DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

/S/

FROM: Stuart Wright
Deputy Inspector General
for Evaluation and Inspections

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

This memorandum report fulfills the annual reporting mandate from the Patient Protection and Affordable Care Act of 2010 (ACA) for 2012. The ACA requires that the Office of Inspector General (OIG) conduct a study of the extent to which formularies used by stand-alone prescription drug plans (PDP) and Medicare Advantage prescription drug plans (MA-PD) under Medicare Part D include drugs commonly used by full-benefit dual-eligible individuals (i.e., individuals who are eligible for both Medicare and Medicaid and who receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing).[1] Pursuant to the ACA, OIG must annually issue a report, with recommendations as appropriate. This is the second report the OIG has produced to meet this mandate. For the relevant text of the ACA, see Appendix A.

SUMMARY

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

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

[1] ACA, P.L. 111-148 § 3313(a), 42 U.S.C. § 1395w-101 note.
[2] MMA, P.L. 108-173 § 101, Social Security Act, § 1860D-1(a), 42 U.S.C. § 1395w-101(a).

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

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

For this memorandum report, we determined whether the 272 unique formularies used by the 3,107 Part D plans operating in 2012 cover the 200 drugs most commonly used by dual eligibles. We also determined the extent to which those commonly used drugs are subject to utilization management tools. To create the list of the 200 drugs most commonly used by dual eligibles, we used the 2008 Medicare Current Beneficiary Survey (MCBS). Of these 200 drugs, 191 are eligible for Part D prescription drug coverage and 9 are not eligible for coverage under Part D.[5]

Overall, we found that the rate of Part D plan formularies' inclusion of the 191 drugs commonly used by dual eligibles is high, with some variation. On average, Part D plan formularies include 96 percent of the 191 commonly used drugs. In addition, more than 60 percent of the commonly used drugs are included by all Part D plan formularies. These results are largely unchanged from OIG's findings from 2011, as stated in the mandated report for that year.[6]

We also found that from 2011 to 2012, plan formularies increased the proportion of unique drugs subject to utilization management tools. On average, formularies applied utilization management tools to 24 percent of the unique drugs we reviewed in 2012, compared to 19 percent of the unique drugs we reviewed in 2011.

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

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

[5] Eight of the two hundred commonly used drugs are statutorily excluded, and one is no longer available in the United States.

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

BACKGROUND

The Medicare Prescription Drug Benefit

Beginning in 2006, the MMA made comprehensive prescription drug coverage under Medicare Part D available to all Medicare beneficiaries.[7] Medicare beneficiaries generally have the option to enroll in a PDP and receive all other Medicare benefits on a fee-for-service basis, or to enroll in an MA-PD and receive all of their Medicare benefits, including prescription drug coverage, through managed care. As of February 2012, 33 million of the 48 million Medicare beneficiaries were enrolled in a Part D plan.[8, 9]

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.[10] In 2012, plan sponsors offer 3,107 unique Part D plans, with many plan sponsors offering multiple Part D plans.

Dual Eligibles Under Medicare Part D

Approximately 9 million Medicare beneficiaries are dual eligibles. About 7 million dual eligibles, referred to as "full-benefit dual eligibles," receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing.[11] Other dual eligibles receive assistance with only their Medicare premiums or cost-sharing, depending on their level of income and assets.

Dual eligibles are a particularly vulnerable population. Overall, most dual eligibles have very low incomes: 55 percent have annual incomes below $10,000, compared to 6 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, twice the rate of others in Medicare.[12] Because of their health needs, dual eligibles typically use more prescription drugs and health care services in general than other Medicare beneficiaries.

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

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[7] MMA, P.L. 108-173 § 101, Social Security Act, § 1860D-1(a), 42 U.S.C. § 1395w-101(a).
[8] CMS, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report—Monthly Summary Report* (data as of February 2012). Accessed at http://www.cms.hhs.gov on February 27, 2012.
[9] Medicare Board of Trustees, *The 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Accessed at http://www.cms.hhs.gov on March 12, 2011.
[10] CMS, *Prescription Drug Benefit Manual (PDBM)*, Pub. 100-18, ch. 5, Appendixes 2 and 3. Accessed at http://www.cms.hhs.gov on January 23, 2012.
[11] Kaiser Family Foundation, *Dual Eligibles: Medicaid's Role for Low-Income Beneficiaries*, May 2011. Accessed at http://www.kff.org on January 23, 2012.
[12] Ibid.
[13] MMA, P.L. 108-173 § 101.

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

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

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

CMS annually reassigns some dual eligibles to new PDPs if their current PDPs will have premiums above the regional benchmark premium for the following year.[20] CMS reassigns dual eligibles who were randomly assigned to their current PDPs to new PDPs that will have premiums at or below the regional benchmark premium.[21] In addition, CMS notifies dual eligibles who elected their current Part D plans that their plans will have premiums above the regional benchmark premium. According to CMS, for 2012 CMS reassigned approximately 823,000 Medicare beneficiaries, including but not exclusively dual eligibles, because of premium increases.

[14] 42 CFR § 423.780(b)(2)(i).
[15] Social Security Act, § 1860D-14(a)(3)(f), 42 U.S.C. § 1395w-114(a)(3)(f). Dual eligibles residing in territories are not eligible to receive cost-sharing assistance from Medicare. As such, there are no benchmarks for Part D plans offered in the territories.
[16] Patient Protection and Affordable Care Act (ACA), P.L. 111-148 § 3303, Social Security Act, § 1860D 14(a)(5), 42 U.S.C. § 1395w-114(a)(5). The ACA established a "de minimis" premium policy, whereby a Part D plan may elect to charge dual eligibles the benchmark premium amount if the Part D plan's basic premium exceeds the regional benchmark by a de minimis amount. For 2012, CMS set the de minimis amount at $2 above the regional benchmark.
[17] *PDBM*, ch. 3, § 40.1.4.
[18] Ibid.
[19] Ibid., § 30.3.2. In general, Medicare beneficiaries can switch Part D plans only once a year during a defined enrollment period.
[20] Ibid., § 40.1.5.
[21] Ibid.

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.[22] These parameters are intended to balance Medicare beneficiaries' needs for adequate prescription drug coverage with Part D plans' needs to contain costs. Generally, a formulary must include at least two drugs in each therapeutic category or class.[23, 24] In addition, Part D plans must include Part D-covered drugs in certain categories and classes.[25]

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.[26] Utilization management tools can help Part D plans and the Part D program limit the cost of drug coverage by placing restrictions on the use of certain drugs.

