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SUBJECT: Memorandum Report: *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles*, OEI-05-10-00390

This memorandum report fulfills a mandate for 2011 from the Patient Protection and Affordable Care Act of 2010 (ACA). 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, beginning July 1, 2011, OIG must annually issue a report with recommendations as appropriate. For the relevant text of the ACA, see Appendix A.

SUMMARY

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) makes comprehensive prescription drug coverage under Medicare Part D 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 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 a dual eligible enrolls in a Part D plan with premiums higher than the regional benchmark, the dual eligible is responsible for paying the premium amount above the regional 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 249 unique formularies used by the 3,072 Part D plans operating in 2011 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 2007 Medicare Current Beneficiary Survey (MCBS). Of these 200 drugs, 191 are eligible for Part D prescription drug coverage and 9 are excluded from coverage.

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, almost 60 percent of the commonly used drugs are included by all Part D plan formularies. However, we found variation in the rate at which Part D plan formularies apply utilization management tools to the drugs commonly used by dual eligibles. Some Part D plan formularies apply these tools to none of the commonly used drugs, whereas at the other end of the range, other formularies apply the tools to 45 percent of the commonly used drugs. For CMS's reference, we have included in Appendix D the list of 200 drugs commonly used by dual eligibles.

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.[5] Medicare beneficiaries generally have the option to enroll in a PDP and receive all other Medicare benefits

[3] A formulary is a list of drugs covered by a Part D plan. Part D plans can exclude drugs from their formulary and can control drug utilization for drugs on the formulary within certain parameters. Social Security Act § 1860D-4(b) & (c), 42 U.S.C. § 1395w-104(b) & (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] MMA, P.L. 108-173 § 101, Social Security Act, § 1860D-1(a), 42 U.S.C. § 1395w-101(a).

through fee-for-service, or to enroll in an MA-PD and receive all of their Medicare benefits, including prescription drug coverage, through managed care. As of January 2011, almost 30 million of the 46 million Medicare beneficiaries were enrolled in a Part D plan.[6, 7]

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.[8] In 2011, plan sponsors offer 3,072 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.[9] 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, these beneficiaries are poorer and in worse health than the average Medicare beneficiary. Most dual eligibles have very low incomes: 61 percent have annual incomes below $10,000, compared to 9 percent of all other Medicare beneficiaries. Over half of dual eligibles are in fair or poor health, twice the rate of others in Medicare.[10] As a consequence of their health needs, dual eligibles typically require and use more prescription drugs, and more 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.[11]

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

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[6] CMS, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report—Monthly Summary Report* (data as of January 2011). Accessed at http://www.cms.hhs.gov on January 20, 2011.
[7] Medicare Board of Trustees, *The 2010 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 January 20, 2011.
[8] CMS, *Prescription Drug Benefit Manual (PDBM)*, Pub. 100-18, ch. 5, Appendixes 3 and 4. Accessed at http://www.cms.hhs.gov on May 5, 2010.
[9] Kaiser Family Foundation, *Dual Eligibles: Medicaid's Role for Low-Income Beneficiaries*, February 2009. Accessed at http://www.kff.org on May 7, 2010.
[10] Ibid.
[11] MMA, P.L. 108-173 § 101.

region.[12, 13] If dual eligibles enroll in Part D plans with premiums higher than the regional benchmark, they are responsible for paying the premium amounts above the regional benchmark.[14]

Dual eligibles' assignment to Part D plans. When individuals become eligible for both Medicaid and Medicare, 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.[15] 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).[16] 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 Part D plans 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.[17] 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.[18] For dual eligibles who were randomly assigned to their current PDPs, CMS reassigns them to new PDPs that will have premiums at or below the regional benchmark premium.[19] For dual eligibles who elected their current Part D plans, CMS notifies them that their plans will have premiums above the regional benchmark premium. According to CMS staff, CMS reassigned approximately 900,000 Medicare beneficiaries, including but not exclusively dual eligibles, for 2011 because of premium increases.

[12] 42 CFR. § 423.780(b)(2)(i).
[13] 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.
[14] 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 2011, CMS set the de minimis amount at $2 above the regional benchmark.
[15] *PDBM*, ch. 3, § 30.1.4.
[16] Ibid.
[17] Ibid., §§ 20.2 and 20.3. In general, Medicare beneficiaries can switch Part D plans only once a year during a defined enrollment period.
[18] Ibid., § 30.1.5.
[19] 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. 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.[20, 21] In addition, Part D plans must include Part D-covered drugs in certain categories and classes.[22]

Part D plans may also control drug utilization by applying utilization management tools to individual drugs to encourage the use of generic or older drugs and to prevent overutilization or underutilization of drugs. These tools include requiring prior authorization to obtain drugs that are on plan formularies, establishing quantity limits, and requiring step therapy.[23]

The MMA mandates that certain categories of drugs be excluded from Medicare Part D prescription drug coverage.[24] For example, prescription vitamins and mineral products, nonprescription drugs, barbiturates, and benzodiazepines are excluded from Part D prescription drug coverage.[25]

