TO:  
Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  

FROM:  
Suzanne Murrin  
Deputy Inspector General  
for Evaluation and Inspections


This memorandum report fulfills the annual reporting mandate from the Patient Protection and Affordable Care Act (ACA) for 2015. 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 (PDPs) and Medicare Advantage prescription drug plans (MA-PDs) under Medicare Part D include drugs commonly used by full-benefit dual-eligible individuals (i.e., individuals who are eligible for both Medicare and full Medicaid benefits).\(^1\) Pursuant to the ACA, OIG must annually issue a report, with recommendations as appropriate. This is the fifth report that OIG has produced to meet this mandate. For the relevant text of the ACA, see Appendix A.

SUMMARY

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

For beneficiaries who are eligible for both Medicare and Medicaid (hereinafter referred to as dual eligibles), Medicare covers Part D plan premiums, deductibles, and other cost-sharing up to a determined premium benchmark that varies by region. If dual eligibles enroll in Part D plans with premiums higher than the regional benchmark, they are responsible for paying the premium amounts above that benchmark.

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

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

For this memorandum report, we determined whether the 341 unique formularies used by the 3,152 Part D plans operating in 2015 cover the 200 drugs most commonly used by dual eligibles. We also determined the extent to which those commonly used drugs are subject to utilization management tools.

Overall, we found that the rate of Part D plan formularies’ inclusion of the drugs commonly used by dual eligibles is high, with some variation. On average, Part D plan formularies include 95 percent of the commonly used drugs. In addition, 71 percent of the commonly used drugs are included by all Part D plan formularies.

We also found that from 2014 to 2015, the proportion of unique drugs subject to utilization management tools remained relatively the same. On average, formularies applied utilization management tools to 29 percent of the unique drugs we reviewed in 2015, compared to 28 percent of those we reviewed in 2014.

The results of our analysis for 2015 are largely unchanged from OIG’s findings in 2011, 2012, 2013, and 2014.

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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).

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

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

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


Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2015 (OEI-05-15-00120)
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. 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 April 2015, approximately 39.1 million of the 53.6 million Medicare beneficiaries were enrolled in a Part D plan.

Part D plans are administered by private companies, known as plan sponsors, that contract with CMS to offer prescription drug coverage in one or more PDP or MA-PD regions. CMS has designated 34 PDP regions and 26 MA-PD regions. In 2015, plan sponsors offer 3,152 unique Part D plans, with many plan sponsors offering multiple Part D plans.

Dual Eligibles Under Medicare Part D

Approximately 10.7 million Medicare beneficiaries are dual eligibles. About 7.7 million dual eligibles, referred to as “full-benefit dual eligibles,” receive full Medicaid benefits and may receive assistance with premiums and cost-sharing for Medicare fee-for-service or Medicare managed care. Other dual eligibles receive only assistance with their Medicare premiums or cost-sharing, depending on their level of income and assets.

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

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

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13 Ibid.
Medicare covers Part D plan premiums for dual eligibles up to a set benchmark. The benchmark is a statute-defined amount that is based on the average premium amounts for Part D plans for each region.\textsuperscript{15,16} 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.\textsuperscript{17}

\textit{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.\textsuperscript{18} 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).\textsuperscript{19} 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.\textsuperscript{20} When dual eligibles change plans, their prescription drug coverage under the new Part D plan becomes effective at the beginning of the following month.

CMS annually reassigns some dual eligibles to new PDPs if their current PDPs will have premiums above the regional benchmark premium for the following year.\textsuperscript{21} 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.\textsuperscript{22} In addition, CMS notifies dual eligibles who elected their current Part D plans that their plans will have premiums above the regional benchmark premium. For 2015, CMS reported reassigning approximately 372,000 Medicare beneficiaries, including but not exclusively dual eligibles, because of premium increases.

\textbf{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

\begin{enumerate}
\item Social Security Act, § 1860D-14(b); 42 CFR § 423.780(b)(2)(i).
\item 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. Social Security Act, § 1860D-14(a)(3)(F).
\item The ACA established a “de minimis” premium policy, whereby a Part D plan may elect to charge dual eligibles the benchmark premium amount if the Part D plan’s basic premium exceeds the regional benchmark by a de minimis amount. Patient Protection and Affordable Care Act (ACA), P.L. No. 111-148 § 3303, Social Security Act, § 1860D-14(a)(5). For 2014, CMS set the de minimis amount at $2 above the regional benchmark.
\item CMS, \textit{PDBM}, ch. 3, § 40.1.4.
\item Ibid.
\item Ibid., § 30.3.2. In general, Medicare beneficiaries can switch Part D plans only once a year during a defined enrollment period.
\item Ibid., § 40.1.5.
\item Ibid.
\end{enumerate}
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. In addition, Part D plans must include Part D-covered drugs in certain categories and classes.

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

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

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

**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. 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.

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23 CMS, *PDBM*, ch. 6, § 30.2.1.
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.
30 CMS, *PDBM*, ch. 6, § 30.2.7.
31 Ibid.

Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2015 (OEI-05-15-00120)
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.32, 33, 34

*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.35 If their plans make negative determinations, beneficiaries have the right to appeal.36 If their plans deny their appeals, beneficiaries would need to get prescriptions from their physicians for therapeutically alternative drugs that are covered by their plans.

*Transitioning new enrollees to Part D.* CMS requires that Part D plans establish a transition process for new enrollees (including dual eligibles) who are transitioning to their respective Part D plans either from different Part D plans or from other prescription drug coverage. During Medicare beneficiaries’ first 90 days under a new Part D plan, the new plan must provide one temporary refill of a prescription when beneficiaries request either a drug that is not in the plan’s formulary or a drug that requires prior authorization or step therapy under the formulary’s utilization management tools.37 The temporary fill accommodates beneficiaries’ immediate drug needs the first time they attempt to fill a prescription. The transition period also allows beneficiaries time to work with their prescribing physicians to obtain prescriptions for therapeutically alternative drugs or to request formulary exceptions from Part D plans.

**Related OIG Work**

In 2006, OIG published a report assessing the extent to which PDP formularies included drugs commonly used by dual eligibles under Medicaid. The study found that PDP formularies included between 76 and 100 percent of the 178 drugs commonly used by dual eligibles under Medicaid prior to the implementation of Part D. Approximately half of the 178 commonly used drugs were covered by all formularies.38

In 2011, OIG issued the first annual mandated memorandum report examining dual eligibles’ access to drugs under Medicare Part D.39 In 2012, OIG issued the second annual mandated memorandum report examining dual eligibles’ access to drugs under

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32 Ibid., § 30.2.2.
33 Ibid., § 30.2.7.
34 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.
35 CMS, *PDBM*, ch. 18, §§ 30.1 and 30.2.
36 Ibid., § 60.1.
37 Ibid., ch. 6, § 30.4.4.

Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2015 (OEI-05-15-00120)
Medicare Part D. In 2013, OIG issued the third annual mandated memorandum report examining dual eligibles’ access to drug under Medicare Part D. In 2014, OIG issued the fourth annual mandated memorandum report. In the current memorandum report, we compare the results from 2014 and 2015.

