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PART D PLANS GENERALLY INCLUDE DRUGS COMMONLY USED BY DUAL ELIGIBLES: 2018

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2018

Why OIG Did This Review

The Patient Protection and Affordable Care Act (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 eighth report OIG has produced to meet this mandate.

How OIG Did This Review

For this report, we determined whether the 386 unique formularies used by the 3,476 Part D plans operating in 2018 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 2013 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, 2 are excluded from coverage, and 1 is a Part D covered medical supply item.

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 96 percent of the 197 commonly used drugs. In addition, 68 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 2017, as well as our findings from 2011 through 2016.

We also found that the percentage of drugs to which plan formularies applied utilization management tools increased slightly between 2017 and 2018. On average, formularies applied utilization management tools to 29 percent of the unique drugs we reviewed in 2018, an increase of 1 percentage point from 2017.

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 and utilization management of these drugs, some dual eligibles may need to make additional efforts to access the drugs they take. For instance, they may chose to 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.

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 high percentage of these commonly used drugs in 2018 as they did in 2017.

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.

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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 2018, approximately 43.8 million of the 59.2 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 2018, plan sponsors offer 3,476 unique Part D plans, with many plan sponsors offering multiple Part D plans.

Dual Eligibles Under Medicare Part D

Approximately 10.9 million Medicare beneficiaries are dual eligibles. For about 8 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

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[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

[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 2018, 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.

following year.[15] For dual eligibles who were randomly assigned to their 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 2018, CMS reported reassigning approximately 351,000 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,

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[15] Ibid., § 40.1.5.

[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

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[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 fill 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. See Appendix A for statutory mandate. We have released an annual mandated report each year since then. See Appendix B for list of reports. The current report is the eighth report released.

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 2018. As part of our assessment, we included dual eligibles' enrollment data from January 2018, the most recent enrollment data

[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.

available from CMS at the time of our study. We also compared the results of our 2018 study with those of our 2017 study.[33]

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 2013 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."

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 to 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.

Data Sources

MCBS. We used the 2013 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 2013 MCBS Cost and Use data were the most recent data available at the time of our study. 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 2018 overlapped by 91 percent with the list for 2017, which in turn overlapped by 91 percent with the list for 2015.[34]

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

[34] In 2018, we used the 2013 data and in 2017 and 2016, we used the 2012 data. In 2015, we used 2011 data.

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 2013, the MCBS surveyed 11,049 Medicare beneficiaries, of whom 2,456 were dual eligibles who had used prescription drugs during the year (out of 2,718 dual-eligible survey respondents).

First DataBank National Drug Data File. We used the March 2013 First DataBank National Drug Data File to identify the drug product information for the 200 drugs with the highest utilization by dual eligibles.[35] 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).[36]

Part D plan data. In February 2018, we collected from CMS the formulary data and the plan data for Part D plans operating in 2018. The formulary data includes Part D plans' formularies and utilization management tools for plans operating in 2018. In 2018, there are 386 unique formularies offered by 3,476 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.

We also collected 2018 enrollment data for Part D plans. These data provide the number of dual eligibles enrolled in each Part D plan as of January 2018.

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 2013 MCBS. We excluded respondents from territories because they are not eligible to receive cost-sharing assistance

[35] The Mach 2013 First Databank National Drug Data File would have been in effect when the MCBS survey was being conducted

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

under Part D. The MCBS listed 188,685 drug events for 2,456 dual eligibles who did not reside in territories.[37]

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 188,685 drug events associated with 871 drugs.
3. We ranked the 871 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 C.
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 2013 MCBS. One additional drug is eligible for Part D prescription drug coverage. However, we did not include it in our analysis because the drug represents a medical supply item that is covered under Part D. For details on the two drugs excluded under Part D, see Appendix D.

Formulary Analysis

We analyzed the 386 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.

[37] 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 2013. 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.

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 386 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 January 2018 to Part D plans available in 2018.

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 2013 account for 88 percent of

all prescriptions dispensed to the dual-eligible respondents in the 2013 MCBS.