In addition to these drug coverage decisions made with regard to individual formularies, certain categories of drugs are excluded from Medicare Part D prescription drug coverage as mandated by the MMA.[27] For example, prescription vitamins and mineral products, nonprescription drugs, barbiturates, and benzodiazepines are excluded from Part D prescription drug coverage.[28]

CMS Efforts To Ensure Prescription Drug Coverage

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

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

[23] *PDBM*, ch. 6, § 40.2.1.

[24] 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.

[25] ACA, P.L. 111-148 § 3307, Social Security Act, § 1860D 4(b)(3)(G), 42 U.S.C. § 1395w 104(b)(3)(G).

[26] Prior authorization, often required for very expensive drugs, requires that physicians obtain approval from Part D plans to prescribe a specific drug. Quantity limits are intended to ensure that beneficiaries receive the proper dose and recommended duration of drug therapy. Step therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective or safest drug therapy and progressing if necessary to more costly or risky drug therapy. *PDBM*, ch. 6, § 30.2.2.

[27] MMA, P.L. 108-173 § 101, Social Security Act, § 1860D-2(e), 42 U.S.C. § 1395w-102(e).

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

[29] *PDBM*, ch. 6, §§ 30.2.1 and 30.2.5.

[30] Ibid., § 30.2.7.

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

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

Transitioning new enrollees to Part D. CMS requires that Part D plans establish a transition process for new enrollees (including dual eligibles) who are transitioning to their respective Part D plans either from different Part D plans or from other prescription drug coverage. During Medicare beneficiaries' first 90 days under a new Part D plan, the new plan must provide one temporary 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.[36] The temporary fill accommodates beneficiaries' immediate drug needs the first time they attempt to fill a prescription. The transition period also allows beneficiaries time to work with their prescribing physicians to obtain prescriptions for therapeutically alternative drugs or to request formulary exceptions from Part D plans.

Related Office of Inspector General Work

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

In 2011, OIG issued the first annual mandated memorandum report examining dual eligibles' access to drugs under Medicare Part D.[38] In the current memorandum report, we compare the results from 2011 and 2012.

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[31] *PDBM*, ch. 6, § 30.2.2.
[32] Ibid., § 30.2.7.
[33] CMS looks to appropriate guidelines from expert organizations such as the National Committee for Quality Assurance, the Academy of Managed Care Pharmacy, and the National Association of Insurance Commissioners.
[34] *PDBM*, ch. 18, §§ 130.1 and 130.2.
[35] *PDBM*, ch. 18, § 60.1.
[36] Ibid., ch. 6, § 30.4.4.
[37] OIG, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, January 2006.
[38] OIG, *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles*, OEI-05-10-00390, July 2011.

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 2012. As part of our assessment, we included dual eligibles' enrollment data from March 2012, the most recent enrollment data available from CMS at the time of our study. We also compared the results of our 2012 study with those of our 2011 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 2008 Medicare Current Beneficiary Survey (MCBS). We used the MCBS because it contains drugs that dual eligibles received through multiple sources (e.g., Part D, Medicaid, and the Department of Veterans Affairs) and, as such, it provides a comprehensive picture of drug utilization. Of the 200 most commonly used drugs identified using the MCBS, 191 are eligible for coverage under Part D. For purposes of this memorandum report, we refer to these 191 drugs eligible for coverage under Part D as the most commonly used drugs.

The list of 191 commonly used drugs referenced in this 2012 memorandum report is similar but not identical to the list of drugs referenced in the 2011 memorandum report. Specifically, of the 191 drugs commonly used by dual eligibles listed in the 2011 report, 184 drugs (92 percent) are also listed in this 2012 report.

Both the 2011 and 2012 studies 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 the drugs they used from the total population of dual eligibles.

We also went beyond the ACA's mandate in both the 2011 and 2012 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 2008 MCBS Cost and Use data to create a list of 200 drugs commonly used by dual eligibles. The MCBS Cost and Use data contain information on hospitals, physicians, and prescription drug costs and utilization. The 2008 MCBS Cost and Use data are the most recent data available.

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

The MCBS is a CMS-conducted continuous, multipurpose survey of a representative national sample of the Medicare population, including dual eligibles. Sampled Medicare beneficiaries are interviewed three times per year and asked what drugs they are taking and whether they have started taking any new drugs since the previous interview. The MCBS also includes Part D prescription drug events for surveyed Medicare beneficiaries. In 2008, the MCBS surveyed 11,723 Medicare beneficiaries, of which 2,229 were dual eligibles who had used prescription drugs during the year (out of a total of 2,234 dual-eligible survey respondents).

First Databank National Drug Data File. We used the November 2011 First DataBank National Drug Data File to identify the drug product information for the drugs on our list of 200 drugs commonly used by dual eligibles. The National Drug Data File is a database containing information—such as drug name, therapeutic class, and the unique combination of active ingredients—for each drug defined by the Food and Drug Administration's National Drug Code (NDC).[40]

Part D plan data. In December 2011, we collected from CMS the plan and formulary data for Part D plans operating in 2012. The 2012 Part D plan data provide information such as the State in which a Part D plan is offered, whether the Part D plan is a PDP or an MA-PD, and whether the Part D plan premium is below the regional benchmark. The 2012 Part D formulary data include Part D plans' formularies and utilization management tools. In 2012, there are 272 unique formularies offered by the 3,107 Part D plans.

We also collected 2012 Part D plan enrollment data. These data provide the number of dual eligibles enrolled in each Part D plan as of February 2012.

Determining the Most Commonly Used Drugs

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

1. Created a list of all drugs reported by dual eligibles surveyed in the MCBS. We excluded respondents from territories because they are not eligible to receive cost-sharing assistance under Part D. There were 159,046 drug events listed for 2,229 dual eligibles in the MCBS.

2. Collapsed this list to a list of drugs based on their active ingredients, using the Ingredient List Identifier located in First DataBank's National Drug Data File. For example, a multiple-source drug such as fluoxetine hydrochloride (the active ingredient for the multiple-source brand-name drug Prozac) has only one entry on our list, covering all strengths of both the brand-name drug Prozac and the generic versions of fluoxetine hydrochloride available. From this point forward, unless otherwise stated, we will use the term "drug" to refer to any drug in the same Ingredient List Identifier category, and the term "unique drug" to refer to an NDC

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

corresponding to a drug, as a given drug can have multiple NDCs. This process left 158,544 drug events associated with 880 drugs. There were 502 drug events in the MCBS that could not be matched with an Ingredient List Identifier in First DataBank's National Drug Data File.