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 2015. As part of our assessment, we included dual eligibles’ enrollment data from April 2015, the most recent enrollment data available from CMS at the time of our study. We also compared the results of our 2015 study with those of our 2014 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 latest Medicare Current Beneficiary Survey (MCBS). We used the MCBS because it contains drugs that dual eligibles received through multiple sources (e.g., Part D, Medicaid, and the Department of Veterans Affairs) and, as such, it provides a comprehensive picture of drug utilization. Of the 200 highest utilization drugs that we identified using the MCBS, 196 are eligible for coverage under Part D. In this report, we refer to these 196 Part D-eligible high-utilization drugs as “commonly used drugs.”

The list of 200 drugs with the highest utilization by dual eligibles referenced in this 2015 memorandum report is similar but not identical to the list of drugs referenced in the 2014 memorandum report. Specifically, 185 of the 200 drugs (93 percent) listed in the 2014 memorandum report are also listed in this 2015 memorandum report.

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

We also went beyond the ACA’s mandate in the 2013, 2014, and 2015 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

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40 OIG, Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2012, OEI-05-12-00060, June 2012.
43 Ibid.
to which Part D plan formularies apply these tools to drugs commonly used by dual eligibles allows us to provide a comprehensive picture of Part D plan formularies’ coverage of, and dual eligibles’ access to, those drugs.

Data Sources

MCBS. We used the 2011 MCBS Cost and Use data to create a list of the 200 drugs with the highest utilization by dual eligibles. The MCBS Cost and Use data contain information on hospitals, physicians, and prescription drug costs and utilization. The 2011 MCBS Cost and Use data are the most recent data available.

The MCBS is a continuous, multipurpose survey that CMS conducts of a representative national sample of the Medicare population, including dual eligibles. Sampled Medicare beneficiaries 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 2011, the MCBS surveyed 10,901 Medicare beneficiaries, of whom 2,149 were dual eligibles who had used prescription drugs during the year (out of 2,402 dual-eligible survey respondents).

First Databank National Drug Data File. We used the April 2015 First DataBank National Drug Data File to identify the drug product information for the 200 drugs with the highest utilization by dual eligibles. The National Drug Data File is a database that contains information—such as drug name, therapeutic category or class, and the unique combination of active ingredients—for each drug as defined by a National Drug Code (NDC).44

Part D plan data. In January 2015, we collected from CMS the formulary data and the plan data for Part D plans operating in 2015. The formulary data includes Part D plans’ formularies and utilization management tools for plans operating in 2015. In 2015, there are 341 unique formularies offered by 3,152 Part D plans. The plan data provides information such as the State in which a Part D plan is offered, whether the Part D plan is a PDP or an MA-PD, and whether the Part D plan premium is below the regional benchmark.

We also collected 2015 enrollment data for Part D plans. These data provide the number of dual eligibles enrolled in each Part D plan as of April 2015.

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44 An NDC is a three-part universal identifier that specifies the drug manufacturer’s name, the drug form and strength, and the package size.
Determining the Most Commonly Used Drugs

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

1. We created a list of all drugs reported by dual eligibles surveyed in the MCBS. We excluded respondents from territories because they are not eligible to receive cost-sharing assistance under Part D. The MCBS listed 155,265 drug events for 2,149 dual eligibles who did not reside in territories.45

2. We collapsed this list to a list of drugs based on their active ingredients, using the Ingredient List Identifier located in First DataBank’s National Drug Data File. For example, a multiple-source drug such as fluoxetine hydrochloride (the active ingredient for the brand-name drug Prozac) has only one entry on our list, covering all strengths of both the brand-name drug Prozac and the available generic versions of fluoxetine hydrochloride. From this point forward, unless otherwise stated, we will use the term “drug” to refer to any drug in the same Ingredient List Identifier category, and the term “unique drug” to refer to an NDC corresponding to a drug, as a given drug can have multiple NDCs. This process left 155,265 drug events associated with 872 drugs.

3. We ranked the 872 drugs by frequency of utilization, weighting the drug-event information from MCBS by sample weight.

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

5. We removed all drugs not covered under Part D. Of the 200 drugs with the highest utilization, 196 are eligible under Part D. Three fell into drug categories excluded under Part D, and one is no longer prescribed in the form taken by beneficiaries surveyed in the 2011 MCBS. For details on these four drugs, see Appendix C.

Formulary Analysis

We analyzed the 341 unique Part D plan formularies to determine their rates of inclusion of the 196 drugs commonly used by dual eligibles. We counted a drug as included in a Part D plan’s formulary if the formulary included the active ingredient. When a drug included multiple ingredients that could be dispensed separately and combined by the patient to the same effect as the combined drug, we treated the drug as included if the ingredients were included in the formulary either separately or in combination.

Low rates of inclusion by formularies. We determined which of the 196 commonly used drugs had low rates of inclusion by formularies by counting how many of the

45 For the purposes of this report, a drug event is an MCBS survey response indicating that the responding beneficiary took a specific drug at least once in 2011. For example, one MCBS survey respondent reported taking zolpidem tartrate (Ambien) seven times in 2011. We counted this beneficiary/drug combination as seven drug events.
341 formularies covered each drug. We considered a drug to have a low rate of inclusion if it was included by 75 percent or less of formularies. For such drugs, we counted the number of drugs (if any) that each formulary covered in the same therapeutic category or class.

We conducted this analysis to ensure that dual eligibles have access to therapeutically similar drugs. We also conducted additional research to identify potential reasons why some of the 196 commonly used drugs were included by 75 percent or less of formularies.

*Utilization management tools.* We determined the extent to which Part D plans apply utilization management tools to the 196 drugs that we reviewed. The tools that we reviewed are prior authorization, quantity limits, and step therapy.

To determine the extent to which the 196 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 196 commonly used drugs that are on each Part D formulary. We then calculated the percentage of unique drugs to which each Part D plan formulary applies utilization management tools.

**Enrollment Analysis**
We weighted the formulary analysis by dual-eligible enrollment and weighted the analysis of utilization management tools by both dual-eligible enrollment and Medicare enrollment. To do this, we applied enrollment data from April 2015 to Part D plans available in 2015.

**Data Limitations**
We did not assess individual dual eligibles’ prescription drug use or whether individual dual eligibles are enrolled in Part D plans that include the specific drugs that each individual uses. Because we relied on a sample of dual eligibles responding to the MCBS to develop our list of commonly used drugs, a particular dual eligible might not use any of the drugs on our list. However, the drugs most commonly used by dual-eligible MCBS survey participants in 2011 account for 88 percent of all prescriptions dispensed to the dual-eligible respondents in the 2011 MCBS.

Because the lists of commonly used drugs in the 2014 and 2015 memorandum reports are not identical, the changes in rates of inclusion by formularies and in application of utilization management tools between 2014 and 2015 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; 93 percent of the drugs on the list in our 2014 report were also on the list in this 2015 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 86 and 100 Percent of the Drugs Commonly Used by Dual Eligibles

On average, Part D plan formularies include 95 percent of the drugs commonly used by dual eligibles. Of the 341 unique formularies used by Part D plans in 2015, 12 formularies include 100 percent of the commonly used drugs. At the other end of the inclusion range, one formulary includes 86 percent of the commonly used drugs. CMS generally requires Part D plan formularies to include at least two drugs—rather than all drugs—in each therapeutic category or class. Therefore, Part D plan formularies may still meet CMS’s formulary requirements even if they do not include all of the drugs we identified as commonly used by dual eligibles.