Standards

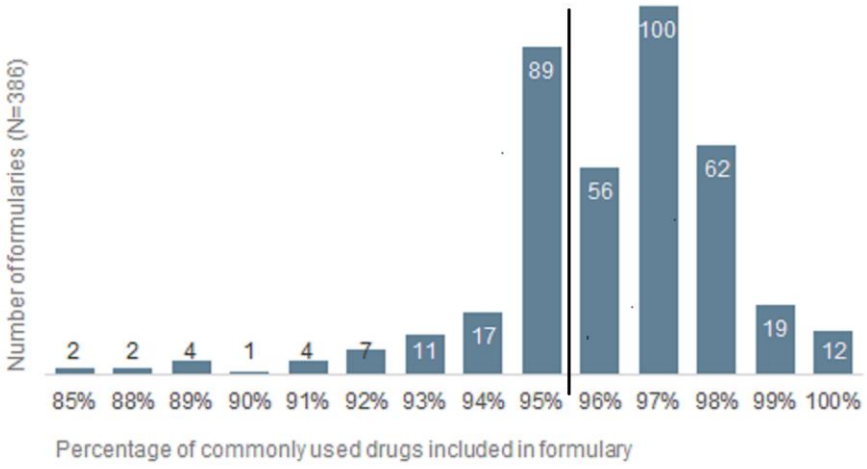
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Part D Plan Formularies Include Between 85 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 386 unique formularies used by Part D plans in 2018, 12 formularies include 100 percent of the commonly used drugs. At the other end of the inclusion range, two formularies include 85 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 96 percent of the drugs commonly used by dual eligibles.



Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2018.

Part D plan formularies' rate of inclusion of the drugs commonly used by dual eligibles in 2018 is similar to that of 2017. The average rate of inclusion decreased slightly between 2017 and 2018, from 97 percent to 96 percent. The range of inclusion rates in 2017 and 2018 differ slightly with 85 to 100 percent of drugs commonly used by dual eligibles in 2018 compared with 88 to 100 percent in 2017.

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 formularies, the rates of inclusion ranged from 85 to 99 percent. For MA-PD formularies, the rates of inclusion ranged from 85 to 100 percent. Seven formularies—2 percent of the 386 unique formularies used by Part D plans in 2018—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 E 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 85 percent to 100 percent. Approximately 86 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 10.8 million dual eligibles enrolled in Part D plans, approximately 93 percent are enrolled in Part D plans that use formularies that include at least 90 percent of the commonly used drugs. Seven 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	222,880	2%
95% to 99% of commonly used drugs	3,631,810	34%
90% to 94% of commonly used drugs	6,133,779	57%
85% to 89% of commonly used drugs	766,106	7%
Total	**10.754,575**	**100%**

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles and dual eligibles' enrollment, 2018.

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 96 percent in 2017 to 93 percent in 2018.

Sixty-Eight 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 43 percent to 100 percent. At one end of the range, there is a drug that is included in 43 percent of Part D plan formularies, and at the other end, 134 drugs are included in all plan formularies. The average rate of inclusion in formularies is 96 percent. Exhibit 3 shows the rates at which formularies include the 197 drugs. Appendix C 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 386 Formularies	Percentage of the 197 Commonly Used Drugs Included in Formularies
100%	68% (134 drugs)
85% to 99%	22% (44 drugs)
76% to 84%	4% (7 drugs)
43% to 75%	6% (12 drugs)
Total	**100% (197 drugs)**

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2018.

The rates at which formularies include the drugs commonly used by dual eligibles in 2018 are similar to those in 2017. The percentage of

commonly used drugs included in all formularies decreased slightly between 2017 and 2018, from 70 percent to 68 percent.

Part D plan formularies include certain drugs less frequently than others

Of the commonly used drugs, 6 percent (12 drugs) are included by 75 percent or less of Part D plan formularies. Exhibit 4 provides the percentage of formularies covering each of these 12 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. Six of the 12 drugs are brand-name drugs, which are typically more costly than generic drugs. As for the primary indications, 4 of the 12 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
Solifenacin succinate	Overactive bladder, incontinence	74%
Hydroxyzine Pamoate	Anxiety, Allergy Treatment	73%
Insulin aspart	Diabetes	72%
Nebivolo Hcl	Hypertension	71%
Tiotropium Bromide	Chronic Obstructive Pulmonary Disease	70%
Esomeprazole magnesium	Dyspepsia, peptic ulcer disease, gastroesophageal reflux disease, Zollinger-Ellison syndrome	64%
Methocarbamol	Musculoskeletal pain	59%
Insulin lispro	Diabetes	53%
Dexlansoprazole	Gastroesophageal reflux disease	52%
Glyburide	Diabetes	48%
Carisoprodol	Musculoskeletal pain	45%
Glyburide/Metformin Hcl	Diabetes	43%

Source: OIG analysis of formularies' inclusion of drugs commonly used by dual eligibles, 2018.
The drugs in the shaded rows also had low rates of inclusion by formularies in 2017.