3. Ranked all drugs by their frequency of utilization based on weighting from the MCBS sample design.

4. Selected the 200 drugs with the highest utilization by dual eligibles. For a full list of the top 200 drugs, see Appendix B.

5. Removed all drugs excluded under Part D. Of the 200 drugs with the highest utilization, 191 are eligible under Part D, 8 fell into drug categories excluded under Part D, and 1 is no longer available in the United States. For details on the nine excluded drugs, see Appendix C.

Formulary Analysis

We analyzed the 272 unique Part D plan formularies to determine formulary inclusion rates for the 191 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 category. 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.

Utilization management tools. In addition, we determined the extent to which Part D plans apply utilization management tools to the 191 drugs that we reviewed. The tools that we reviewed are prior authorization, quantity limits, and step therapy.

To determine the extent to which the 191 commonly used drugs are subject to utilization management tools, we conducted an analysis of the NDCs that correspond to the commonly used drugs. Part D plan formularies do not apply utilization management tools at the active ingredient level. Rather, Part D plan formularies apply utilization management tools at a more specific level that identifies whether a drug is brand-name or generic and its dosage form, strength, and route of administration, irrespective of package size. To conduct this analysis, we determined the NDCs (unique drugs) associated with each of the 191 commonly used drugs that are on each Part D formulary. We then calculated the percentage of unique drugs to which each Part D plan formulary applies utilization management tools.

Enrollment Analysis

We weighted the formulary analysis by dual-eligible enrollment and weighted the utilization management tool analysis both by dual-eligible enrollment and Medicare enrollment. To do this, we applied February 2012 enrollment data to 2012 Part D plans.

Data Limitations
We did not assess individual dual eligibles' prescription drug use or whether individual dual eligibles are enrolled in Part D plans that include the specific drugs that each individual uses. Because we relied on a sample of dual eligibles responding to the MCBS to develop our list of commonly used drugs, it is possible that 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 2008 account for 87 percent of all prescriptions dispensed to the dual-eligible respondents in the 2008 MCBS.

Because the lists of 191 commonly used drugs in the 2011 and 2012 memorandum reports are not identical, changes in formulary inclusion rates and application of utilization management tools between 2011 and 2012 may reflect changes as to which specific drugs were included in the lists, rather than changes regarding any specific drug. However, the two lists largely overlap; 92 percent of the drugs reviewed in the 2011 memorandum report are the same as those reviewed in this 2012 memorandum report.

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

RESULTS

Part D Plan Formularies Include Between 83 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 272 unique formularies used by Part D plans in 2012, 23 formularies include 100 percent of the commonly used drugs. At the other end of the inclusion range, one formulary includes 83 percent of the commonly used drugs. CMS generally requires Part D plan formularies to include at least two drugs, rather than all drugs, in each therapeutic category or class. Therefore, Part D plan formularies may still meet CMS's formulary requirements even if they do not include all drugs identified as commonly used by dual eligibles.

Part D plan formularies' inclusion of the drugs commonly used by dual eligibles in 2012 is nearly identical to that of 2011. The average rate of inclusion—96 percent—was unchanged between 2011 and 2012. In addition, we found that in 2011 Part D plan formularies included between 82 and 100 percent of the drugs commonly used by dual eligibles, whereas in 2012 they included between 83 and 100 percent of the drugs.

Nationally, PDP and MA-PD formularies have the same average rates of inclusion—96 percent—of the drugs commonly used by dual eligibles. PDP formulary inclusion ranges from 86 to 100 percent of the commonly used drugs, with MA-PD formulary inclusion ranging from 83 to 100 percent. Thirty formularies—11 percent—are offered by both PDPs and MA-PDs.

Regionally, all dual eligibles have the choice of a Part D plan that includes at least 97 percent of the commonly used drugs. Every PDP region has a plan that includes at least 99 percent of the commonly used drugs, and every MA-PD region has a plan that covers at least 97 percent of these drugs. Appendix D provides a breakdown of formulary inclusion by PDP and MA-PD region.

On average, formularies for Part D plans with premiums below the regional benchmark include 95 percent of the drugs commonly used by dual eligibles. The percentage of drugs included by Part D plans with premiums below the regional benchmark is important because dual eligibles are automatically enrolled in, or annually reassigned to, these plans. For drugs commonly used by dual eligibles, formularies for Part D plans with premiums below the regional benchmark have a rate of inclusion that ranges from a low of 86 percent to a high of 100 percent. Approximately 76 percent of dual eligibles are enrolled in such Part D plans.

Ninety-nine percent of dual eligibles are enrolled in Part D plans that include at least 90 percent of the drugs commonly used by dual eligibles. Of the approximately 9.2 million dual eligibles, 99 percent are enrolled in Part D plans that use formularies that include at least 90 percent of the commonly used drugs. Only 1 percent of dual eligibles are enrolled in Part D plans that use formularies that include less than 90 percent of these drugs. Table 1 provides a breakdown of dual eligibles' enrollment in Part D plans by the plans' formulary inclusion rates.

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

Part D Plans That Include:	Number of Dual Eligibles Enrolled*	Percentage of Dual Eligibles Enrolled
100% of commonly used drugs	209,000	2%
95% to 99% of commonly used drugs	3,504,000	38%
90% to 94% of commonly used drugs	5,336,000	58%
83% to 89% of commonly used drugs	131,000	1%
Total	9,180,000	100%**

*Rounded to the nearest 1,000.
** Percentages do not add to 100 percent because of rounding.
Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles and dual eligibles' enrollment, 2012.

The percentage of dual eligibles enrolled in Part D plans that include at least 90 percent of the drugs commonly used by dual eligibles increased between 2011 and 2012, from 90 percent to 99 percent.

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

Because most of the commonly used drugs are included in a large percentage of formularies, dual eligibles are guaranteed formulary inclusion of many of these drugs regardless of the Part D plan in which they are enrolled. By drug, formulary inclusion ranges from 44 percent to 100 percent. In other words, one drug commonly used by dual eligibles is included in as few as 44 percent of Part D plan formularies, and 116 drugs are included in all plan formularies. The average rate of formulary inclusion is 96 percent.