Part D plan formularies’ rate of inclusion of the drugs commonly used by dual eligibles in 2015 is nearly identical to that of 2014. The average rate of inclusion decreased slightly between 2014 and 2015, from 96 percent to 95 percent. The range of inclusion rates was the same in 2015 as in 2014—from 86 to 100 percent of the drugs.

Nationally, PDP and MA-PD formularies have similar rates of inclusion of the drugs commonly used by dual eligibles, averaging 94 percent and 95 percent, respectively. For PDP formularies, the rates of inclusion ranged from 88 to 100 percent; for MA-PD formularies, they ranged from 86 to 100 percent. Eighteen formularies—5 percent of the 341 unique formularies used by Part D plans in 2015—are offered by both PDPs and MA-PDs.

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

On average, formularies for Part D plans with premiums below the regional benchmark include 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, such plans. For drugs commonly used by dual eligibles, formularies for such plans have rates of inclusion that range from 88 percent to 100 percent. Approximately 86 percent of dual eligibles are enrolled in Part D plans with premiums below the regional benchmark.
Ninety-four 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 9.7 million dual eligibles enrolled in Part D plans, 94 percent are enrolled in Part D plans that use formularies that include at least 90 percent of the commonly used drugs. Only 6 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>
<thead>
<tr>
<th>Part D Plans With Formularies That Include:</th>
<th>Number of Dual Eligibles Enrolled*</th>
<th>Percentage of Dual Eligibles Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of commonly used drugs</td>
<td>159,954</td>
<td>2%</td>
</tr>
<tr>
<td>95% to 99% of commonly used drugs</td>
<td>2,209,253</td>
<td>23%</td>
</tr>
<tr>
<td>90% to 94% of commonly used drugs</td>
<td>6,866,185</td>
<td>70%</td>
</tr>
<tr>
<td>85% to 89% of commonly used drugs</td>
<td>548,415</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>9,783,807</td>
<td>100%**</td>
</tr>
</tbody>
</table>

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles and dual eligibles’ enrollment, 2015.
* Rounded to the nearest 1,000.
** Percentages do not add to 100 percent because of rounding.

The percentage of dual eligibles enrolled in Part D plans that include at least 90 percent of the drugs commonly used by dual eligibles decreased from 99 percent in 2014 to 94 percent in 2015.

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

Because most of the commonly used drugs are included in a large percentage of formularies, dual eligibles are guaranteed that regardless of the Part D plan in which they are enrolled, the plan’s formulary will include many of these drugs. By drug, formulary inclusion ranges from 33 percent to 100 percent. At one end of the range, there is a commonly used drug that is included in 33 percent of Part D plan formularies, and at the other end, 130 drugs are included in all plan formularies. The average rate of inclusion by formularies is 95 percent. Table 2 provides a summary of rates of inclusion by formularies. Appendix B lists the commonly used drugs and their respective rates of inclusion by formularies.
Table 2: Formularies’ Rates of Inclusion of Commonly Used Drugs

<table>
<thead>
<tr>
<th>Percentage of the 341 Formularies</th>
<th>Percentage of the 196 Commonly Used Drugs Included in Formularies</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>66% (130 drugs)</td>
</tr>
<tr>
<td>85% to 99%</td>
<td>21% (42 drugs)</td>
</tr>
<tr>
<td>76% to 84%</td>
<td>7% (13 drugs)</td>
</tr>
<tr>
<td>33% to 75%</td>
<td>6% (11 drugs)</td>
</tr>
<tr>
<td>Total</td>
<td>100% (196 drugs)</td>
</tr>
</tbody>
</table>

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2015.

The rates of formulary inclusion of the drugs commonly used by dual eligibles in 2015 are similar to those in 2014. The percentage of commonly used drugs included in all formularies increased slightly between 2014 and 2015, from 64 percent to 66 percent.

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

The drugs that make up this group include both brand-name and generic drugs, and are used to treat a variety of primary indications. Six of the eleven drugs are brand-name drugs, which are typically more costly than generic drugs. As for the primary indications, 3 of the 11 drugs are used for diabetic therapy, 2 of the 11 drugs are muscle relaxants, and the remaining drugs treat a variety of conditions including overactive bladder, high cholesterol, anxiety, and hypertension.

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

<table>
<thead>
<tr>
<th>Generic Name of Drug</th>
<th>Primary Indication(s)</th>
<th>Rate of Inclusion by Formularies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin lispro</td>
<td>Diabetes</td>
<td>75%</td>
</tr>
<tr>
<td>Valsartan*</td>
<td>Hypertension (high blood pressure)</td>
<td>67%</td>
</tr>
<tr>
<td>Glyburide/metformin HCl</td>
<td>Diabetes</td>
<td>62%</td>
</tr>
<tr>
<td>Glyburide</td>
<td>Diabetes</td>
<td>61%</td>
</tr>
<tr>
<td>Conjugated estrogen/medroxyprogesterone acet</td>
<td>Menopause</td>
<td>59%</td>
</tr>
<tr>
<td>Ezetimibe/simvastatin*</td>
<td>Hyperlipidemia (high cholesterol)</td>
<td>57%</td>
</tr>
<tr>
<td>Methocarbamol*</td>
<td>Musculoskeletal pain</td>
<td>55%</td>
</tr>
<tr>
<td>Esomeprazole magnesium*</td>
<td>Dyspepsia, peptic ulcer disease, gastroesophageal reflux disease, Zollinger-Ellison syndrome</td>
<td>49%</td>
</tr>
<tr>
<td>Hydroxyzine pamoate*</td>
<td>Anxiety</td>
<td>46%</td>
</tr>
<tr>
<td>Carisoprodol*</td>
<td>Musculoskeletal pain</td>
<td>42%</td>
</tr>
<tr>
<td>Darifenacin hydrobromide*</td>
<td>Overactive bladder</td>
<td>33%</td>
</tr>
</tbody>
</table>

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2015.

* These drugs also had low formulary inclusion rates in 2014.
Although Part D formularies frequently omit these 11 drugs, they all cover other drugs in the same therapeutic classes. For these 11 drugs, 100 percent of formularies cover at least 1 drug in the same therapeutic class that is also on the list of 196 drugs commonly used by dual eligibles.

The number of drugs included by 75 percent or less of formularies stayed the same—11 drugs—in 2014 and 2015. There are seven drugs with low inclusion rates in 2015 that were also on the list of commonly used drugs with low inclusion rates in our 2014 report; these drugs are noted in Table 3. Five of these seven drugs were also on the list of drugs with low inclusion rates in our 2013 report.