Although Part D formularies frequently omit these 12 drugs, they all cover other drugs in the same respective therapeutic classes. For each of these 12 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 10 in 2017 to 12 in 2018. There are eight drugs with low inclusion rates in 2018 that were also on the list of commonly used drugs with low inclusion rates in our 2017 report; we note these eight drugs

above in Exhibit 4. Seven of these eight drugs were also on the list of drugs with low inclusion rates in our 2016 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.[38]
- The two drugs above and a third drug—glyburide—are listed by the American Geriatrics Society as being potentially inappropriate for older adults.[39]
- 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.[40]

Dual eligibles can use three options to obtain a nonformulary drug if a formulary does not include a particular drug. All three options require dual eligibles to take additional action. For instance, 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.[41] Finally, dual eligibles may switch to Part D plans with formularies that include their drugs, with the new coverage becoming effective the following month.[42]

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[38] 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 May 31, 2018.

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

[40] Ibid.

[41] CMS, *PDBM*, ch. 18, § 30.2.2.

[42] Ibid., ch. 3, § 30.3.2.

The Percentage of Commonly Used Drugs To Which Plan Formularies Applied Utilization Management Tools Increased Slightly Between 2017 and 2018

For the unique drugs that compose the list of commonly used drugs, the percentage to which Part D plan formularies applied utilization management tools increased slightly from 28 percent in 2017 to 29 percent in 2018. 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 26 percent and 31 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 2017 and 2018.

Exhibit 5: Part D Plan Formularies' Application of Utilization Management Tools to Commonly Used Drugs, 2017 and 2018

Percentage of Unique Drugs to Which Utilization Management Tools Are Applied	Number of 2017 Part D Plan Formularies	Percentage of 2017 Part D Plan Formularies	Number of 2018 Part D Plan Formularies	Percentage of 2018 Part D Plan Formularies
Greater than 40%	60	16%	78	20%
30% to 39%	85	23%	130	34%
20% to 29%	140	38%	90	23%
10% to 19%	66	18%	66	17%
Less than 10%	18	5%	22	6%
Totals	**369**	**100%**	**386**	**100%**

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2018.

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.[43]

The percentage of drugs for which formularies applied the utilization management tools of quantity limits, prior authorization, or step therapy[44] changed slightly between 2017 and 2018. Formularies applied quantity limits to 26 percent of drugs in 2018—a 2 percentage point increase from

[43] 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 May 30, 2018.

[44] See footnote 3 for explanations of quantity limits, prior authorization, and step therapy.

2017—, required prior authorization for 4 percent of drugs, and required step therapy for 1 percent of unique drugs.

The rate at which plan formularies apply specific utilization management tools varies widely. In 2018, some formularies applied utilization management tools to very few of the unique drugs, whereas at the other end of the range, some applied tools to 56 percent of the unique drugs. More specifically, formularies apply quantity limits to between 0 and 53 percent of unique drugs, require prior authorization for between less than 1 and 12 percent, and require step therapy for between 0 and 11 percent.

Looking at enrollment across plans provides a slightly different picture than looking only at plans themselves. On average, plan formularies in 2018 apply utilization management tools to 33 percent of unique drugs. However, dual eligibles tend to be enrolled in plans with formularies that apply these tools at a slightly lower rate. In 2018, the median plan weighted by dual-eligible enrollment applies such tools to 31 percent of unique drugs; in 2017, the figure was 29 percent. Similarly, the median plan weighted by overall Medicare enrollment applies these tools to 32 percent of unique drugs in 2018; in 2017, the figure was 30 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 2018, 71 percent of dual eligibles and 66 percent of Medicare beneficiaries overall were enrolled in plans with formularies in this range.