Table 2 provides a summary of formulary inclusion rates. Appendix D provides formulary inclusion rates for each of the commonly used drugs.

Table 2: Formulary Inclusion Rates of Commonly Used Drugs

Percentage of the 272 Formularies	Percentage of the 191 Commonly Used Drugs Included
100%	61% (116 drugs)
85% to 99%	31% (59 drugs)
75% to 84%	3% (5 drugs)
44% to 74%	6% (11 drugs)
Total	100%* (191 drugs)

* Percentages do not add to 100 percent because of rounding.
Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2012

The formulary inclusion rates of the drugs commonly used by dual eligibles in 2012 are similar to those in 2011. The percentage of commonly used drugs included in all formularies increased slightly between 2011 and 2012, from 58 percent to 61 percent.

Part D plan formularies include certain drugs less frequently than others. Of the commonly used drugs, 6 percent (11 drugs) are included by less than 75 percent of Part D plan formularies. Table 3 provides the percentage of formularies covering each of these 11 drugs. Eight of the eleven drugs are brand-name drugs, which are typically more costly than generic drugs. Four of the eleven drugs are used to treat high blood pressure and the remaining treat a variety of conditions including high cholesterol, high blood phosphate levels, and insomnia.

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

Generic Name of Drug	Primary Indication(s)	Formulary Inclusion Rate
Olmesartan/hydrochlorothiazide	Hypertension (high blood pressure)	74%
Olmesartan medoxomil*	Hypertension (high blood pressure)	74%
Carisoprodol	Muscle relaxant	73%
Esomeprazole magnesium	Dyspepsia, peptic ulcer disease, gastroesophageal reflux disease, Zollinger-Ellison syndrome	71%
Rosiglitazone maleate	Insulin sensitizer	66%
Sevelamer HCl	Hyperphosphatemia (high blood phosphate levels)	65%
Ezetimibe/simvastatin*	Hyperlipidemia (high cholesterol)	63%
Eszopiclone*	Insomnia	62%
Irbesartan*	Hypertension (high blood pressure)	46%
Irbesartan/hydrochlorothiazide*	Hypertension (high blood pressure)	45%
Levalbuterol tartrate	Asthma, chronic obstructive pulmonary disease	44%

* These drugs also had low formulary inclusion rates in 2011.
Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2012.

Although Part D formularies frequently omit these 11 drugs, they all cover other therapeutically alternative drugs. For all 11 drugs, 100 percent of formularies cover at least 1 therapeutically alternative drug that is also on the list of 191 drugs commonly used by dual eligibles.

The number of drugs with inclusion rates below 75 percent increased from 8 in 2011 to 11 in 2012. There are five drugs with low inclusion rates in 2012 that were also on the list of commonly used drugs with low inclusion rates in our 2011 report; they are noted in Table 3. An additional 3 of the 11 low-inclusion drugs in 2012 were not on the list of drugs most commonly used by dual eligibles in the 2011 report.

The remaining 3 drugs included by less than 75 percent of formularies in 2012 were among the top 200 drugs commonly used by dual eligibles in 2011 and had lower inclusion rates in 2012 than in 2011. One of these drugs, carisoprodol, was put on the Drug Enforcement Agency's (DEA) schedule IV of federally controlled substances.[41] This may explain why its inclusion rate fell from 88 percent in 2011 to 73 percent in 2012. Formulary inclusion rates for the second drug, an insulin sensitizer called rosiglitazone maleate, fell from 92 percent in 2011 to 66 percent in 2012. This pronounced drop may be explained by guidance issued by the U.S. Food and Drug Administration (FDA) in mid-2011 that restricted access to the drug because of an increased risk of heart attack.[42] The third drug, esomeprazole magnesium, was recently found to potentially cause serious complications in individuals suffering from osteoporosis.

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

Plan formularies increased the percentage of commonly used drugs subject to utilization management tools between 2011 and 2012

Of the unique drugs that compose the list of commonly used drugs, Part D plan formularies increased the percentage subject to utilization management tools from an average of 19 percent in 2011 to an average of 24 percent in 2012. Among the formularies, those for plans with premiums below the regional benchmark increased this percentage slightly less, from an average of 19 percent in 2011 to an average of

[41] The rule was finalized in January 2012. The DEA's schedule lists drugs and other substances that are controlled—i.e., to which access is limited—because of the potential for abuse. Accessed at http://www.usdoj.gov on February 14, 2012.

[42] FDA, *FDA Drug Safety Communication, Updated Risk Evaluation and Mitigation Strategy (REMS) to Restrict Access to Rosiglitazone-containing Medicines Including Avandia, Avandamet, and Avandaryl*, May 18, 2011. Accessed at http://www.fda.gov on February 22, 2012.

22 percent in 2012. See Table 4 for a breakdown of the percentage of unique drugs to which Part D plan formularies apply utilization management tools in 2011 and 2012.

Table 4: Part D Plan Formularies' Application of Utilization Management Tools to Commonly Used Drugs, 2011 to 2012

Percentage of Unique Drugs to Which Utilization Management Tools Are Applied	Number of 2011 Part D Plan Formularies	Percentage of 2011 Part D Plan Formularies	Number of 2012 Part D Plan Formularies	Percentage of 2012 Part D Plan Formularies
40% to 49%	14	6%	31	11%
30% to 39%	29	12%	59	22%
20% to 29%	75	30%	92	34%
10% to 19%	76	31%	54	20%
Less than 10%	55	22%	36	13%
Totals	**249**	**100%***	**272**	**100%**

*Percentages do not add to 100 percent because of rounding.
Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2012.

This increase in plan formularies' application of utilization management tools results primarily from an increase in the rate at which formularies apply quantity limits to the unique drugs that make up commonly used drugs. In 2012, plan formularies applied such quantity limits to an average of 21 percent of unique drugs, up from 16 percent in 2011.[43] Formularies applied the other two utilization management tools—prior authorization and step therapy—at virtually the same rates in 2012 as in 2011, with each being applied to an average of 3 percent of unique drugs.

Although there has been an overall increase, wide variation remains in the rate at which plan formularies apply utilization management tools. In 2012, plan formularies apply utilization management tools to between 0 and 49 percent of the unique drugs. More specifically, formularies apply quantity limits to between 0 and 46 percent of unique drugs, prior authorization to between 0 and 28 percent, and step therapy to between 0 and 22 percent.