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

- Four of these drugs—methocarbamol, carisoprodol, conjugated estrogen/medroxyprogesterone, and hydroxyzine pamoate—are on CMS’s list of Part D medications that are high-risk for the elderly.46
- Further, seven of these drugs—carisoprodol, darifenacin hydrobromide, hydroxyzine pamoate, methocarbamol, glyburide, glyburide/metformin HCl, and estrogens—are listed by the American Geriatrics Society as being potentially inappropriate for older adults.47

Low rates of inclusion by formularies may require dual eligibles to obtain a nonformulary drug. There are several means by which dual eligibles can obtain a nonformulary drug, all of which require them to take additional action. Obtaining therapeutically alternative drugs requires that dual eligibles get new prescriptions from their doctors. Dual eligibles may also submit statements of medical necessity from their physicians as part of appeals to obtain coverage of nonformulary drugs.48 Finally, dual eligibles may switch to Part D plans that include their drugs, with the new coverage becoming effective the following month.49

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46 This list—“Use of High-Risk Medications in the Elderly: High-Risk Medications” —is part of the Healthcare Effectiveness and Information Set national drug code measures published by the National Committee for Quality Assurance. A drug that is listed as being high risk for the elderly is one that has a high risk of serious side effects in that population. CMS uses this medication list to calculate the percentage of Medicare beneficiaries who received at least one high-risk medication in the past year. CMS publishes this percentage and other measures of Part D patient safety so that Medicare beneficiaries can make informed decision in choosing a Part D plan for their prescription drug coverage. National Committee on Quality Assurance, HEDIS 2012 NDC List. Accessed at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPatientSafetyMeasures_071610.pdf on April 15, 2015.

47 The American Geriatrics Society, American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, 2012.

48 CMS, PDBM, ch. 18, § 30.2.2.

49 Ibid., ch. 3, § 30.3.2.
The Percentage of Commonly Used Drugs Subject to Utilization Management Tools by Plan Formularies Increased Slightly Between 2014 and 2015

For the unique drugs that compose the list of commonly used drugs, the percentage subject to utilization management tools by Part D plan formularies increased slightly from an average of 28 percent in 2014 to an average of 29 percent in 2015. Formularies for plans with premiums below and those with premiums above the regional benchmarks had a similar percentage of drugs—27 percent and 29 percent, respectively—that were subject to utilization management tools. See Table 4 for a breakdown of the percentage of unique drugs to which Part D plan formularies apply utilization management tools in 2014 and 2015.

Table 4: Part D Plan Formularies’ Application of Utilization Management Tools to Commonly Used Drugs, 2014 and 2015

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 40%</td>
<td>30</td>
<td>9%</td>
<td>49</td>
<td>14%</td>
</tr>
<tr>
<td>30% to 39%</td>
<td>136</td>
<td>41%</td>
<td>137</td>
<td>40%</td>
</tr>
<tr>
<td>20% to 29%</td>
<td>65</td>
<td>20%</td>
<td>66</td>
<td>19%</td>
</tr>
<tr>
<td>10% to 19%</td>
<td>75</td>
<td>23%</td>
<td>65</td>
<td>19%</td>
</tr>
<tr>
<td>Less than 10%</td>
<td>23</td>
<td>7%</td>
<td>24</td>
<td>7%</td>
</tr>
<tr>
<td>Totals</td>
<td>329</td>
<td>100%</td>
<td>341</td>
<td>100%*</td>
</tr>
</tbody>
</table>

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2015.

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

The percentage of drugs subject to quantity limits or prior authorization increased slightly from 2014 to 2015, while the percentage of drugs subject to step therapy remained the same. Formularies’ use of quantity limits and use of prior authorization each increased by 1 percent—from 24 to 25 percent and from 3 to 4 percent of unique drugs, respectively. The percentage of unique drugs for which formularies required step therapy was 2 percent in both 2014 and 2015.

The rate at which plan formularies apply specific utilization management tools varies widely. In 2015, some formularies applied utilization management tools to none of the unique drugs, whereas at the other end of the range, some applied tools to 47 percent of the unique drugs. More specifically, formularies apply quantity limits to between 0 and 43 percent of unique drugs, require prior authorization for between 0 and 10 percent, and require step therapy for between 0 and 15 percent.

Looking at enrollment across plans provides a slightly different picture than looking only at plans themselves. On average, plan formularies in 2015 apply utilization management tools to 29 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 2015, the median plan weighted by dual-eligible enrollment applies such tools to 35 percent of unique drugs; in 2014, the figure was 34 percent. Similarly, the median plan weighted by overall Medicare enrollment applies these tools to 34 percent of unique drugs in 2015; in 2014, the figure was 33 percent.
Both dual eligibles and Medicare beneficiaries overall tend to be enrolled in plans with formularies that apply utilization management tools to between 30 and 47 percent of unique drugs. In 2015, 63 percent of dual eligibles and 57 percent of Medicare beneficiaries overall were enrolled in plans with formularies in this range. Table 5 shows enrollment in Part D plans by dual eligibles and Medicare beneficiaries, as broken down by the percentages at which the plans’ formularies’ apply utilization management tools.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 40%</td>
<td>5%</td>
<td>14%</td>
<td>8%</td>
<td>16%</td>
</tr>
<tr>
<td>30% to 39%</td>
<td>63%</td>
<td>44%</td>
<td>54%</td>
<td>41%</td>
</tr>
<tr>
<td>20% to 29%</td>
<td>7%</td>
<td>6%</td>
<td>32%</td>
<td>34%</td>
</tr>
<tr>
<td>10% to 19%</td>
<td>24%</td>
<td>32%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Less than 10%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

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, 2015.

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

Further, although utilization management tools control access to drugs, they are important tools for managing costs in Medicare and ensuring appropriate utilization of drugs. For example, oxycodone HCl/acetaminophen drugs saw more than a 30-percent increase in formulary application of utilization management controls in 2013. Such limits may be intended to ensure appropriate utilization, as CMS’s Part D 2013 guidance to Part D sponsors set forth expectations for reviews of opioid overutilization to help ensure that opioids are prescribed and used correctly.50

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 75 percent or less 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

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Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2015 (OEI-05-15-00120)
95 percent of the commonly used drugs. Part D plan formularies’ inclusion of the commonly used drugs ranges from 86 percent to 100 percent. Formulary inclusion rates are similar for PDPs and MA-PDs. Further, formularies for Part D plans with premiums below the regional benchmark include the commonly used drugs at a rate similar to that of Part D plan formularies overall.

Inclusion rates for the 196 drugs commonly used by dual eligibles are largely unchanged compared with those from OIG’s 2014 memorandum report. Part D plan formularies include roughly the same percentage of these commonly used drugs in 2015 as they did in 2014. Enrollment in plans that cover at least 90 percent of unique drugs decreased slightly, with 94 percent of dual eligibles enrolled in such plans in 2015 compared to 99 percent in 2014.