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.[26] During its formulary review, CMS analyzes Part D plan 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.[27]

CMS also assesses the utilization management tools present in each formulary.[28] CMS aims to ensure that these tools are consistent with current industry standards and with

[20] *PDBM*, ch. 6, § 30.2.1.
[21] 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.
[22] ACA, P.L. 111-148 § 3307, Social Security Act, § 1860D 4(b)(3)(G), 42 U.S.C. § 1395w 104(b)(3)(G).
[23] *PDBM*, ch. 6, § 30.2.2.
[24] MMA, P.L. 108-173 § 101, Social Security Act, § 1860D-2(e), 42 U.S.C. § 1395w-102(e).
[25] Social Security Act §§ 1860D-2(e)(2), 1927(d)(2), 42 U.S.C. §§ 1395w-102(e)(2), 1396r-8(d)(2).
[26] *PDBM*, ch. 6, §§ 30.2.1 and 30.2.5.
[27] Ibid., § 30.2.7.
[28] Ibid., § 30.2.2.

standards that are widely used with drugs for the elderly and people with disabilities.[29, 30] For example, some drugs may be considered entirely inappropriate for the elderly, while others may be considered inappropriate for the elderly at certain dosages or in combination with certain other drugs. Utilization management tools are used to prevent the prescription of these drugs, dosages, and combinations.

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.[31] If their Part D plans make negative determinations, beneficiaries have the right to appeal.[32] 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 Part D 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 Part D 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.[33] 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 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 commonly used drugs that we reviewed. Approximately half of the 178 commonly used drugs were covered by all formularies.[34]

[29] *PDBM*, ch. 6, § 30.2.2.
[30] CMS looks to appropriate guidelines that might be found from expert organizations such as the National Committee for Quality Assurance, the Academy of Managed Care Pharmacy, and the National Association of Insurance Commissioners.
[31] *PDBM*, ch. 18, §§ 130.1 and 130.2.
[32] Ibid., § 60.1.
[33] Ibid., ch. 6, § 30.4.4.
[34] OIG, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, January 2006.

METHODOLOGY

Scope

As mandated in the ACA, this study assessed the extent to which drugs commonly used by dual eligibles are available on Part D plan formularies. To make this assessment, we evaluated formularies for Part D plans operating in 2011. As part of our assessment, we included dual eligibles' enrollment data from February 2011, the most recent enrollment data available from CMS at the time of our study.

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 2007 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 under Part D.

This study 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 full-benefit dual eligibles and the drugs they used. However, dual eligibles represent a vulnerable population as a whole, and 80 percent of dual eligibles are full-benefit dual eligibles.

We also went beyond the ACA's mandate by examining the utilization management tools that Part D plan formularies apply to the drugs commonly used by dual eligibles. Because these utilization management tools are used to influence drug utilization, they may affect dual eligibles' access in cases where formularies include the commonly used drugs. Analyzing the extent to which Part D plan formularies apply utilization management 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 2007 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 2007 MCBS Cost and Use data are the most recent data available.

The MCBS is a CMS-conducted continuous, multipurpose survey of a representative national sample of the Medicare population, including dual eligibles. Sampled Medicare beneficiaries are interviewed three times per year and asked what drugs they are taking and whether they have started taking any new drugs since the previous interview. The MCBS also includes Part D prescription drug events for surveyed Medicare beneficiaries.

In 2007, the MCBS surveyed 11,995 Medicare beneficiaries, of which 2,324 were dual eligibles who had used prescription drugs during the year (out of a total of 2,555 dual-eligible survey respondents).

First Databank National Drug Data File. We used the January 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 (FDA) National Drug Code (NDC). (An NDC is a three-part universal identifier that specifies the drug manufacturer's name, the drug form and strength, and the package size.)

Part D plan data. From CMS, we collected Part D plan and formulary data for Part D plans operating in 2011. The 2011 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 2011 Part D formulary data include Part D plans' formularies and utilization management tools. In 2011, there are 249 unique formularies offered by the 3,072 Part D plans.

We also collected 2011 Part D plan enrollment data. These data provide the number of dual eligibles enrolled in each Part D plan as of February 2011.

Determining 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 164,926 drug events listed for 2,324 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 corresponding to a drug. (A given drug can have multiple NDCs.) This process left 163,554 drug events associated with 910 drugs. (There were 1,372 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.

5. Removed all drugs excluded under Part D. Of the 200 drugs with the highest utilization, 191 are eligible under Part D and 9 fell into drug categories excluded under Part D. For a list of the nine excluded drugs, see Appendix B.

Formulary Analysis

We analyzed the 249 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, and the ingredients could be dispensed separately and combined by the patient to the same effect as the combined drug, then 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 provides 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 that each Part D plan formulary covers with utilization management tools.

Enrollment Analysis

We also weighted both the formulary and utilization management tool analysis by enrollment by dual eligibles. To do so, we applied February 2011 enrollment data to 2011 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 2007 account for 87 percent of all prescriptions dispensed to the dual-eligible respondents in the 2007 MCBS.