The number of Medicare beneficiaries that were enrolled in plans that apply utilization management tools to more than 40 percent of unique drugs increased substantially in 2018. In 2017, 8 percent of dual eligibles and 13 percent of Medicare beneficiaries overall were enrolled in plans that applied utilization management tools to more than 40 percent of unique drugs. This increased to 24 percent and 26 percent respectively in 2018. 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, 2017 and 2018

Percentage of Unique Drugs to Which Plan Formularies Apply Utilization Management Tools	Percentage of Dual Eligibles Enrolled, 2017	Percentage of Medicare Beneficiaries Enrolled, 2017	Percentage of Dual Eligibles Enrolled, 2018	Percentage of Medicare Beneficiaries Enrolled, 2018
Greater than 40%	8%	13%	24%	26%
30% to 39%	37%	39%	29%	37%
20% to 29%	50%	40%	41%	29%
10% to 19%	3%	4%	3%	4%
Less than 10%	2%	3%	2%	3%
Totals	**100%***	**100%**	**100%**	**100%***

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2018.
* 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 12 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 96 percent of the commonly used drugs. Part D plan formularies' inclusion of the commonly used drugs ranges from 85 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 2017 report. Part D plan formularies include roughly the same percentage of these commonly used drugs in 2018 as they did in 2017. Enrollment in plans that cover at least 90 percent of unique drugs decreased, with 93 percent of dual eligibles enrolled in such plans in 2018 compared to 96 percent of dual eligibles in 2017.

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

List of Manadated OIG Reports Examining Dual Eligible Access to Drugs Under Part D

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

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

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

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

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

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

OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2017,* OEI-05-17-00016, June 2017

APPENDIX C

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
Lisinopril	4,038	20,381,310	18,552,913–22,209,708	386	100%
Omeprazole	4,425	19,707,133	17,636,412–21,777,854	386	100%
Simvastatin	3,677	18,903,811	16,928,645–20,878,978	384	99%
Amlodipine Besylate	3,855	18,789,961	16,676,942–20,902,979	386	100%
Levothyroxine Sodium	4,242	18,298,908	16,405,768–20,192,048	386	100%
Hydrocodone/Acetaminophen	4,494	17,495,817	15,328,947–19,662,688	386	100%
Furosemide	4,123	17,425,375	15,574,619–19,276,131	386	100%
Metformin Hcl	3,045	15,842,128	14,038,922–17,645,334	386	100%
Atorvastatin Calcium	2,305	12,007,784	10,370,261–13,645,307	386	100%
Metoprolol Tartrate	2,554	11,989,842	10,506,455–13,473,229	386	100%
Potassium Chloride	3,020	11,709,300	10,192,735–13,225,866	386	100%
Gabapentin	2,736	11,258,811	9,908,637–12,608,985	386	100%
Nystatin	3,276	10,800,847	7,318,942–14,282,752	386	100%
Warfarin Sodium	2,512	9,504,416	8,097,300–10,911,531	386	100%
Albuterol Sulfate	2,052	9,204,690	7,942,991–10,466,390	386	100%
Hydrochlorothiazide	1,585	9,049,481	7,557,151–10,541,811	386	100%
Insulin Glargine,hum.Rec.Anlog	1,469	7,319,078	5,814,550–8,823,605	381	99%
Metoprolol Succinate	1,403	7,260,928	6,108,639–8,413,218	385	100%
Clopidogrel Bisulfate	1,388	7,230,886	6,099,241–8,362,532	386	100%
Losartan Potassium	1,341	7,202,477	5,960,029–8,444,926	386	100%
Citalopram Hydrobromide	1,725	7,093,303	5,960,073–8,226,533	386	100%
Carvedilol	1,486	6,952,455	5,706,949–8,197,960	386	100%
Esomeprazole Magnesium	1,582	6,926,582	5,590,920–8,262,244	247	64%
Pantoprazole Sodium	1,616	6,892,160	4,604,999–9,179,321	386	100%
Tramadol Hcl	1,792	6,807,062	5,819,372–7,794,751	386	100%
Alprazolam	1,608	6,597,576	5,415,535–7,779,617	365	95%
Trazodone Hcl	1,551	6,511,067	4,727,359–8,294,774	386	100%
Glipizide	1,155	6,481,486	5,271,745–7,691,227	386	100%
Atenolol	1,323	6,288,611	5,220,203–7,357,019	386	100%
Promethazine Hcl	1,730	6,256,116	4,504,615–8,007,618	384	99%
Pravastatin Sodium	1,260	6,247,140	4,770,713–7,723,567	385	100%