Looking at enrollment across plans provides a slightly different picture than looking only at plans themselves. On average, plan formularies in 2012 apply utilization management tools to 24 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 2012, the median plan weighted by dual-eligible enrollment applies such tools to 26 percent of unique drugs. This is an increase over 2011, when the median plan weighted by dual-eligible enrollment applied utilization management tools to 21 percent of unique drugs. Similarly, the median plan weighted by overall Medicare enrollment applies these tools to at least 26 percent of unique drugs in 2012, up from 23 percent in 2011.

Both dual eligibles and all Medicare beneficiaries tend to be enrolled in plans with formularies that apply utilization management tools to between 20 and 40 percent of unique drugs. In 2012, 66 percent of dual eligibles and 65 percent of all Medicare

[43] This change may be due to an increase in voluntary reporting of certain quantity limits that CMS does not require to be reported.

beneficiaries were enrolled in plans with formularies in this range. Table 5 provides a breakdown of dual eligibles and Medicare beneficiaries' enrollment in Part D plans by the plans' formularies' application of utilization management tools.

Table 5: Beneficiary Enrollment in Part D Plans by Application of Utilization Management Tools to Commonly Used Drugs, 2011 to 2012

Percentage of Unique Drugs to Which Plan Formularies Apply Utilization Management Tools	Percentage of Dual Eligibles Enrolled, 2011	Percentage of Medicare Beneficiaries Enrolled, 2011	Percentage of Dual Eligibles Enrolled, 2012	Percentage of Medicare Beneficiaries Enrolled, 2012
40% to 49%	18%	12%	22%	21%
30% to 39%	14%	24%	22%	23%
20% to 29%	26%	17%	44%	42%
10% to 19%	39%	39%	2%	4%
Less than 10%	4%	7%	9%	10%
Totals	**100%***	**100%***	**100%***	**100%**

*Percentages do not add to 100 percent because of rounding.
Source: OIG analysis of dual-eligible enrollment and Medicaid beneficiary enrollment by rates of utilization management tool application to drugs commonly used by dual eligibles.

Further, although utilization management tools control access to drugs, they also remain important tools for managing costs in Medicare and ensuring appropriate utilization of drugs. For example, carisoprodol drugs saw the greatest increase in the application of quantity limits. Such limits—in addition to formularies' low inclusion rates for these drugs—may be intended to ensure appropriate utilization, as these drugs were recently added to the DEA's schedule of federally controlled substances.

CONCLUSION

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

For the drugs commonly used by dual eligibles, we found that the rate of formulary inclusion is high with some variation. On average, Part D plan formularies include 96 percent of the commonly used drugs. One Part D plan formulary includes as little as 83 percent of the commonly used drugs. 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 191 drugs commonly used by dual eligibles are largely unchanged compared with those from OIG's 2011 memorandum report. Part D plan formularies include roughly the same percentage of these commonly used drugs in 2012 as they did in 2011. Enrollment in plans that cover at least 90 percent of unique drugs increased, with 99 percent of dual eligibles enrolled in such plans.

Although dual eligibles, like all Medicare beneficiaries, are largely enrolled in plans that apply utilization management tools to a higher than average percentage of unique drugs, this increase is largely a result of an increase in plans' use of quantity limits. Plan formularies still vary widely in the rates at which they apply utilization management tools to unique drugs.

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

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

This memorandum report is being issued directly in final form because it contains no recommendations. We have included the list of the 200 drugs most commonly used by dual eligibles. If you have comments or questions about this memorandum report, please provide them within 60 days. Please refer to report number OEI-05-12-00060 in all correspondence.

APPENDIX A

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

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

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

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

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

APPENDIX B

Table B-1: 200 Drugs Commonly Used by Dual Eligibles

Generic Name	Sample Size*	Projected Drugs*	95-Percent Confidence Interval	Number of Formularies Including	Percentage of Formularies Including
Furosemide	4,337	14,685,805	13,193,887 – 16,177,723	272	100%
Lisinopril	3,638	13,441,780	12,115,557 – 14,768,002	272	100%
Hydrocodone bitartrate/acetaminophen	3,788	12,265,705	10,187,490 – 14,343,921	272	100%
Simvastatin	3,323	12,200,581	10,886,194 – 13,514,968	271	100%
Levothyroxine sodium	3,708	12,148,646	10,757,336 – 13,539,956	272	100%
Potassium chloride	3,029	10,184,469	8,784,636 – 11,584,303	272	100%
Omeprazole	2,829	9,651,497	8,339,152 – 10,963,842	272	100%
Metformin hydrochloride (HCl)	2,313	8,676,241	7,659,708 – 9,692,774	272	100%
Amlodipine besylate	2,300	8,363,812	7,211,958 – 9,515,666	272	100%
Atorvastatin calcium	2,072	8,190,308	7,053,038 – 9,327,578	222	82%
Warfarin sodium	2,473	7,736,287	6,301,924 – 9,170,649	272	100%
Metoprolol tartrate	2,000	7,109,660	6,139,709 – 8,079,612	272	100%
Clopidogrel bisulfate	1,863	6,939,176	5,890,222 – 7,988,131	272	100%
Hydrochlorothiazide	1,676	6,829,480	5,641,558 – 8,017,402	272	100%
Albuterol sulfate	1,903	6,749,306	5,721,342 – 7,777,270	272	100%
Atenolol	1,676	6,656,182	5,608,415 – 7,703,949	272	100%
Metoprolol succinate	1,582	5,947,902	4,974,663 – 6,921,140	270	99%
Gabapentin	1,520	5,101,476	4,220,207 – 5,982,745	272	100%
Esomeprazole magnesium	1,308	5,098,976	4,155,417 – 6,042,535	193	71%
Sertraline HCl	1,411	4,738,678	3,646,257 – 5,831,099	272	100%
Zolpidem tartrate	1,284	4,266,954	3,513,634 – 5,020,274	272	100%
Lansoprazole	1,151	4,176,391	3,223,654 – 5,129,128	236	87%
Citalopram hydrobromide	1,154	4,110,952	2,627,240 – 5,594,664	272	100%
Ranitidine HCl	1,332	4,103,165	3,361,383 – 4,844,946	272	100%
Glipizide	1,033	4,044,091	3,240,677 – 4,847,505	272	100%
Alendronate sodium	949	4,042,433	3,284,602 – 4,800,264	272	100%
Isosorbide mononitrate	1,148	3,781,351	2,987,563 – 4,575,139	272	100%
Valsartan	1,022	3,707,643	2,917,377 – 4,497,909	264	97%
Quetiapine fumarate	1,446	3,706,606	2,939,067 – 4,474,146	272	100%
Trazodone HCl	1,169	3,671,406	3,061,488 – 4,281,325	272	100%
Montelukast sodium	1,025	3,612,948	2736246 – 4489650	271	100%
Clonidine HCl	901	3,608,763	2610281 – 4607245	272	100%
Divalproex sodium	1,465	3,576,329	2535872 – 4616786	272	100%
Carvedilol	1,033	3,554,671	2945928 – 4163414	272	100%
Fluticasone/salmeterol	1,038	3,539,979	2835106 – 4244852	237	87%
Pantoprazole sodium	1,005	3,535,665	2953627 – 4117703	240	88%
Tramadol HCl	1,075	3,524,890	2812406 – 4237374	272	100%
Digoxin	1,059	3,474,737	2793941 - 4155533	272	100%
Oxycodone HCl/acetaminophen	971	3,434,934	2457792 - 4412076	272	100%