In addition, more than 80 percent of the commonly used drugs were on the list of drugs commonly used by dual eligibles in the 2006 OIG report *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090. For the 2006 OIG report, we used Medicaid drug utilization data from 2005 to create the list of drugs commonly used by dual eligibles, as those data were the most recent available.

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 82 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 249 unique formularies used by Part D plans in 2011, 14 percent include all of the commonly used drugs. At the other end of the range, two formularies include less than 85 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 include drugs that are not identified as commonly used by dual eligibles and still meet CMS's formulary requirements.

Formularies used by PDPs or MA-PDs have the same average rates of inclusion of the commonly used drugs. On average, formularies used by either PDPs or MA-PDs include 96 percent of the commonly used drugs. PDP formulary inclusion ranges from 88 to 100 percent of the commonly used drugs. The range of formulary inclusion is slightly larger for MA-PDs, ranging from 82 to 100 percent. Twelve percent of formularies are offered by both PDPs and MA-PDs.

All dual eligibles throughout the country have the choice of a Part D plan that includes at least 98 percent of the commonly used drugs. Every PDP region has a plan that includes at least 99 percent of the commonly used drugs and every MA-PD region has a plan that

covers at least 98 percent. Appendix C 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 number 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. On average, formularies for Part D plans with premiums below the regional benchmark include 95 percent of the drugs commonly used by dual eligibles. Like formularies for Part D plans overall, formularies for Part D plans with premiums below the regional benchmark have a rate of inclusion for drugs commonly used by dual eligibles that ranges from a low of 82 percent to a high of 100 percent. Approximately 79 percent of dual eligibles are enrolled in Part D plans with premiums below the regional benchmark.

Ninety 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 million dual eligibles, 90 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 85 percent of the commonly used 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	229,000	3%
95% to 99% of commonly used drugs	5,108,000	56%
90% to 94% of commonly used drugs	2,786,000	31%
85% to 89% of commonly used drugs	851,000	9%
Less than 85% of commonly used drugs	75,000	1%
Totals	**9,049,000**	**100%**

*Rounded to the nearest 1,000.

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles and dual eligibles' enrollment, 2011.

Almost 60 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. In fact, 58 percent of the drugs commonly used by dual eligibles are included in all 249 formularies. An additional 11 percent of these commonly used drugs are included in all but one or two formularies.

By drug, formulary inclusion ranges from 30 percent to 100 percent. In other words, one drug commonly used by dual eligibles is included in as few as 30 percent of Part D plan formularies, and others 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 249 Formularies	Percentage of the 191 Commonly Included Drugs
100%	58% (111 drugs)
85% to 99%	35% (67 drugs)
75% to 84%	3% (5 drugs)
30% to 74%	4% (8 drugs)
Total	**100% (191 drugs)**

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2011.

Part D plan formularies include certain drugs less frequently than others. Of the commonly used drugs, 4 percent (eight drugs) are included by less than 75 percent of Part D plan formularies. Table 3 provides the percentage of formularies covering each of these eight drugs. Six of the eight drugs are brand-name drugs, which are typically more costly than generic drugs. Three of the eight drugs are used to treat high blood pressure and two are used to lower cholesterol.

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 medoxomil	Hypertension (high blood pressure)	69%
Ezetimibe/simvastatin	Hyperlipidemia (high cholesterol)	64%
Propoxyphene/acetaminophen*	Pain relief	59%
Eszopiclone	Insomnia	58%
Irbesartan	Hypertension (high blood pressure)	50%
Irbesartan/hydrochlorothiazide	Hypertension (high blood pressure)	49%
Fluvastatin sodium	Hyperlipidemia (high cholesterol)	47%
Rabeprazole sodium	Gastroesophageal reflux disease, ulcers, and Zollinger-Ellison syndrome	30%

* In November 2010, FDA requested that drug makers voluntarily withdraw propoxyphene/acetaminophen from the market because of serious or fatal heart risks. According to FDA, drug makers agreed to this request.

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2011.

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

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 effective the following month).

Part D Plan Formularies Vary in the Rate at Which They Apply Utilization Management Tools to the Drugs Commonly Used by Dual Eligibles

The rate at which Part D plan formularies apply utilization management tools varies from between 0 and 45 percent of the unique drugs. On average, Part D plan formularies apply utilization management tools to 19 percent of the unique drugs that compose the drugs commonly used by dual eligibles. Utilization management tools can help Part D plans and the Part D program limit the cost of drug coverage and can help prevent the overutilization or underutilization of certain drugs. Formularies for Part D plans with premiums below the regional benchmark apply utilization management tools at the same rates as Part D plan formularies overall.

Part D plan formularies also vary in the rate at which they apply individual utilization management tools. The rate at which Part D plan formularies apply quantity limits, the most frequently applied utilization management tool, varies from between zero and 45 percent of the unique drugs. The rates at which Part D plan formularies apply prior authorization and step therapy vary from 0 to 35 percent and 0 to 22 percent, respectively.