Sertraline Hcl	1,543	6,022,241	4,987,710–7,056,771	386	100%
Clonazepam	1,590	5,877,149	4,656,463–7,097,835	386	100%
Quetiapine Fumarate	1,648	5,801,415	4,446,747–7,156,082	386	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
Zolpidem Tartrate	1,345	5,607,270	4,429,096–6,785,444	378	98%
Ranitidine Hcl	1,412	5,450,546	4,356,459–6,544,634	386	100%
Fluticasone/Salmeterol	1,136	5,427,435	4,383,617–6,471,253	372	96%
Montelukast Sodium	1,145	5,240,144	3,928,815–6,551,473	386	100%
Rosuvastatin Calcium	929	5,137,546	4,054,742–6,220,350	376	97%
Oxycodone Hcl/ Acetaminophen	1,212	4,957,132	3,982,154–5,932,110	386	100%
Clobetasol Propionate	1,507	4,930,172	2,690,032–7,170,312	302	78%
Donepezil Hcl	1,404	4,870,667	4,189,206–5,552,128	384	99%
Lorazepam	1,374	4,837,237	3,946,993–5,727,481	386	100%
Fluticasone Propionate	1,168	4,776,350	4,033,937–5,518,762	386	100%
Oxycodone Hcl	1,188	4,660,197	3,374,303–5,946,091	385	100%
Tamsulosin Hcl	879	4,490,524	3,658,245–5,322,803	386	100%
Memantine Hcl	1,316	4,209,279	3,461,970–4,956,589	386	100%
Prednisone	1,035	4,114,787	3,508,209–4,721,364	386	100%
Bupropion Hcl	951	4,038,001	2,740,350–5,335,653	386	100%
Alendronate Sodium	824	4,002,546	3,172,023–4,833,070	386	100%
Allopurinol	792	3,970,410	3,153,877–4,786,944	386	100%
Duloxetine Hcl	1,062	3,965,375	3,018,646–4,912,104	386	100%
Valsartan	895	3,950,999	3,159,255–4,742,743	383	99%
Divalproex Sodium	1,179	3,864,519	2,625,743–5,103,295	386	100%
Risperidone	1,263	3,822,970	2,947,217–4,698,723	386	100%
Fluoxetine Hcl	832	3,699,624	2,704,123–4,695,126	386	100%
Tiotropium Bromide	718	3,696,364	2,719,547–4,673,181	271	70%
Ibuprofen	1,014	3,690,403	3,130,468–4,250,339	386	100%
Lisinopril/Hydrochlorothiazide	610	3,672,967	2,948,971–4,396,963	386	100%
Isosorbide Mononitrate	781	3,589,706	2,863,637–4,315,775	386	100%
Mirtazapine	930	3,588,107	2,763,598–4,412,615	386	100%
Cyclobenzaprine Hcl	912	3,572,843	2,872,182–4,273,504	383	99%
Aripiprazole	938	3,516,759	2,734,316–4,299,201	386	100%
Clonidine Hcl	782	3,328,949	2,503,272–4,154,625	386	100%
Paroxetine Hcl	731	3,282,143	2,465,231–4,099,056	386	100%
Meloxicam	698	3,220,620	2,481,759–3,959,481	386	100%
Fluocinonide	777	3,165,499	852,695–5,478,304	379	98%
Escitalopram Oxalate	843	3,163,799	2,577,363–3,750,234	386	100%

Sitagliptin Phosphate	669	3,145,817	2,351,761–3,939,873	374	97%
Levetiracetam	996	3,127,461	2,400,044–3,854,879	386	100%
Famotidine	751	3,076,189	2,392,508–3,759,870	382	99%