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Table B-1: 200 Drugs Commonly Used by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Drugs*	95-Percent Confidence Interval	Number of Formularies Including	Percentage of Formularies Including
Diltiazem HCl	1,037	3,412,223	2651112 - 4173334	272	100%
Escitalopram oxalate	1,067	3,361,299	2782036 - 3940562	226	83%
Donepezil HCl	1,153	3,327,287	2728469 - 3926104	272	100%
Prednisone	908	3,221,210	2647192 - 3795227	272	100%
Insulin glargine, human recombinant analog	879	3,116,960	2525959 - 3707962	269	99%
Enalapril maleate	823	3,114,860	2433873 - 3795847	272	100%
Paroxetine HCl	886	2,970,274	2321417 - 3619132	272	100%
Alprazolam	843	2,965,959	2387894 - 3544024	Excluded	Excluded
Spironolactone	739	2,894,286	2183730 - 3604841	272	100%
Risperidone	1,103	2,864,033	2237878 - 3490187	272	100%
Fluticasone propionate	771	2,796,087	2217498 - 3374676	272	100%
Ibuprofen	773	2,694,287	2164457 - 3224117	272	100%
Lovastatin	700	2,646,252	2085719 - 3206785	267	98%
Venlafaxine HCl	881	2,631,793	1884901 - 3378686	272	100%
Pioglitazone HCl	720	2,630,131	2031147 - 3229114	271	100%
Naproxen	790	2,593,580	1921730 - 3265429	272	100%
Propoxyphene/ acetaminophen	826	2,544,654	2064770 - 3024538	Excluded	Excluded
Mirtazapine	817	2,459,380	1900636 - 3018124	272	100%
Nitroglycerin	676	2,412,856	1857936 - 2967776	272	100%
Risedronate sodium	638	2,328,091	1688961 - 2967221	213	78%
Rosuvastatin calcium	605	2,324,733	1666051 - 2983416	243	89%
Allopurinol	660	2,305,299	1807758 - 2802841	272	100%
Ezetimibe/simvastatin	539	2,281,341	1695437 - 2867245	172	63%
Tiotropium bromide	585	2,271,519	1683066 - 2859973	272	100%
Olanzapine	930	2,225,593	1642272 - 2808913	272	100%
Fluoxetine HCl	704	2,210,005	1676917 - 2743093	272	100%
Cyclobenzaprine HCl	712	2,208,315	1766234 - 2650395	242	89%
Nifedipine	587	2,184,461	1672322 - 2696600	271	100%
Triamterene/ hydrochlorothiazide	583	2,151,470	1644770 - 2658171	272	100%
Ipratropium/albuterol sulfate	518	2,146,990	1469609 - 2824372	266	98%
Bupropion HCl	669	2,092,615	1537431 - 2647798	272	100%
Human insulin neutral protamine hagerdorn/regular human insulin	579	2,089,492	1576428 - 2602556	272	100%
Metoclopramide HCl	558	2,045,974	1484240 - 2607708	272	100%
Duloxetine HCl	649	2,018,238	1509781 - 2526695	272	100%
Tamsulosin HCl	568	2,008,282	1486550 - 2530014	271	100%
Fexofenadine HCl	663	1,999,433	1470782 - 2528085	240	88%
Oxycodone HCl	637	1,993,053	1248484 - 2737622	270	99%
Amitriptyline HCl	551	1,990,104	1428406 - 2551802	272	100%
Glyburide	574	1,979,902	1490571 - 2469232	272	100%
Oxybutynin chloride	577	1,956,602	1387744 - 2525461	271	100%