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

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

This memorandum report is being issued directly in final form because it contains no recommendations. We have included the list of the 200 drugs with the highest utilization by dual eligibles. If you have comments or questions about this memorandum report, please provide them within 60 days. Please refer to report number OEI-05-15-00120 in all correspondence.
APPENDIX A

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

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

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

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

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

## Commonly Used Drugs and Rates of Inclusion by Formularies

### Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Sample Size*</th>
<th>Projected Drugs*</th>
<th>95-Percent Confidence Interval*</th>
<th>Number of Formularies Including</th>
<th>Percentage of Formularies Including</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simvastatin</td>
<td>3,900</td>
<td>17,347,406</td>
<td>(15,514,367–19,180,445)</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Lisinopril</td>
<td>3,853</td>
<td>17,267,881</td>
<td>(15,114,378–19,421,384)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Hydrocodone/acetaminophen</td>
<td>4,632</td>
<td>16,947,722</td>
<td>(15,258,697–18,636,747)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>4,014</td>
<td>16,727,875</td>
<td>(14,093,417–17,252,333)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Levothyroxine sodium</td>
<td>3,476</td>
<td>14,830,579</td>
<td>(13,126,542–16,534,615)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Furosemide</td>
<td>3,428</td>
<td>14,434,347</td>
<td>(12,915,250–15,953,443)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Amlodipine besylate</td>
<td>2,919</td>
<td>13,077,400</td>
<td>(11,368,250–14,786,550)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Metformin HCl</td>
<td>2,865</td>
<td>12,804,478</td>
<td>(11,154,960–14,453,996)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Potassium chloride</td>
<td>2,745</td>
<td>10,583,238</td>
<td>(9,213,268–11,953,209)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Metoprolol tartrate</td>
<td>2,352</td>
<td>9,997,980</td>
<td>(8,527,265–11,468,696)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>1,856</td>
<td>7,678,814</td>
<td>(6,546,945–8,810,682)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Warfarin sodium</td>
<td>1,969</td>
<td>7,669,750</td>
<td>(6,220,257–9,119,244)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Atorvastatin calcium</td>
<td>1,658</td>
<td>7,345,895</td>
<td>(6,149,446–8,542,344)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Hydrochlorothiazide</td>
<td>1,557</td>
<td>6,986,485</td>
<td>(5,967,217–8,005,753)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Clopidogrel bisulfate</td>
<td>1,544</td>
<td>6,943,517</td>
<td>(5,750,562–8,136,471)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Albuterol sulfate</td>
<td>1,594</td>
<td>6,785,246</td>
<td>(5,751,649–7,818,843)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Esomeprazole magnesium</td>
<td>1,409</td>
<td>6,652,500</td>
<td>(5,333,170–7,907,989)</td>
<td>167</td>
<td>49%</td>
</tr>
<tr>
<td>Citalopram hydrobromide</td>
<td>1,680</td>
<td>6,426,818</td>
<td>(5,291,102–7,562,533)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Atenolol</td>
<td>1,308</td>
<td>6,334,483</td>
<td>(5,181,329–7,487,637)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Tramadol HCl</td>
<td>1,443</td>
<td>5,544,220</td>
<td>(4,444,084–6,644,356)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Zolpidem tartrate</td>
<td>1,310</td>
<td>5,454,634</td>
<td>(4,429,932–6,479,336)</td>
<td>328</td>
<td>96%</td>
</tr>
<tr>
<td>Carvedilol</td>
<td>1,236</td>
<td>5,320,616</td>
<td>(4,330,462–6,310,771)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Ranitidine HCl</td>
<td>1,381</td>
<td>5,134,725</td>
<td>(3,948,479–6,320,972)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Valsartan</td>
<td>1,074</td>
<td>4,944,768</td>
<td>(3,960,182–5,929,353)</td>
<td>228</td>
<td>67%</td>
</tr>
<tr>
<td>Trazodone HCl</td>
<td>1,289</td>
<td>4,925,948</td>
<td>(3,836,052–6,015,844)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Oxycodone HCl/acetaminophen</td>
<td>1,346</td>
<td>4,865,501</td>
<td>(3,572,611–6,158,391)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Glipizide</td>
<td>1,118</td>
<td>4,768,378</td>
<td>(3,897,329–5,639,428)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Sertraline HCl</td>
<td>1,186</td>
<td>4,657,331</td>
<td>(3,757,053–5,557,609)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Fluticasone/salmeterol</td>
<td>1,037</td>
<td>4,674,993</td>
<td>(3,735,988–5,559,997)</td>
<td>304</td>
<td>89%</td>
</tr>
<tr>
<td>Metoprolol succinate</td>
<td>874</td>
<td>4,576,199</td>
<td>(3,687,311–5,465,088)</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Insulin glargine,hum.rec.analog</td>
<td>1,057</td>
<td>4,519,573</td>
<td>(3,638,096–5,401,051)</td>
<td>329</td>
<td>96%</td>
</tr>
<tr>
<td>Alendronate sodium</td>
<td>1,098</td>
<td>4,517,069</td>
<td>(3,714,312–5,319,827)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Risperidone</td>
<td>1,337</td>
<td>4,321,416</td>
<td>(3,370,755–5,272,076)</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Quetiapine fumarate</td>
<td>1,486</td>
<td>4,139,968</td>
<td>(3,230,748–5,049,188)</td>
<td>341</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Sample Size*</th>
<th>Projected Drugs*</th>
<th>95-Percent Confidence Interval*</th>
<th>Number of Formularies Including</th>
<th>Percentage of Formularies Including</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prednisone</td>
<td>1,043</td>
<td>4,060,613</td>
<td>3,342,786–4,778,439</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Fluticasone propionate</td>
<td>967</td>
<td>3,994,341</td>
<td>3,322,845–4,665,836</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Rosuvastatin calcium</td>
<td>749</td>
<td>3,946,728</td>
<td>3,150,322–4,743,134</td>
<td>279</td>
<td>82%</td>
</tr>
<tr>
<td>Pravastatin sodium</td>
<td>792</td>
<td>3,669,913</td>
<td>2,920,688–4,419,137</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Donepezil HCl</td>
<td>1,100</td>
<td>3,629,564</td>
<td>2,875,141–4,383,988</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Isosorbide mononitrate</td>
<td>748</td>
<td>3,561,729</td>
<td>2,815,323–4,308,136</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Cyclobenzaprine HCl</td>
<td>802</td>
<td>3,507,572</td>
<td>2,743,874–4,271,270</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Montelukast sodium</td>
<td>845</td>
<td>3,433,580</td>
<td>2,539,837–4,327,323</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Pioglitazone HCl</td>
<td>740</td>
<td>3,315,739</td>
<td>2,511,944–4,119,534</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Diltiazem HCl</td>
<td>791</td>
<td>3,236,508</td>
<td>2,409,349–4,063,667</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Clonidine HCl</td>
<td>785</td>
<td>3,207,052</td>
<td>2,329,831–4,084,273</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Lovastatin</td>
<td>655</td>
<td>3,180,423</td>
<td>2,491,792–3,869,054</td>
<td>338</td>
<td>99%</td>
</tr>
<tr>
<td>Divalproex sodium</td>
<td>1,080</td>
<td>3,083,963</td>
<td>2,353,057–3,814,868</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Meloxicam</td>
<td>715</td>
<td>3,045,674</td>
<td>2,442,247–3,649,102</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Famotidine</td>
<td>716</td>
<td>3,002,313</td>
<td>2,222,260–3,782,365</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Allopurinil</td>
<td>721</td>
<td>2,959,137</td>
<td>2,201,749–3,716,525</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>828</td>
<td>2,920,144</td>
<td>2,333,892–3,506,396</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Escitalopram oxalate</td>
<td>858</td>
<td>2,894,303</td>
<td>2,278,119–3,510,486</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Losartan potassium</td>
<td>587</td>
<td>2,883,618</td>
<td>2,142,589–3,624,648</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Bupropion HCl</td>
<td>689</td>
<td>2,871,472</td>
<td>2,059,562–3,683,383</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Amantadine HCl</td>
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<td>341</td>
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</tr>
<tr>
<td>Glimepiride</td>
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</tr>
<tr>
<td>Lisinopril/hydrochlorothiazide</td>
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<td>2,838,412</td>
<td>2,174,963–3,501,861</td>
<td>341</td>
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<tr>
<td>Pantoprazole sodium</td>
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<td>340</td>
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</tr>
<tr>
<td>Tiotropium bromide</td>
<td>593</td>
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<tr>
<td>Tamsulosin HCl</td>
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<td>Aripiprazole</td>
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<td>2,507,449</td>
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<tr>
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<tr>
<td>Enalapril maleate</td>
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<td>2,486,122</td>
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<tr>
<td>Triamterene/hydrochlorothiazide</td>
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<td>2,472,394</td>
<td>1,698,398–3,246,390</td>
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<tr>
<td>Fluoxetine HCl</td>
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</tr>
<tr>
<td>Lansoprazole</td>
<td>520</td>
<td>2,432,783</td>
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<td>80%</td>
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</tbody>
</table>