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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
Diltiazem Hcl	759	3,034,429	2,389,782–3,679,076	386	100%
Pregabalin	647	3,032,962	2,084,114–3,981,811	386	100%
Glimepiride	568	3,027,684	2,309,913–3,745,454	386	100%
Amitriptyline Hcl	651	3,006,497	2,338,978–3,674,016	386	100%
Lovastatin	580	2,905,667	2,303,928–3,507,406	384	99%
Enalapril Maleate	554	2,859,600	2,095,511–3,623,689	386	100%
Diazepam	683	2,859,179	2,145,764–3,572,593	386	100%
Olanzapine	935	2,805,880	2,153,123–3,458,637	386	100%
Polyethylene Glycol 3350	791	2,794,905	2,261,081–3,328,728	386	100%
Morphine Sulfate	671	2,785,883	2,016,589–3,555,177	386	100%
Lamotrigine	792	2,584,433	1,820,559–3,348,306	386	100%
Ciprofloxacin Hcl	710	2,572,783	2,250,615–2,894,952	386	100%
Nitroglycerin	567	2,516,794	1,989,315–3,044,272	386	100%
Digoxin	671	2,499,207	1,849,180–3,149,233	386	100%
Topiramate	768	2,497,034	1,765,504–3,228,563	386	100%
Oxybutynin Chloride	611	2,496,353	1,865,024–3,127,681	386	100%
Insulin Aspart	576	2,457,698	1,734,741–3,180,655	277	72%
Latanoprost	570	2,362,248	1,830,307–2,894,189	386	100%
Azithromycin	656	2,360,326	2,078,870–2,641,781	386	100%
Diclofenac Sodium	564	2,347,071	1,797,777–2,896,364	386	100%
Sulfamethoxazole/ Trimethoprim	679	2,316,522	1,948,947–2,684,096	386	100%
Benztropine Mesylate	831	2,315,393	1,755,885–2,874,901	385	100%
Spironolactone	564	2,309,373	1,714,941–2,903,804	386	100%
Celecoxib	536	2,308,905	1,617,011–3,000,799	363	94%
Baclofen	640	2,259,728	1,773,860–2,745,596	386	100%
Hydrocortisone	355	2,228,990	393,049–4,064,931	386	100%
Valsartan/ Hydrochlorothiazide	362	2,148,809	1,446,999–2,850,620	382	99%
Ketoconazole	643	2,118,032	1,508,222–2,727,841	386	100%
Buspirone Hcl	544	2,117,000	1,566,401–2,667,599	386	100%
Venlafaxine Hcl	676	2,086,177	1,603,806–2,568,547	386	100%
Ipratropium/Albuterol Sulfate	514	2,071,560	1,613,340–2,529,780	379	98%
Nifedipine	399	2,061,785	1,496,922–2,626,648	377	98%

Triamterene/ Hydrochlorothiazid	434	1,998,788	1,490,958–2,506,617	386	100%
Lidocaine	566	1,991,949	1,504,848–2,479,050	386	100%
Lactulose	478	1,971,518	1,048,559–2,894,477	386	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	475	1,935,742	1,514,931–2,356,553	386	100%
Carbamazepine	557	1,892,355	1,301,937–2,482,774	386	100%
Budesonide/Formoterol Fumarate	354	1,877,636	1,080,548–2,674,725	306	79%
Hydralazine Hcl	423	1,870,997	1,381,326–2,360,669	386	100%
Cephalexin	576	1,859,516	1,586,809–2,132,222	386	100%
Amoxicillin	502	1,859,250	1,639,830–2,078,670	386	100%
Carbidopa/Levodopa	524	1,840,512	1,292,455–2,388,569	386	100%
Meclizine Hcl	430	1,825,694	1,314,979–2,336,409	386	100%
Hydroxyzine Hcl	332	1,816,899	683,133–2,950,664	368	95%
Levofloxacin	525	1,815,766	1,491,041–2,140,491	386	100%
Insulin Detemir	424	1,804,441	1,267,928–2,340,954	315	82%
Phenytoin Sodium Extended	565	1,796,703	1,343,910–2,249,496	386	100%
Pioglitazone Hcl	402	1,778,633	1,249,826–2,307,440	386	100%
Losartan/Hydrochlorothiazide	323	1,756,708	1,195,562–2,317,854	386	100%
Propranolol Hcl	441	1,671,564	1,144,349–2,198,778	386	100%
Ropinirole Hcl	342	1,668,001	946,318–2,389,683	386	100%
Triamcinolone Acetonide	417	1,636,176	1,228,192–2,044,160	386	100%
Verapamil Hcl	347	1,604,821	980,059–2,229,583	386	100%
Clozapine	475	1,570,432	374,731–2,766,134	386	100%
Temazepam	400	1,555,608	1,137,384–1,973,832	359	93%
Fenofibrate Nanocrystallized	400	1,535,334	1,046,334–2,024,334	376	97%
Omega-3 Acid Ethyl Esters	342	1,493,157	979,970–2,006,343	364	94%
Terazosin Hcl	281	1,492,288	963,820–2,020,756	386	100%
Fentanyl	447	1,476,511	927,847–2,025,175	386	100%
Tizanidine Hcl	386	1,427,368	969,496–1,885,240	386	100%
Benazepril Hcl	299	1,413,392	933,212–1,893,572	385	100%
Insulin Lispro	332	1,399,742	956,645–1,842,840	204	53%
Finasteride	279	1,368,049	837,874–1,898,225	386	100%
Bimatoprost	236	1,364,658	897,674–1,831,642	372	96%
Mometasone Furoate	313	1,351,763	984,967–1,718,558	385	100%
Ezetimibe	282	1,341,551	937,005–1,746,098	386	100%
Fenofibrate	239	1,324,483	859,187–1,789,779	385	100%
Amoxicillin/Potassium Clav	324	1,313,164	1,018,028–1,608,301	386	100%