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Table B-1: 200 Drugs Commonly Used by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Drugs*	95-Percent Confidence Interval	Number of Formularies Including	Percentage of Formularies Including
Celecoxib	542	1,951,785	1475384 - 2428186	240	88%
Morphine sulfate	559	1,944,457	1273695 - 2615219	272	100%
Losartan potassium	464	1,926,721	1429114 - 2424328	272	100%
Famotidine	587	1,889,265	1383531 - 2394999	269	99%
Ezetimibe	470	1,859,398	1252463 - 2466333	258	95%
Lisinopril/ hydrochlorothizide	470	1,842,345	1396106 - 2288583	271	100%
Phenytoin sodium extended	672	1,807,778	1357338 - 2258218	272	100%
Azithromycin	570	1,792,085	1566126 - 2018043	272	100%
Amlodipine besylate/benazepril	472	1,771,154	1277515 - 2264793	263	97%
Pravastatin sodium	457	1,756,636	1212294 - 2300978	271	100%
Promethazine HCl	530	1,726,657	1320104 - 2133210	255	94%
Levofloxacin	541	1,677,469	1469043 - 1885894	248	91%
Valsartan/ hydrochlorothizide	442	1,675,897	1151485 - 2200309	263	97%
Triamcinolone acetonide	465	1,638,579	1299882 - 1977277	272	100%
Ciprofloxacin HCl	519	1,611,117	1397358 - 1824875	272	100%
Polyethylene glycol 3350	573	1,582,521	1145034 - 2020008	Excluded	Excluded
Latanoprost	366	1,579,313	999644 - 2158983	264	97%
Pregabalin	544	1,555,936	1149681 - 1962192	272	100%
Carbamazepine	653	1,548,840	1126173 - 1971506	272	100%
Sulfamethoxazole/ trimethoprim	515	1,537,819	1296125 - 1779512	272	100%
Meclizine HCl	458	1,530,711	1134681 - 1926741	263	97%
Fentanyl	511	1,528,398	1050797 - 2005999	272	100%
Carisoprodol	514	1,523,632	996317 - 2050946	199	73%
Mometasone furoate	460	1,504,992	1033429 - 1976556	270	99%
Memantine HCl	578	1,470,854	1170138 - 1771570	272	100%
Meloxicam	388	1,464,145	1030222 - 1898068	270	99%
Topiramate	520	1,457,016	850357 - 2063676	272	100%
Ziprasidone HCl	556	1,446,603	574246 - 2318960	272	100%
Acetaminophen with codeine	399	1,434,600	1009935 - 1859265	272	100%
Aripiprazole	580	1,428,529	1031445 - 1825614	272	100%
Fenofibrate nanocrystallized	472	1,359,334	1055971 - 1662698	221	81%
Clonazepam	517	1,351,688	982369 - 1721007	Excluded	Excluded
Tolterodine tartrate	416	1,314,991	1005040 - 1624941	228	84%
Estrogens, conjugated	381	1,311,282	863950 - 1758615	240	88%
Lorazepam	417	1,306,594	998485 - 1614703	Excluded	Excluded
Glimepiride	356	1,289,174	851327 - 1727022	272	100%
Amoxicillin	418	1,257,789	939066 - 1576512	272	100%
Insulin regular, human	374	1,256,184	910927 - 1601440	272	100%
Ramipril	375	1,255,814	874340 - 1637288	266	98%
Cephalexin monohydrate	409	1,250,553	1034309 - 1466797	272	100%

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Table B-1: 200 Drugs Commonly Used by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Drugs*	95-Percent Confidence Interval	Number of Formularies Including	Percentage of Formularies Including
Lidocaine	329	1,246,987	785982 - 1707992	269	99%
Clozapine	343	1,224,932	279540 - 2170325	272	100%
Buspirone HCl	390	1,191,990	835238 - 1548741	272	100%
Verapamil HCl	337	1,191,624	825285 - 1557962	272	100%
Baclofen	396	1,170,146	664247 - 1676045	272	100%
Brimonidine tartrate	321	1,165,063	776923 - 1553203	272	100%
Glyburide/metformin HCl	293	1,156,580	742359 - 1570801	268	99%
Ropinirole HCl	341	1,146,087	798195 - 1493979	272	100%
Lactulose	363	1,141,046	764364 - 1517728	272	100%
Isosorbide dinitrate	315	1,129,644	713004 - 1546284	272	100%
Hydroxyzine HCl	318	1,109,764	705599 - 1513929	251	92%
Propranolol HCl	372	1,109,183	661977 - 1556389	272	100%
Benztropine mesylate	547	1,085,890	741371 - 1430409	272	100%
Ipratropium bromide	287	1,082,885	744368 - 1421402	272	100%
Carbidopa/levodopa	369	1,080,702	806051 - 1355353	272	100%
Temazepam	247	1,067,644	576409 - 1558879	Excluded	Excluded
Rosiglitazone Maleate	250	1,060,782	700262 - 1421302	180	66%
Hydralazine HCl	302	1,042,882	708441 - 1377323	272	100%
Diazepam	316	1,037,764	639871 - 1435657	Excluded	Excluded
Raloxifene HCl	274	1,019,231	619027 - 1419435	272	100%
Nystatin	345	1,011,486	728013 - 1294960	272	100%
Sitagliptin phosphate	272	1,008,877	674685 - 1343068	271	100%
Insulin aspart	288	1,000,026	720934 - 1279118	259	95%
Neutral protamine hagedorn, human insulin isophane	243	983,481	615817 - 1351145	272	100%
Felodipine	237	982,218	207778 - 1756658	267	98%
Amoxicillin/ potassium clavulanate	289	946,810	762446 - 1131174	272	100%
Nitrofurantoin macrocrystal	312	945,590	687395 - 1203786	264	97%
Benazepril HCl	260	937,695	568591 - 1306799	271	100%
Folic acid	230	874,301	570174 - 1178429	Excluded	Excluded
Lithium carbonate	341	868,164	510514 - 1225813	272	100%
Gemfibrozil	247	861,901	527971 - 1195832	272	100%
Levetiracetam	333	859,610	599818 - 1119402	272	100%
Doxazosin mesylate	244	857,633	584525 - 1130740	272	100%
Lamotrigine	364	857,597	601909 - 1113286	272	100%
Doxycycline hyclate	324	848,531	589213 - 1107849	272	100%
Aspirin/dipyridamole	241	834,516	537845 - 1131187	272	100%
Colchicine	261	834,188	442023 - 1226354	272	100%
Diclofenac sodium	242	833,173	559917 - 1106430	272	100%
Travoprost	236	830,131	528,679 - 1,131,583	236	87%
Terazosin HCl	194	815,795	563406 - 1068183	271	100%
Estradiol	226	815,044	429758 - 1200330	272	100%

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Table B-1: 200 Drugs Commonly Used by Dual Eligibles, *continued*