*continued on next page*
<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Sample Size</th>
<th>Projected Drugs*</th>
<th>95-Percent Confidence Interval*</th>
<th>Number of Formularies Including</th>
<th>Percentage of Formularies Including</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memantine HCl</td>
<td>676</td>
<td>2,342,026</td>
<td>1,726,810–2,957,242</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>646</td>
<td>2,266,382</td>
<td>1,667,334–2,865,431</td>
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<td>100%</td>
</tr>
<tr>
<td>Fexofenadine HCl</td>
<td>516</td>
<td>2,230,968</td>
<td>1,530,394–2,931,543</td>
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<td></td>
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<tr>
<td>Benztrapine mesylate</td>
<td>805</td>
<td>2,226,864</td>
<td>1,615,882–2,837,845</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Ezetimibe</td>
<td>418</td>
<td>2,160,362</td>
<td>1,594,728–2,725,996</td>
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<td>99%</td>
</tr>
<tr>
<td>Naproxen</td>
<td>557</td>
<td>2,141,422</td>
<td>1,665,511–2,617,333</td>
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<tr>
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<td>Spironolactone</td>
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<tr>
<td>Sulfamethoxazole/trimethoprim</td>
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<td>2,057,059</td>
<td>1,708,114–2,406,003</td>
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<td>100%</td>
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<tr>
<td>Diclofenac sodium</td>
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<tr>
<td>Valsartan/hydrochlorothiazide</td>
<td>430</td>
<td>2,030,978</td>
<td>1,418,545–2,643,412</td>
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<tr>
<td>Ciprofloxacin HCl</td>
<td>608</td>
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<tr>
<td>Topiramate</td>
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<td>1,240,195–2,743,760</td>
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<tr>
<td>Mirtazapine</td>
<td>641</td>
<td>1,962,056</td>
<td>1,543,919–2,360,194</td>
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<tr>
<td>Carbamazepine</td>
<td>595</td>
<td>1,924,763</td>
<td>1,352,454–2,497,073</td>
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<tr>
<td>Promethazine HCl</td>
<td>527</td>
<td>1,911,351</td>
<td>1,452,229–2,370,473</td>
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<tr>
<td>Meclazine HCl</td>
<td>399</td>
<td>1,906,646</td>
<td>1,148,154–2,665,138</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Cephalexin</td>
<td>511</td>
<td>1,899,305</td>
<td>1,508,958–2,289,651</td>
<td>341</td>
<td>100%</td>
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<tr>
<td>Fenofibrate nanocrystallized</td>
<td>413</td>
<td>1,898,960</td>
<td>1,336,984–2,460,935</td>
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<td>92%</td>
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<tr>
<td>Ipratropium/albuterol sulfate</td>
<td>463</td>
<td>1,888,932</td>
<td>1,347,400–2,430,464</td>
<td>333</td>
<td>98%</td>
</tr>
<tr>
<td>Venlafaxine HCl</td>
<td>627</td>
<td>1,861,582</td>
<td>1,234,559–2,488,604</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Oxybutynin chloride</td>
<td>568</td>
<td>1,849,363</td>
<td>1,498,605–2,200,122</td>
<td>341</td>
<td>100%</td>
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<tr>
<td>Morphine sulfate</td>
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<td>1,845,759</td>
<td>1,195,157–2,496,362</td>
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<td>100%</td>
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<tr>
<td>Digoxin</td>
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<td>1,427,800–2,263,512</td>
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<td>100%</td>
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<tr>
<td>Olanzapine</td>
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<td>1,790,633</td>
<td>1,160,005–2,421,261</td>
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</tr>
<tr>
<td>Lorazepam</td>
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<td>1,786,878</td>
<td>1,296,097–2,277,659</td>
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<tr>
<td>Verapamil HCl</td>
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<td>1,786,033</td>
<td>1,240,416–2,331,649</td>
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<td>100%</td>
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<tr>
<td>Levetiracetam</td>
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<td>1,162,363–2,402,794</td>
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<tr>
<td>Nitroglycerin</td>
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<td>1,318,075–2,158,095</td>
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<tr>
<td>Propranolol HCl</td>
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<tr>
<td>Pramipexole di-HCl</td>
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<td>Pregabalin</td>
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<td>Glyburide</td>
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<td>Traroprost</td>
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<td>1,101,440–2,236,998</td>
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<tr>
<td>Nifedipine</td>
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<tr>
<td>Insulin aspart</td>
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<td>1,659,889</td>
<td>1,219,121–2,100,657</td>
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<td>81%</td>
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</tbody>
</table>