Acetaminophen With Codeine	334	1,301,414	987,348–1,615,481	386	100%
Lansoprazole	298	1,296,387	849,556–1,743,219	302	78%
Brimonidine Tartrate	314	1,282,393	892,130–1,672,657	386	100%

**See Appendix D.

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
Solifenacin Succinate	319	1,274,551	822,905–1,726,196	284	74%
Carisoprodol	344	1,266,633	832,511–1,700,754	173	45%
Estradiol	186	1,237,965	694,043–1,781,887	386	100%
Glyburide	210	1,237,276	752,972–1,721,581	187	48%
Gemfibrozil	373	1,226,890	843,027–1,610,754	386	100%
Metoclopramide Hcl	297	1,220,585	817,332–1,623,838	386	100%
Doxycycline Hyclate	367	1,205,416	874,913–1,535,919	386	100%
Estrogens, Conjugated	196	1,205,404	718,999–1,691,810	310	80%
Fluconazole	352	1,200,530	913,815–1,487,245	386	100%
Timolol Maleate	252	1,199,817	791,436–1,608,199	386	100%
Dexlansoprazole	232	1,183,857	561,313–1,806,402	201	52%
Raloxifene Hcl	235	1,183,587	614,731–1,752,442	386	100%
Pramipexole Di-Hcl	263	1,142,484	657,526–1,627,442	386	100%
Sucralfate	366	1,139,606	826,665–1,452,547	386	100%
Metronidazole	331	1,135,808	843,094–1,428,522	386	100%
Bumetanide	278	1,111,267	589,762–1,632,772	386	100%
Alcohol Antiseptic Pads*	153	1,029,885	651,603–1,408,167	Supply	Supply
Doxazosin Mesylate	255	1,029,363	668,462–1,390,263	386	100%
Torsemide	192	1,026,453	640,900–1,412,006	378	98%
Prednisolone Acetate	223	1,022,524	722,209–1,322,839	374	97%
Nph, Human Insulin Isophane	195	1,007,125	587,060–1,427,190	386	100%
Olopatadine Hcl	266	1,006,336	643,460–1,369,212	369	96%
Colchicine	179	1,005,889	639,022–1,372,756	386	100%
Rivastigmine	298	959,298	618,966–1,299,630	378	98%
Niacin	219	957,366	521,221–1,393,511	386	100%
Folic Acid**	243	957,331	612,086–1,302,575	Excluded	Excluded
Haloperidol	308	956,071	643,517–1,268,625	386	100%
Dorzolamide Hcl/Timolol Maleat	196	954,636	615,415–1,293,858	380	98%
Olmesartan Medoxomil	162	951,864	475,332–1,428,396	296	77%
Cyclosporine	238	924,140	652,810–1,195,471	386	100%
Ergocalciferol (Vitamin D2)**	258	915,961	611,911–1,220,011	Excluded	Excluded

Insulin Regular, Human	294	913,137	530,888–1,295,387	386	100%
Ipratropium Bromide	262	904,182	563,910–1,244,455	386	100%
Tolterodine Tartrate	243	902,139	567,891–1,236,388	370	96%
Methocarbamol	202	896,527	592,249–1,200,805	226	59%

**See Appendix D.

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
Lithium Carbonate	310	894,184	460,392–1,327,975	386	100%
Nebivolol Hcl	204	888,540	570,909–1,206,171	273	71%
Ziprasidone Hcl	280	887,738	486,410–1,289,066	386	100%
Phenobarbital	197	878,403	385,109–1,371,696	386	100%
Methadone Hcl	218	875,640	436,833–1,314,448	378	98%
Methylprednisolone	210	870,654	686,948–1,054,361	386	100%
Dicyclomine Hcl	253	869,035	570,356–1,167,714	386	100%
Desvenlafaxine Succinate	192	853,705	189,589–1,517,822	381	99%
Ciclopirox Olamine	201	844,790	240,577–1,449,004	371	96%
Glyburide/Metformin Hcl	191	843,420	311,508–1,375,332	166	43%
Travoprost	210	841,574	569,616–1,113,531	359	93%
Hydroxyzine Pamoate	240	839,497	585,752–1,093,241	282	73%
Methotrexate Sodium	173	829,816	416,386–1,243,246	386	100%
Mupirocin	246	828,189	583,299–1,073,078	384	99%
Hydroxychloroquine Sulfate	166	819,701	443,539–1,195,863	386	100%
Cinacalcet Hcl	215	817,054	330,264–1,303,843	386	100%
Amlodipine Besylate/ Benazepril	216	792,127	436,368–1,147,887	371	96%
Ramipril	190	784,878	417,990–1,151,766	384	99%
Isosorbide Dinitrate	174	753,498	371,545–1,135,451	384	99%
Ondansetron Hcl	201	752,416	556,573–948,260	386	100%
Dextroamphetamine/ Amphetamine	251	740,436	301,160–1,179,711	386	100%
Rivaroxaban	191	736,498	393,445–1,079,550	296	77%
Clindamycin Hcl	207	733,660	539,565–927,755	386	100%