Generic Name	Sample Size*	Projected Drugs*	95-Percent Confidence Interval	Number of Formularies Including	Percentage of Formularies Including
Diphenoxylate HCl/atropine	210	809,881	504818 - 1114944	236	87%
Finasteride	234	796,833	461202 - 1132463	272	100%
Dicyclomine HCl	240	795,973	523817- 1068129	239	88%
Eszopiclone	232	787,150	467844 - 1106455	168	62%
Budesonide	241	760,794	369378 - 1152210	272	100%
Dorzolamide HCl/ timolol maleate	193	755,718	463277 - 1048158	272	100%
Metolazone	192	743,961	424989 - 1062933	271	100%
Megestrol acetate	247	734,198	476455 - 991941	272	100%
Irbesartan	206	708,918	406569 - 1011268	124	46%
Insulin lispro	194	697,182	424507 - 969858	236	87%
Solifenacin succinate	201	692,920	420471 - 965370	239	88%
Olmesartan medoxomil	186	682,523	428135 - 936912	202	74%
Timolol maleate	175	680,521	359267 - 1001774	272	100%
Amiodarone HCl	194	673,811	429122 - 918500	272	100%
Olmesartan/ hydrochlorothiazide	136	671,025	303900 - 1038149	202	74%
Tramadol HCl/ acetaminophen	214	661,553	365944 - 957163	238	88%
Clotrimazole/ betamet diprop	207	658,680	440329 - 877031	233	86%
Tizanidine HCl	236	651,966	429197 - 874735	269	99%
Methylprednisolone	160	651,291	296663 - 1005918	272	100%
Methocarbamol	218	630,227	322937 - 937517	236	87%
Cilostazol	168	627,132	358096 - 896168	272	100%
Fluconazole	207	614,764	471735 - 757793	272	100%
Oxcarbazepine	201	607,650	229494 - 985806	272	100%
Irbesartan/ hydrochlorothiazide	132	597,953	272441 - 923465	123	45%
Sucralfate	205	594,980	396840 - 793120	272	100%
Metronidazole	208	582,146	436251 - 728040	272	100%
Hydrocortisone	189	577,352	311485 - 843220	272	100%
Bumetanide	151	566,568	289593 - 843543	272	100%
Ketoconazole	191	562,166	360215 - 764117	272	100%
Prednisolone acetate	165	560,873	384412 - 737333	272	100%
Olopatadine HCl	155	558,911	333324 - 784497	249	92%
Labetalol HCl	172	554,598	319726 - 789471	271	100%
Sevelamer HCl	171	544,742	301870 - 787613	177	65%
Dutasteride	124	542,207	277954 - 806460	231	85%
Insulin aspart protamine/insulin aspart	143	541,749	327249 - 756249	259	95%
Losartan/ hydrochlorothiazide	183	536,132	312843 - 759421	271	100%
Bimatoprost	147	520,009	234135 - 805882	253	93%
Methadone HCl	172	519,198	179316 - 859081	268	99%
Levalbuterol tartrate	141	516,901	268,774 - 765,027	119	44%
Loratadine	166	513,975	321,300 - 706,650	Excluded	Excluded

Source: Office of Inspector General (OIG) analysis of drugs commonly used by dual eligibles, 2012.

APPENDIX C

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

Generic Name	Reason Excluded Under Part D
Alprazolam*	Benzodiazepine
Clonazepam*	Benzodiazepine
Diazepam*	Benzodiazepine
Folic acid*	Vitamin or mineral product
Lorazepam*	Benzodiazepine
Polyethylene glycol 3350*	Nonprescription drug
Propoxyphene/acetaminophen	No longer available in the United States
Temazepam*	Benzodiazepine
Loratadine	Nonprescription drug

Source: Office of Inspector General analysis of formulary inclusion of drugs commonly used by dual eligibles, 2012.
* These drugs were also on the 2011 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

Table D-1: PDP Formulary Inclusion

PDP Region	State(s)	Number of PDPs	Average Formulary Inclusion Rate	Minimum Rate	Maximum Rate
1	Maine, New Hampshire	28	95%	86%	99%
2	Connecticut, Massachusetts, Rhode Island, Vermont	30	95%	86%	99%
3	New York	29	95%	86%	99%
4	New Jersey	30	94%	86%	99%
5	Delaware, the District of Columbia, Maryland	31	95%	86%	99%
6	Pennsylvania, West Virginia	36	95%	86%	100%
7	Virginia	30	95%	86%	99%
8	North Carolina	30	95%	86%	99%
9	South Carolina	32	95%	86%	99%
10	Georgia	30	95%	86%	99%
11	Florida	33	95%	86%	99%
12	Alabama, Tennessee	32	95%	86%	99%
13	Michigan	34	95%	86%	99%
14	Ohio	33	95%	86%	100%
15	Indiana, Kentucky	31	95%	86%	99%
16	Wisconsin	29	95%	86%	99%
17	Illinois	33	95%	86%	100%
18	Missouri	30	95%	86%	99%
19	Arkansas	30	95%	90%	99%
20	Mississippi	30	94%	86%	99%
21	Louisiana	30	94%	86%	99%
22	Texas	33	95%	86%	99%
23	Oklahoma	30	94%	86%	99%
24	Kansas	31	95%	86%	99%
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	33	95%	86%	99%
26	New Mexico	30	95%	86%	99%
27	Colorado	28	95%	86%	99%
28	Arizona	30	95%	86%	99%
29	Nevada	29	95%	86%	99%
30	Oregon, Washington	30	94%	86%	99%
31	Idaho, Utah	33	94%	86%	99%
32	California	33	95%	86%	99%
33	Hawaii	25	94%	86%	99%
34	Alaska	25	95%	90%	99%

Source: Office of Inspector General (OIG) analysis of formulary inclusion of drugs commonly used by dual eligibles, 2012.

*PDP.
**MA-PD.

Table D-2: MA-PD Formulary Inclusion by Region

MA PD Region***	State(s)	Number of MA PDs	Average Formulary Inclusion Rate	Minimum Rate	Maximum Rate
1	Maine, New Hampshire	31	95%	94%	97%
2	Connecticut, Massachusetts, Rhode Island, Vermont	56	96%	90%	99%
3	New York	183	96%	87%	100%
4	New Jersey	28	95%	90%	100%
5	Delaware, the District of Columbia, Maryland	29	96%	94%	100%
6	Pennsylvania, West Virginia	133	97%	87%	100%
7	North Carolina, Virginia	119	96%	94%	100%
8	Georgia, South Carolina	129	96%	90%	100%
9	Florida	254	96%	85%	100%
10	Alabama, Tennessee	86	95%	83%	97%
11	Michigan	63	96%	91%	100%
12	Ohio	75	96%	90%	100%
13	Indiana, Kentucky	83	96%	94%	99%
14	Illinois, Wisconsin	133	96%	88%	100%
15	Arkansas, Missouri	117	96%	90%	99%
16	Louisiana, Mississippi	81	96%	90%	99%
17	Texas	152	95%	90%	99%
18	Kansas, Oklahoma	62	95%	87%	100%
19	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	105	96%	88%	100%
20	Colorado, New Mexico	60	97%	91%	100%
21	Arizona	69	95%	90%	99%
22	Nevada	40	95%	90%	100%
23	Idaho, Oregon, Utah, Washington	154	96%	90%	100%
24	California	228	96%	90%	100%
25	Hawaii	21	96%	90%	100%

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2012.
*Region 26, which covers Alaska, has no MA-PDs available for 2012.