*continued on next page*
<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Sample Size*</th>
<th>Projected Drugs*</th>
<th>95-Percent Confidence Interval*</th>
<th>Number of Formularies Including</th>
<th>Percentage of Formularies Including</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lidocaine</td>
<td>432</td>
<td>1,643,259</td>
<td>1,137,819–2,148,699</td>
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<tr>
<td>Phenytoin sodium extended</td>
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<td>1,576,690</td>
<td>1,162,249–1,991,130</td>
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<tr>
<td>Polyethylene glycol 3350</td>
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<td>1,246,909–1,888,216</td>
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<tr>
<td>Buspirone HCl</td>
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<td>1,033,893–2,093,859</td>
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<tr>
<td>Hydroxyzine HCl</td>
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<td>1,170,925–1,955,945</td>
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<tr>
<td>Baclofen</td>
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<td>1,536,847</td>
<td>996,284–2,077,411</td>
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</tr>
<tr>
<td>Hydralazine HCl</td>
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<td>1,460,232</td>
<td>1,067,908–1,852,555</td>
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</tr>
<tr>
<td>Sitaglitin phosphate</td>
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</tr>
<tr>
<td>Ipratropium bromide</td>
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<tr>
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</tr>
<tr>
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<tr>
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<tr>
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</tr>
<tr>
<td>Lactotrigine</td>
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<td>915,124–1,771,888</td>
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<td>100%</td>
</tr>
<tr>
<td>Insulin regular, human</td>
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<td>1,330,468</td>
<td>885,107–1,775,828</td>
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<td>100%</td>
</tr>
<tr>
<td>Doxazosin mesylate</td>
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<td>1,326,945</td>
<td>924,407–1,729,482</td>
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<td>100%</td>
</tr>
<tr>
<td>Acetaminophen with codeine</td>
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<td>931,475–1,682,370</td>
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<tr>
<td>Levofoxacin</td>
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<td>1,289,250</td>
<td>1,014,165–1,564,336</td>
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<td>100%</td>
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<tr>
<td>Gemfibrozil</td>
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<td>1,271,415</td>
<td>854,041–1,688,788</td>
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<tr>
<td>Ropinirole HCl</td>
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<td>1,239,322</td>
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</tr>
<tr>
<td>Tizanidine HCl</td>
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<td>1,235,871</td>
<td>775,568–1,696,175</td>
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<td>100%</td>
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<tr>
<td>Ezetimibe/simvastatin</td>
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<td>1,190,684</td>
<td>703,085–1,678,284</td>
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<tr>
<td>Dicyclomine HCl</td>
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<td>1,188,897</td>
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<td>99%</td>
</tr>
<tr>
<td>Nph, human insulin isophane</td>
<td>228</td>
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<td>617,196–1,736,663</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Losartan/hydrochlorothiazide</td>
<td>263</td>
<td>1,176,050</td>
<td>755,814–1,596,286</td>
<td>341</td>
<td>100%</td>
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<tr>
<td>Metoclopramide HCl</td>
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<td>1,167,293</td>
<td>728,971–1,605,615</td>
<td>341</td>
<td>100%</td>
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<tr>
<td>Methocarbamol</td>
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<td>1,140,023</td>
<td>818,332–1,461,714</td>
<td>187</td>
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<tr>
<td>Finasteride</td>
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<td>1,134,898</td>
<td>652,093–1,617,704</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Lactulose</td>
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<td>1,134,620</td>
<td>627,955–1,641,286</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Tolterodine tartrate</td>
<td>272</td>
<td>1,129,540</td>
<td>738,696–1,520,385</td>
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<td>94%</td>
</tr>
<tr>
<td>Carbidopa/levodopa</td>
<td>345</td>
<td>1,121,177</td>
<td>715,869–1,526,485</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Bimatoprost</td>
<td>206</td>
<td>1,094,783</td>
<td>676,449–1,513,117</td>
<td>298</td>
<td>87%</td>
</tr>
<tr>
<td>Budesonide/formoterol fumarate</td>
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<td>1,086,250</td>
<td>644,063–1,528,437</td>
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<td>84%</td>
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<tr>
<td>Nystatin</td>
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<td>1,084,400</td>
<td>818,338–1,350,463</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Doxycycline hyclate</td>
<td>361</td>
<td>1,082,007</td>
<td>834,313–1,329,702</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Methadone HCl</td>
<td>230</td>
<td>1,080,920</td>
<td>418,188–1,743,653</td>
<td>337</td>
<td>99%</td>
</tr>
<tr>
<td>Triamcinolone acetonide</td>
<td>327</td>
<td>1,076,999</td>
<td>882,920–1,271,077</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Glyburide/metformin HCl</td>
<td>205</td>
<td>1,063,514</td>
<td>723,157–1,403,871</td>
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<td>62%</td>
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</table>

Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2015 (OEI-05-15-00120)
### Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles, continued

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Sample Size*</th>
<th>Projected Drugs*</th>
<th>95-Percent Confidence Interval*</th>
<th>Number of Formularies Including</th>
<th>Percentage of Formularies Including</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ramipril</td>
<td>187</td>
<td>1,036,844</td>
<td>646,839–1,426,849</td>
<td>339</td>
<td>99%</td>
</tr>
<tr>
<td>Brimonidine tartrate</td>
<td>233</td>
<td>1,003,480</td>
<td>659,803–1,347,156</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Omega-3 acid ethyl esters</td>
<td>224</td>
<td>999,736</td>
<td>606,370–1,393,102</td>
<td>339</td>
<td>99%</td>
</tr>
<tr>
<td>Estrogens, conjugated</td>
<td>208</td>
<td>984,811</td>
<td>642,302–1,327,320</td>
<td>324</td>
<td>95%</td>
</tr>
<tr>
<td>Mometasone furoate</td>
<td>247</td>
<td>972,134</td>
<td>684,519–1,259,748</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Amlodipine besylate/benazepril</td>
<td>228</td>
<td>959,920</td>
<td>603,084–1,316,756</td>
<td>325</td>
<td>95%</td>
</tr>
<tr>
<td>Niacin</td>
<td>284</td>
<td>950,310</td>
<td>593,958–1,306,662</td>
<td>338</td>
<td>99%</td>
</tr>
<tr>
<td>Folic acid</td>
<td>234</td>
<td>917,230</td>
<td>579,814–1,254,647</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam</td>
<td>242</td>
<td>914,849</td>
<td>602,056–1,227,643</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Risedronate sodium</td>
<td>177</td>
<td>909,354</td>
<td>496,506–1,322,202</td>
<td>262</td>
<td>77%</td>
</tr>
<tr>
<td>Solifenacin succinate</td>
<td>212</td>
<td>905,807</td>
<td>544,630–1,266,985</td>
<td>261</td>
<td>77%</td>
</tr>
<tr>
<td>Hum insulin nph/reg insulin hm</td>
<td>277</td>
<td>891,664</td>
<td>585,937–1,197,392</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Insulin lispro</td>
<td>204</td>
<td>886,766</td>
<td>488,887–1,284,646</td>
<td>255</td>
<td>75%</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>244</td>
<td>876,604</td>
<td>629,792–1,123,416</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Megestrol acetate</td>
<td>190</td>
<td>860,802</td>
<td>550,566–1,171,039</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Olopataidine HCI</td>
<td>233</td>
<td>856,208</td>
<td>531,929–1,180,487</td>
<td>297</td>
<td>87%</td>
</tr>
<tr>
<td>Amoxicillin/potassium clav</td>
<td>249</td>
<td>842,524</td>
<td>675,798–1,009,249</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Ergocalciferol (vitamin D₃)</td>
<td>246</td>
<td>840,670</td>
<td>572,795–1,108,546</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metolazone</td>
<td>175</td>
<td>821,115</td>
<td>473,109–1,169,121</td>
<td>337</td>
<td>99%</td>
</tr>
<tr>
<td>Ibandronate sodium</td>
<td>180</td>
<td>811,781</td>
<td>469,371–1,154,191</td>
<td>319</td>
<td>94%</td>
</tr>
<tr>
<td>Clozapine</td>
<td>258</td>
<td>810,313</td>
<td>187,555–1,433,071</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Insulin detemir</td>
<td>219</td>
<td>791,709</td>
<td>502,659–1,080,758</td>
<td>289</td>
<td>85%</td>
</tr>
<tr>
<td>Timolol maleate</td>
<td>171</td>
<td>791,425</td>
<td>446,936–1,135,915</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Fenofibrate</td>
<td>217</td>
<td>789,433</td>
<td>472,615–1,106,252</td>
<td>340</td>
<td>100%</td>
</tr>
<tr>
<td>Estradiol</td>
<td>139</td>
<td>779,861</td>
<td>406,740–1,152,981</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Quinapril HCl</td>
<td>166</td>
<td>767,100</td>
<td>405,556–1,128,644</td>
<td>338</td>
<td>99%</td>
</tr>
<tr>
<td>Dutasteride</td>
<td>144</td>
<td>766,689</td>
<td>374,966–1,158,412</td>
<td>306</td>
<td>90%</td>
</tr>
<tr>
<td>Nitrofurantoin monohyd/ m-cryst</td>
<td>211</td>
<td>754,425</td>
<td>528,967–979,883</td>
<td>326</td>
<td>96%</td>
</tr>
<tr>
<td>Terazosin HCl</td>
<td>182</td>
<td>749,047</td>
<td>398,590–1,099,504</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Calcitriol</td>
<td>174</td>
<td>742,544</td>
<td>394,387–1,090,700</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Amiodarone HCl</td>
<td>159</td>
<td>726,161</td>
<td>428,049–1,024,273</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Fenofibrinic acid (choline)</td>
<td>183</td>
<td>697,843</td>
<td>242,136–1,153,549</td>
<td>274</td>
<td>80%</td>
</tr>
<tr>
<td>Temazepam</td>
<td>183</td>
<td>696,803</td>
<td>364,561–1,029,045</td>
<td>259</td>
<td>76%</td>
</tr>
<tr>
<td>Olmesartan medoxomil</td>
<td>133</td>
<td>691,273</td>
<td>352,024–1,030,523</td>
<td>269</td>
<td>79%</td>
</tr>
<tr>
<td>Cinacalcet HCl</td>
<td>204</td>
<td>689,875</td>
<td>378,315–1,001,435</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Ziprasidone HCl</td>
<td>335</td>
<td>685,268</td>
<td>386,358–984,178</td>
<td>341</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table B-1: 200 Drugs With the Highest Utilization by Dual Eligibles, continued