Source: OIG analysis of drugs commonly used by dual eligibles, 2018.
**See Appendix D.

APPENDIX D

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

Generic Name	Reason Excluded Under Part D
Folic Acid	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, 2018.

APPENDIX E

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

Exhibit E-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	24	95%	88%	99%
2	Connecticut, Massachusetts, Rhode Island, Vermont	22	95%	88%	99%
3	New York	20	95%	88%	99%
4	New Jersey	22	94%	88%	99%
5	Delaware, the District of Columbia, Maryland	21	95%	88%	99%
6	Pennsylvania, West Virginia	26	95%	88%	99%
7	Virginia	24	95%	88%	99%
8	North Carolina	24	94%	88%	99%
9	South Carolina	22	95%	88%	99%
10	Georgia	24	95%	88%	99%
11	Florida	21	95%	88%	99%
12	Alabama, Tennessee	25	95%	88%	99%
13	Michigan	24	95%	88%	99%
14	Ohio	23	95%	88%	99%
15	Indiana, Kentucky	24	95%	88%	99%
16	Wisconsin	25	95%	88%	99%
17	Illinois	24	94%	85%	99%
18	Missouri	24	95%	88%	99%
19	Arkansas	21	95%	88%	99%
20	Mississippi	20	95%	88%	99%
21	Louisiana	21	95%	88%	99%
22	Texas	24	94%	85%	99%
23	Oklahoma	23	94%	85%	99%
24	Kansas	23	95%	88%	99%
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	23	95%	88%	99%
26	New Mexico	24	94%	85%	99%
27	Colorado	24	95%	88%	99%
28	Arizona	23	95%	88%	99%
29	Nevada	24	95%	88%	99%
30	Oregon, Washington	22	95%	88%	99%
31	Idaho, Utah	25	95%	88%	99%
32	California	25	95%	88%	99%
33	Hawaii	20	95%	88%	99%
34	Alaska	19	94%	88%	99%

Source: OIG analysis of formularies' inclusion of drugs commonly used by dual eligibles, 2018.

*PDP.
**MA-PD.

Exhibit E-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	55	97%	91%	99%
2	Connecticut, Massachusetts, Rhode Island, Vermont	99	96%	92%	99%
3	New York	199	97%	91%	100%
4	New Jersey	42	96%	89%	98%
5	Delaware, the District of Columbia, Maryland	40	97%	95%	100%
6	Pennsylvania, West Virginia	192	97%	91%	100%
7	North Carolina, Virginia	144	97%	89%	100%
8	Georgia, South Carolina	112	97%	91%	100%
9	Florida	283	97%	91%	100%
10	Alabama, Tennessee	91	97%	95%	98%
11	Michigan	69	97%	95%	98%
12	Ohio	127	97%	92%	100%
13	Indiana, Kentucky	112	97%	94%	100%
14	Illinois, Wisconsin	157	97%	85%	99%
15	Arkansas, Missouri	90	97%	91%	100%
16	Louisiana, Mississippi	65	97%	91%	100%
17	Texas	159	97%	94%	100%
18	Kansas, Oklahoma	57	97%	91%	100%
19	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	97	96%	91%	100%
20	Colorado, New Mexico	62	97%	91%	100%
21	Arizona	68	97%	95%	100%
22	Nevada	34	97%	91%	99%
23	Idaho, Oregon, Utah, Washington	193	97%	92%	100%
24	California	266	97%	93%	100%
25	Hawaii	19	97%	95%	100%

Source: OIG analysis of formularies' inclusion of drugs commonly used by dual eligibles, 2018.
***Region 26, which covers Alaska, had no MA-PDs available for 2018.

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