Although Part D plan formularies vary in the rates at which they apply utilization management tools, Part D plan formularies mostly apply these tools to brand-name drugs. Sixty-four percent of the unique drugs to which Part D plan formularies apply utilization management tools are brand-name drugs. Limiting brand-name drug utilization can help Part D plans minimize the cost of drug coverage.

The majority of dual eligibles are enrolled in Part D plans that apply utilization management tools to at least 20 percent of the unique drugs composing the commonly used drugs. Fifty-eight percent of dual eligibles are enrolled in Part D plans that use formularies that apply utilization management tools to at least 20 percent of the unique drugs. By comparison, 53 percent of all Medicare beneficiaries are enrolled in these same Part D plans. Eighteen percent of dual eligibles are enrolled in Part D plans that use formularies that apply utilization management tools to at least 40 percent of the unique drugs. Table 4 provides a breakdown of dual eligibles' enrollment in Part D plans by the plans' application of utilization management tools.

Table 4: Beneficiary Enrollment and Part D Plan Formularies' Application of Utilization Management Tools to Commonly Used Drugs

Percentage of Unique Drugs to Which Utilization Management Tools Are Applied	Number of Part D Plan Formularies	Percentage of Dual Eligibles Enrolled	Percentage of Medicare Beneficiaries Enrolled
40% to 45%	14	18%	12%
30% to 39%	29	14%	24%
20% to 29%	75	26%	17%
10% to 19%	76	39%	39%
Less than 10%	55	4%	7%
Totals	**249**	**100*%**	**100%***

*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 eligible enrollment, 2011.

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. 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 eight drugs that this 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. A few Part D plan formularies include as few as 82 percent of the commonly used drugs. Formulary inclusion rates are similar irrespective of whether Part D plans are PDPs or MA-PDs. Further, formularies for Part D plans with premiums below the regional benchmark include the commonly used drugs at the same rate as Part D plan formularies overall.

We found greater variation in the rate at which Part D plan formularies apply utilization management tools to the unique drugs that compose the drugs commonly used by dual eligibles. Some Part D plan formularies apply utilization management tools to none of the unique drugs, whereas others apply utilization management tools to 45 percent of the unique drugs.

Because some variation exists both 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 navigate the options available for accessing the drugs they take. They could do so by appealing prescription drug coverage decisions, switching prescription drugs, or switching Part D plans. Any of these scenarios requires dual eligibles to have a certain level of understanding of Medicare Part D. Dual eligibles may have to take specific actions that are minor administrative barriers to some and major barriers to others.

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 report is being issued directly in final form because it contains no recommendations. For CMS's reference, we have included the list of the 200 drugs most commonly used by

dual eligibles. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-05-10-00390 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

Nine Drugs Commonly Used by Dual Eligibles and Excluded Under Part D

Generic Name	Reason Excluded Under Part D
Alprazolam	Benzodiazepine
Cetirizine hydrochloride	Non-prescription drug
Clonazepam	Benzodiazepine
Diazepam	Benzodiazepine
Folic acid	Vitamin or mineral product
Lorazepam	Benzodiazepine
Omeprazole magnesium	Non-prescription drug
Polyethylene glycol 3350	Non-prescription drug
Temazepam	Benzodiazepine

Source: Office of Inspector General analysis of formulary inclusion of drugs commonly used by dual eligibles, 2011.

APPENDIX C

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

Table C-1: PDP Formulary Inclusion

PDP Region	State(s)	Number of PDPs	Average Formulary Inclusion Rate	Minimum Rate	Maximum Rate
1	Maine, New Hampshire	30	95%	88%	99%
2	Connecticut, Massachusetts, Rhode Island, Vermont	34	95%	88%	100%
3	New York	33	95%	88%	100%
4	New Jersey	33	95%	88%	100%
5	Delaware, the District of Columbia, Maryland	33	95%	88%	100%
6	Pennsylvania, West Virginia	38	95%	88%	100%
7	Virginia	32	95%	88%	99%
8	North Carolina	33	95%	88%	100%
9	South Carolina	34	95%	88%	99%
10	Georgia	32	95%	88%	99%
11	Florida	32	95%	88%	100%
12	Alabama, Tennessee	34	95%	88%	99%
13	Michigan	35	95%	88%	100%
14	Ohio	34	95%	88%	100%
15	Indiana, Kentucky	32	95%	88%	100%
16	Wisconsin	32	95%	88%	99%
17	Illinois	35	95%	88%	100%
18	Missouri	32	95%	88%	100%
19	Arkansas	34	95%	88%	99%
20	Mississippi	32	95%	88%	99%
21	Louisiana	32	95%	88%	100%
22	Texas	33	95%	88%	100%
23	Oklahoma	33	95%	88%	99%
24	Kansas	33	95%	88%	99%
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	33	95%	88%	99%
26	New Mexico	32	95%	88%	100%
27	Colorado	31	95%	88%	100%
28	Arizona	30	95%	88%	100%
29	Nevada	31	95%	88%	100%
30	Oregon, Washington	32	95%	88%	100%

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*PDP.

