%
Dorzolamide HCl/ Timolol Maleate	183	820,248	535,827–1,104,669	363	98%
Raloxifene HCl	170	817,458	404,826–1,230,090	369	100%
Ergocalciferol (Vitamin D ₂)	238	815,762	577,444–1,054,081	0	0%**
Dutasteride	175	812,367	421,163–1,203,571	345	93%

**See Appendix C.

continued on next page

The 200 Drugs With the Highest Utilization by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Drug Events*	95-Percent Confidence Interval*	Number of Formularies Including Drug	Percentage of Formularies Including Drug
Cyclosporine	206	811,780	542,087–1,081,473	369	100%
Ipratropium Bromide	212	809,312	479,306–1,139,318	369	100%
Methylprednisolone	208	804,664	635,543–973,784	369	100%
Prednisolone Acetate	186	793,727	589,346–998,109	363	98%
Clotrimazole/Betamethasone Dip	215	793,462	607,917–979,006	289	78%
Estradiol	152	785,815	436,414–1,135,216	369	100%
Primidone	200	780,692	193,858–1,367,527	369	100%
Torsemide	197	780,054	485,186–1,074,923	361	98%
Nitrofurantoin Monohyd/ M-Cryst	192	773,126	516,975–1,029,278	344	93%
Albuterol	176	770,589	478,225–1,062,953	0	0%**
Sumatriptan Succinate	146	Excluded	Excluded	Excluded	Excluded
Risedronate Sodium	147	763,979	295,176–1,232,781	275	75%
0.9% Sodium Chloride	216	754,836	155,720–1,353,952	369	100%
Cilostazol	202	751,130	399,943–1,102,317	369	100%
Amiodarone HCl	149	750,614	391,667–1,109,561	369	100%
Chlorthalidone	150	735,530	370,480–1,100,580	366	99%
Doxepin HCl	202	724,154	404,293–1,044,015	369	100%
Mupirocin	204	697,884	520,300–875,469	369	100%
Ondansetron HCl	183	663,507	421,480–905,535	369	100%
Metolazone	127	657,608	251,543–1,063,674	361	98%
Clonidine	114	654,668	234,616–1,074,720	369	100%

Source: OIG analysis of drugs commonly used by dual eligibles, 2017.

**See Appendix C.

APPENDIX C

Two 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
Ergocalciferol (vitamin D ₂)*	Vitamin or mineral product

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2017.

*These drugs were also on the 2016 report's list of drugs commonly used by dual eligibles and not covered under Part D.

APPENDIX D

Formulary Inclusion of Stand-Alone Prescription Drug Plans* and Medicare Advantage Prescription Drug Plans**, by Region

Exhibit D-1: PDP Formularies' Inclusion of Commonly Used Drugs, by PDP Region

PDP Region	State(s)	Number of PDPs	Average Rate of Drug Inclusion by Formularies	Minimum Rate	Maximum Rate
1	Maine, New Hampshire	21	95%	89%	100%
2	Connecticut, Massachusetts, Rhode Island, Vermont	19	95%	89%	99%
3	New York	17	95%	89%	100%
4	New Jersey	19	95%	89%	99%
5	Delaware, the District of Columbia, Maryland	18	95%	89%	100%
6	Pennsylvania, West Virginia	22	96%	89%	100%
7	Virginia	21	95%	89%	100%
8	North Carolina	20	95%	89%	100%
9	South Carolina	19	95%	89%	99%
10	Georgia	21	95%	89%	100%
11	Florida	18	95%	89%	99%
12	Alabama, Tennessee	22	96%	89%	100%
13	Michigan	21	95%	89%	100%
14	Ohio	20	95%	89%	99%
15	Indiana, Kentucky	21	95%	89%	100%
16	Wisconsin	22	95%	89%	99%
17	Illinois	21	95%	88%	100%
18	Missouri	21	95%	89%	100%
19	Arkansas	20	95%	89%	100%
20	Mississippi	17	95%	89%	99%
21	Louisiana	18	95%	89%	100%
22	Texas	21	95%	88%	100%
23	Oklahoma	20	95%	88%	99%
24	Kansas	20	95%	89%	99%
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	20	95%	89%	100%
26	New Mexico	21	95%	88%	100%
27	Colorado	21	95%	89%	100%
28	Arizona	20	95%	89%	100%
29	Nevada	21	95%	89%	99%
30	Oregon, Washington	19	95%	89%	99%
31	Idaho, Utah	22	95%	89%	100%
32	California	22	95%	89%	99%
33	Hawaii	17	95%	89%	99%
34	Alaska	16	95%	89%	99%

Source: OIG analysis of formularies' inclusion of drugs commonly used by dual eligibles, 2017.

*PDP.

**MA-PD.

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

MA-PD Region***	State(s)	Number of MA-PDs	Average Rate of Drug Inclusion by Formularies	Minimum Rate	Maximum Rate
1	Maine, New Hampshire	45	97%	95%	99%
2	Connecticut, Massachusetts, Rhode Island, Vermont	93	97%	94%	99%
3	New York	185	97%	94%	100%
4	New Jersey	38	96%	88%	98%
5	Delaware, the District of Columbia, Maryland	28	98%	96%	100%
6	Pennsylvania, West Virginia	148	98%	94%	100%
7	North Carolina, Virginia	112	97%	89%	100%
8	Georgia, South Carolina	89	98%	94%	100%
9	Florida	243	98%	90%	100%
10	Alabama, Tennessee	76	97%	95%	99%
11	Michigan	66	98%	94%	99%
12	Ohio	117	97%	93%	99%
13	Indiana, Kentucky	100	97%	94%	99%
14	Illinois, Wisconsin	140	97%	92%	99%
15	Arkansas, Missouri	69	97%	88%	99%
16	Louisiana, Mississippi	59	98%	95%	100%
17	Texas	142	97%	93%	100%
18	Kansas, Oklahoma	53	97%	95%	99%
19	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	79	97%	92%	99%
20	Colorado, New Mexico	59	98%	96%	100%
21	Arizona	59	97%	94%	100%
22	Nevada	31	97%	94%	99%
23	Idaho, Oregon, Utah, Washington	168	97%	93%	100%
24	California	259	97%	93%	100%
25	Hawaii	18	98%	95%	100%

Source: OIG analysis of formularies' inclusion of drugs commonly used by dual eligibles, 2017.

***Region 26, which covers Alaska, had no MA-PDs available for 2017.

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