**MA-PD.

Table C-1: PDP Formulary Inclusion, *continued*

PDP Region	State(s)	Number of PDPs	Average Formulary Inclusion Rate	Minimum Rate	Maximum Rate
31	Idaho, Utah	35	95%	88%	99%
32	California	33	95%	88%	100%
33	Hawaii	28	95%	88%	100%
34	Alaska	29	95%	88%	99%

Source: Office of Inspector General (OIG) analysis of formulary inclusion of drugs commonly used by dual eligibles, 2011.

Table C-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	29	96%	91%	99%
2	Connecticut, Massachusetts, Rhode Island, Vermont	55	97%	92%	100%
3	New York	173	97%	91%	100%
4	New Jersey	30	95%	91%	100%
5	Delaware, the District of Columbia, Maryland	37	93%	82%	98%
6	Pennsylvania, West Virginia	126	97%	88%	100%
7	North Carolina, Virginia	110	96%	82%	100%
8	Georgia, South Carolina	113	96%	82%	99%
9	Florida	242	97%	85%	100%
10	Alabama, Tennessee	81	96%	91%	98%
11	Michigan	56	97%	90%	100%
12	Ohio	71	96%	82%	100%
13	Indiana, Kentucky	70	97%	91%	99%
14	Illinois, Wisconsin	123	97%	86%	100%
15	Arkansas, Missouri	100	96%	91%	100%
16	Louisiana, Mississippi	84	96%	91%	100%
17	Texas	146	96%	91%	99%
18	Kansas, Oklahoma	53	97%	91%	100%
19	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming	109	97%	88%	100%
20	Colorado, New Mexico	57	95%	82%	100%
21	Arizona	71	95%	89%	100%
22	Nevada	42	96%	91%	100%
23	Idaho, Oregon, Utah, Washington	153	96%	82%	100%
24	California	213	95%	82%	100%
25	Hawaii	18	94%	82%	98%

*Region 26, which covers Alaska, has no MA-PDs available for 2011.

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2011.

APPENDIX D

Commonly Used Drugs and Formulary Inclusion

Table D-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	4,077	12,777,427	11,494,529 - 14,060,326	249	100%
Lisinopril	3,580	12,151,502	10,576,310 - 13,726,694	249	100%
Levothyroxine sodium	3,589	11,127,522	9,954,546 - 12,300,497	249	100%
Hydrocodone bit/acetaminophen	3,620	10,565,039	9,157,245 - 11,972,832	249	100%
Potassium chloride	2,995	9,539,793	8,192,121 - 10,887,464	249	100%
Atorvastatin calcium	2,769	9,511,085	8,153,698 - 10,868,472	219	88%
Metformin hydrochloride (HCl)	2,451	9,337,868	7,956,543 - 10,719,194	249	100%
Simvastatin	2,572	8,787,495	7,703,775 - 9,871,216	248	100%
Amlodipine besylate	2,182	7,058,486	6,087,271 - 8,029,700	249	100%
Omeprazole	2,215	7,025,621	6,049,913 - 8,001,330	247	99%
Atenolol	1,995	7,014,178	5,799,615 - 8,228,742	249	100%
Warfarin sodium	2,327	6,816,713	5,528,604 - 8,104,823	249	100%
Albuterol sulfate	1,995	6,527,476	5,303,260 - 7,751,692	249	100%
Clopidogrel bisulfate	1,908	6,517,472	5,554,124 - 7,480,821	249	100%
Metoprolol tartrate	1,916	6,040,847	5,115,012 - 6,966,682	249	100%
Metoprolol succinate	1,765	5,707,503	4,793,878 - 6,621,128	247	99%
Hydrochlorothiazide	1,743	5,616,691	4,823,923 - 6,409,460	249	100%
Esomeprazole magnesium trihydrate	1,518	4,734,962	3,874,345 - 5,595,578	189	76%
Lansoprazole	1,503	4,612,946	3,647,598 - 5,578,293	211	85%
Gabapentin	1,411	4,511,832	3,754,739 - 5,268,925	249	100%
Glipizide	1,194	4,360,420	3,538,784 - 5,182,055	249	100%
Diltiazem HCl	1,247	4,118,699	3,359,488 - 4,877,910	249	100%
Escitalopram oxalate	1,385	3,952,017	3,273,236 - 4,630,798	222	89%
Sertraline HCl	1,447	3,923,532	3,334,070 - 4,512,993	249	100%
Ranitidine HCl	1,277	3,653,877	3,002,661 - 4,305,092	249	100%
Oxycodone HCl/acetaminophen	1,218	3,635,428	2,811,065 - 4,459,792	249	100%
Quetiapine fumarate	1,503	3,626,187	2,842,454 - 4,409,919	249	100%
Alendronate sodium	954	3,560,263	2,863,184 - 4,257,341	249	100%
Montelukast sodium	1,127	3,509,414	2,669,878 - 4,348,950	248	100%

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Table D-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
Fluticasone/salmeterol	1,030	3,470,763	2,735,303 - 4,206,224	247	99%
Isosorbide mononitrate	1,086	3,458,585	2,741,228 - 4,175,942	249	100%
Pantoprazole sodium	949	3,394,600	2,671,993 - 4,117,207	200	80%
Donepezil HCl	1,164	3,393,695	2,895,181- 3,892,210	233	94%
Digoxin	1,031	3,371,050	2,704,365 - 4,037,735	249	100%
Trazodone HCl	1,165	3,334,296	2,638,788 - 4,029,804	249	100%
Paroxetine HCl	1,013	3,334,072	2,566,110 - 4,102,033	249	100%
Divalproex sodium	1,460	3,313,752	2,554,887 - 4,072,618	249	100%
Zolpidem tartrate	1,048	3,133,709	2,513,629 - 3,753,788	247	99%
Alprazolam	957	3,126,563	2,527,121 - 3,726,005	Excluded	Excluded
Risperidone	1,350	3,104,611	2,434,354 - 3,774,868	249	100%
Carvedilol	887	3,074,987	2,454,495 - 3,695,480	249	100%
Pioglitazone HCl	830	3,063,261	2,395,363 - 3,731,158	249	100%
Valsartan	948	3,053,856	2,398,364 - 3,709,348	238	96%
Clonidine HCl	949	3,004,950	2,445,603 - 3,564,296	249	100%
Fluticasone propionate	841	2,892,719	2,333,605 - 3,451,833	249	100%
Risedronate sodium	777	2,891,758	2,168,585 - 3,614,931	195	78%
Citalopram hydrobromide	1,024	2,877,584	2,031,680 - 3,723,489	248	100%
Propoxyphene/acetaminophen	918	2,751,015	2,258,560 - 3,243,471	147	59%
Enalapril maleate	817	2,731,343	2,163,046 - 3,299,640	249	100%
Tramadol HCl	914	2,729,513	2,217,482 - 3,241,544	249	100%
Prednisone	948	2,727,256	2,262,168 - 3,192,343	249	100%
Venlafaxine HCl	855	2,636,123	1,658,931 - 3,613,316	249	100%
Insulin glargine, human recombinant analog	870	2,621,879	2,042,038 - 3,201,721	234	94%
Olanzapine	1,039	2,615,352	1,970,439 - 3,260,266	249	100%
Ezetimibe/simvastatin	701	2,557,026	1,998,199 - 3,115,853	160	64%
Glyburide	740	2,459,147	1,854,805 - 3,063,488	248	100%
Lovastatin	668	2,436,700	1,821,359 - 3,052,040	240	96%
Metoclopramide HCl	593	2,394,861	1,530,517 - 3,259,205	249	100%
Amitriptyline HCl	693	2,369,238	1,767,592 - 2,970,884	249	100%

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Table D-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
Ibuprofen	754	2,271,424	1,779,250 - 2,763,598	249	100%
Nitroglycerin	734	2,213,718	1,754,009 - 2,673,427	249	100%
Triamterene/hydrochlorothiazide	751	2,207,727	1,756,978 - 2,658,477	249	100%
Fluoxetine HCl	860	2,195,279	1,797,853 - 2,592,704	249	100%
Rosiglitazone maleate	637	2,145,517	1,592,639 - 2,698,395	229	92%
Oxycodone HCl	776	2,142,921	1,549,037 - 2,736,805	247	99%
Nifedipine	656	2,120,320	1,450,216 - 2,790,424	249	100%
Tamsulosin HCl	595	2,074,869	1,445,951 - 2,703,788	239	96%
Amlodipine besylate/benazepril	637	2,001,914	1,465,679 - 2,538,148	243	98%
Mirtazapine	746	2,001,234	1,462,548 - 2,539,921	249	100%
Allopurinol	638	1,997,730	1,527,395 - 2,468,065	249	100%
Rosuvastatin calcium	580	1,988,951	1,456,510 - 2,521,392	211	85%
Bupropion HCl	704	1,987,687	1,465,122 - 2,510,253	249	100%
Spironolactone	596	1,943,670	1,425,116 - 2,462,223	249	100%
Fexofenadine HCl	671	1,929,230	1,312,291 - 2,546,169	249	100%
Oxybutynin chloride	584	1,913,166	1,281,868 - 2,544,464	249	100%
Phenytoin sodium extended	818	1,872,447	1,412,431 - 2,332,463	249	100%
Naproxen	710	1,859,738	1,384,929 - 2,334,547	249	100%
Tiotropium bromide	447	1,852,676	1,314,499 - 2,390,853	249	100%
Ipratropium/albuterol sulfate	552	1,828,202	1,320,203 - 2,336,200	239	96%
Human insulin neutral protamine hagedorn/regular human insulin	533	1,805,084	1,326,756 - 2,283,412	249	100%
Ciprofloxacin HCl	592	1,787,974	1,493,189 - 2,082,759	249	100%
Celecoxib	517	1,776,141	1,353,725 - 2,198,557	235	94%
Aripiprazole	770	1,773,656	1,157,694 - 2,389,618	249	100%
Ezetimibe	518	1,765,552	1,234,755 - 2,296,349	248	100%
Valsartan/hydrochlorothiazide	500	1,760,273	1,172,232 - 2,348,313	236	95%
Lorazepam	593	1,733,563	1,306,363 - 2,160,763	Excluded	Excluded
Carbamazepine	754	1,708,009	1,273,991 - 2,142,028	249	100%
Memantine HCl	694	1,677,803	1,327,062 - 2,028,544	249	100%
Cyclobenzaprine HCl	684	1,668,548	1,347,110 - 1,989,986	242	97%

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Table D-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
Acetaminophen with codeine	550	1,657,322	1,276,026 - 2,038,619	249	100%
Duloxetine HCl	551	1,646,063	1,180,919 - 2,111,207	249	100%
Carisoprodol	619	1,641,904	1,108,632 - 2,175,176	219	88%
Azithromycin	566	1,618,927	1,376,359 - 1,861,495	249	100%
Benztropine mesylate	796	1,618,896	1,060,569 - 2,177,224	249	100%
Levofloxacin	525	1,615,709	1,304,334 - 1,927,085	220	88%
Losartan potassium	433	1,614,799	1,162,715 - 2,066,884	232	93%
Clozapine	588	1,586,624	586,928 - 2,586,320	249	100%
Promethazine HCl	609	1,557,329	1,197,304 - 1,917,354	235	94%
Topiramate	563	1,536,671	503,601 - 2,569,741	249	100%
Famotidine	511	1,531,816	1,102,603 - 1,961,030	247	99%
Fentanyl	520	1,507,159	1,035,967 - 1,978,351	242	97%
Meclizine HCl	430	1,476,528	1,101,060 - 1,851,997	229	92%
Triamcinolone acetonide	490	1,470,186	1,062,870 - 1,877,501	249	100%
Polyethylene glycol 3350	527	1,468,094	1,174,696 - 1,761,492	Excluded	Excluded
Lisinopril/hydrochlorothiazide	425	1,465,727	1,091,460 - 1,839,993	248	100%
Pravastatin sodium	408	1,426,419	902,937 - 1,949,901	246	99%
Mometasone furoate	410	1,403,173	943,387 - 1,862,959	247	99%
Glimepiride	352	1,397,945	893,743 - 1,902,147	248	100%
Sulfamethoxazole/trimethoprim	523	1,396,698	1,176,645 - 1,616,750	249	100%
Neutral protamine hagedorn, human insulin isophane	393	1,373,091	931,526 - 1,814,655	249	100%
Pregabalin	466	1,366,898	919,796 - 1,814,000	249	100%
Brimonidine tartrate	388	1,320,432	873,395 - 1,767,469	249	100%
Irbesartan	312	1,318,177	813,749 - 1,822,604	125	50%
Amoxicillin trihydrate	454	1,309,462	1,075,245 - 1,543,678	249	100%
Cephalexin monohydrate	507	1,307,532	1,127,307 - 1,487,756	249	100%
Raloxifene HCl	320	1,302,736	615,860 - 1,989,613	249	100%
Fenofibrate nanocrystallized	480	1,291,694	847,376 - 1,736,013	188	76%
Clonazepam	546	1,263,661	929,985 - 1,597,337	Excluded	Excluded
Estrogens, conjugated	420	1,223,449	820,507 - 1,626,390	248	100%

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Table D-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	383	1,209,849	884,949 - 1,534,750	249	100%
Buspirone HCl	438	1,198,749	768,521 - 1,628,976	249	100%
Lactulose	435	1,179,101	821,601 - 1,536,601	249	100%
Tolterodine tartrate	417	1,169,170	820,678 - 1,517,663	218	88%
Benazepril HCl	314	1,128,689	647,767 - 1,609,612	248	100%
Baclofen	406	1,118,826	669,463 - 1,568,190	249	100%
Ramipril	364	1,110,784	712,041 - 1,509,527	240	96%
Verapamil HCl	362	1,107,285	732,129 - 1,482,440	249	100%
Morphine sulfate	427	1,103,898	764,321 - 1,443,475	249	100%
Ziprasidone HCl	468	1,093,177	521,471 - 1,664,884	249	100%
Cetirizine HCl	336	1,056,576	681,238 - 1,431,914	Excluded	Excluded
Diazepam	401	1,026,894	768,735 - 1,285,053	Excluded	Excluded
Hydroxyzine HCl	378	1,026,368	746,962 - 1,305,775	237	95%
Insulin regular, human	342	1,024,407	721,721 - 1,327,094	249	100%
Carbidopa/levodopa	376	997,534	679,004 - 1,316,064	249	100%
Isosorbide dinitrate	305	994,437	638,305 - 1,350,569	249	100%
Latanoprost	299	970,335	675,857 - 1,264,814	224	90%
Nystatin	364	969,703	738,140 - 1,201,266	249	100%
Meloxicam	309	956,673	713,757 - 1,199,588	246	99%
Propranolol HCl	354	946,417	596,114 - 1,296,721	249	100%
Levetiracetam	370	936,163	578,489 - 1,293,838	249	100%
Ipratropium bromide	314	922,228	597,469 - 1,246,987	249	100%
Gemfibrozil	295	921,373	573,994 - 1,268,752	249	100%
Ropinirole HCl	308	881,021	608,079 - 1,153,963	249	100%
Insulin aspart	306	870,863	624,044 - 1,117,682	241	97%
Hydralazine HCl	231	862,014	545,877 - 1,178,151	249	100%
Lamotrigine	455	827,055	545,735 - 1,108,375	249	100%
Temazepam	244	816,043	525,866 - 1,106,220	Excluded	Excluded
Terazosin HCl	230	812,406	541,091 - 1,083,720	249	100%
Colchicine	267	810,269	559,038 - 1,061,501	249	100%

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Table D-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
Felodipine	235	769,722	463,439 - 1,076,005	243	98%
Bumetanide	191	768,702	457,022 - 1,080,382	248	100%
Amoxicillin trihydrate/potassium clavulanate	266	764,684	586,528 - 942,840	249	100%
Travoprost	229	756,219	480,776 - 1,031,661	231	93%
Diphenoxylate HCl/atropine	221	754,080	466,449 - 1,041,710	245	98%
Megestrol acetate	271	740,912	538,759 - 943,066	249	100%
Diclofenac sodium	212	736,974	486,774 - 987,175	249	100%
Losartan/hydrochlorothiazide	221	712,163	449,294 - 975,031	234	94%
Tizanidine HCl	256	694,162	428,677 - 959,648	243	98%
Theophylline anhydrous	140	684,833	82,581 - 1,287,085	249	100%
Doxazosin mesylate	195	670,456	429,203 - 911,709	249	100%
Folic acid	215	658,492	443,715 - 873,270	Excluded	Excluded
Tramadol HCl/acetaminophen	217	649,721	397,502 - 901,940	218	88%
Irbesartan/hydrochlorothiazide	159	643,163	328,146 - 958,181	121	49%
Doxycycline hyclate	269	617,464	480,356 - 754,572	249	100%
Budesonide	209	609,856	345,874 - 873,839	230	92%
Moxifloxacin HCl	208	608,086	460,483 - 755,689	240	96%
Dutasteride	158	605,711	313,522 - 897,900	232	93%
Olmesartan medoxomil	179	601,304	393,023 - 809,585	171	69%
Nabumetone	188	594,424	353,638 - 835,210	247	99%
Eszopiclone	211	593,130	353,762 - 832,498	145	58%
Timolol maleate	204	591,072	361,329 - 820,815	249	100%
Methylprednisolone	181	577,634	426,689 - 728,578	249	100%
Lithium carbonate	278	573,115	326,818 - 819,413	249	100%
Fluconazole	208	573,017	411,820 - 734,214	249	100%
Olopatadine HCl	214	570,664	400,211 - 741,118	226	91%
Amiodarone HCl	147	554,006	315,652 - 792,360	249	100%
Metolazone	162	540,187	330,312 - 750,063	247	99%
Dicyclomine HCl	194	537,393	303,002 - 771,785	226	91%
Fosinopril sodium	154	534,663	231,594 - 837,731	243	98%

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Table D-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
Torsemide	165	528,402	271,876 - 784,927	244	98%
Calcitonin, salmon, synthetic	207	527,733	256,162 - 799,304	249	100%
Estradiol	137	522,640	325,468 - 719,811	249	100%
Oxcarbazepine	324	520,192	330,601 - 709,783	249	100%
Rabeprazole sodium	153	518,430	245,457 - 791,402	75	30%
Sotalol HCl	136	517,828	219,069 - 816,586	249	100%
Nitrofurantoin/nitrofuran macrobid	189	517,759	390,147 - 645,370	246	99%
Omeprazole magnesium	190	516,660	300,055 - 733,265	Excluded	Excluded
Aspirin/dipyridamole	165	516,070	290,485 - 741,656	249	100%
Captopril	144	510,883	285,878 - 735,888	248	100%
Metronidazole	185	510,150	366,545 - 653,756	249	100%
Quinapril HCl	187	505,622	314,655 - 696,588	243	98%
Fluvastatin sodium	116	504,417	259,785 - 749,049	117	47%
Labetalol HCl	150	501,741	237,363 - 766,119	248	100%
Hydroxyzine pamoate	232	500,012	278,759 - 721,265	222	89%
Amylase/lipase/protease	141	490,764	231,696 - 749,832	233	94%
Indomethacin	127	489,032	246,451 - 731,612	245	98%
Prednisolone acetate	138	480,194	316,967 - 643,421	249	100%
Bimatoprost	153	474,235	257,753 - 690,717	205	82%
Finasteride	130	471,681	241,566 - 701,795	249	100%
Hydrocortisone	170	470,577	310,651 - 630,502	249	100%

*Sample is from the 2007 Medicare Current Beneficiary Survey. Projections and confidence intervals are derived from its survey methodology.

Source: Office of Inspector General analysis of formulary inclusion of drugs commonly used by dual eligibles, 2011.