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Sample Size</th>
<th>Projected Drugs</th>
<th>95-Percent Confidence Interval</th>
<th>Number of Formularies Including</th>
<th>Percentage of Formularies Including</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estrogen,con/m-progest acet</td>
<td>89</td>
<td>680,598</td>
<td>163,753–1,197,443</td>
<td>201</td>
<td>59%</td>
</tr>
<tr>
<td>Hydroxyzine pamoate</td>
<td>176</td>
<td>673,614</td>
<td>299,916–1,047,312</td>
<td>155</td>
<td>45%</td>
</tr>
<tr>
<td>Prednisolone acetate</td>
<td>148</td>
<td>647,730</td>
<td>466,124–829,336</td>
<td>301</td>
<td>88%</td>
</tr>
<tr>
<td>Clotrimazole/betamethasone dip</td>
<td>170</td>
<td>645,039</td>
<td>374,168–915,909</td>
<td>284</td>
<td>83%</td>
</tr>
<tr>
<td>Darifenacin hydrobromide</td>
<td>167</td>
<td>643,527</td>
<td>364,924–922,130</td>
<td>113</td>
<td>33%</td>
</tr>
<tr>
<td>Hydrocortisone</td>
<td>152</td>
<td>613,981</td>
<td>360,669–867,293</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Ketoconazole</td>
<td>175</td>
<td>609,470</td>
<td>407,703–811,237</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Mycophenolate mofetil</td>
<td>184</td>
<td>603,446</td>
<td>282,168–924,724</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Hydroxychloroquine sulfate</td>
<td>112</td>
<td>602,009</td>
<td>406,799–797,218</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>261</td>
<td>594,843</td>
<td>343,034–846,652</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Sevelamer carbonate</td>
<td>157</td>
<td>592,190</td>
<td>348,152–836,228</td>
<td>316</td>
<td>93%</td>
</tr>
<tr>
<td>Cyclosporine</td>
<td>157</td>
<td>589,434</td>
<td>314,216–864,653</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Isosorbide dinitrate</td>
<td>121</td>
<td>578,099</td>
<td>267,561–888,636</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Doxepin HCl</td>
<td>169</td>
<td>578,028</td>
<td>275,021–881,036</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Bumetanide</td>
<td>115</td>
<td>574,123</td>
<td>220,061–928,186</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Mupirocin</td>
<td>166</td>
<td>559,222</td>
<td>377,854–740,591</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Labetalol HCl</td>
<td>146</td>
<td>559,195</td>
<td>303,504–814,886</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Albuterol</td>
<td>131</td>
<td>553,548</td>
<td>388,411–718,684</td>
<td>341</td>
<td>100%</td>
</tr>
<tr>
<td>Theophylline anhydrous</td>
<td>137</td>
<td>552,738</td>
<td>232,889–872,588</td>
<td>341</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: OIG analysis of drugs commonly used by dual eligibles, 2015.
*Sample is from the 2011 MCBS. Projections and confidence intervals are derived from its survey methodology.
## APPENDIX C

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

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Reason Excluded Under Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol*</td>
<td>No longer prescribed without sulfate</td>
</tr>
<tr>
<td>Fexofenadine HCl*</td>
<td>Nonprescription drug</td>
</tr>
<tr>
<td>Folic acid*</td>
<td>Vitamin or mineral product</td>
</tr>
<tr>
<td>Ergocalciferol (Vitamin D₂)*</td>
<td>Vitamin or mineral product</td>
</tr>
</tbody>
</table>

Source: OIG analysis of formulary inclusion of drugs commonly used by dual eligibles, 2015.

*These drugs were also on the 2014 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 Formularies’ Inclusion of Commonly Used Drugs, by Region

<table>
<thead>
<tr>
<th>PDP Region</th>
<th>State(s)</th>
<th>Number of PDPs</th>
<th>Average Rate of Inclusion by Formularies</th>
<th>Minimum Rate</th>
<th>Maximum Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maine, New Hampshire</td>
<td>27</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>2</td>
<td>Connecticut, Massachusetts, Rhode Island, Vermont</td>
<td>26</td>
<td>94%</td>
<td>89%</td>
<td>98%</td>
</tr>
<tr>
<td>3</td>
<td>New York</td>
<td>24</td>
<td>94%</td>
<td>89%</td>
<td>98%</td>
</tr>
<tr>
<td>4</td>
<td>New Jersey</td>
<td>28</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>5</td>
<td>Delaware, the District of Columbia, Maryland</td>
<td>26</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>6</td>
<td>Pennsylvania, West Virginia</td>
<td>26</td>
<td>94%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>7</td>
<td>Virginia</td>
<td>30</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>8</td>
<td>North Carolina</td>
<td>28</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>9</td>
<td>South Carolina</td>
<td>30</td>
<td>95%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>10</td>
<td>Georgia</td>
<td>29</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>11</td>
<td>Florida</td>
<td>26</td>
<td>94%</td>
<td>89%</td>
<td>98%</td>
</tr>
<tr>
<td>12</td>
<td>Alabama, Tennessee</td>
<td>29</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>13</td>
<td>Michigan</td>
<td>30</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>14</td>
<td>Ohio</td>
<td>30</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>15</td>
<td>Indiana, Kentucky</td>
<td>30</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>16</td>
<td>Wisconsin</td>
<td>28</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>17</td>
<td>Illinois</td>
<td>32</td>
<td>94%</td>
<td>88%</td>
<td>99%</td>
</tr>
<tr>
<td>18</td>
<td>Missouri</td>
<td>30</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>19</td>
<td>Arkansas</td>
<td>28</td>
<td>95%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>20</td>
<td>Mississippi</td>
<td>27</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>21</td>
<td>Louisiana</td>
<td>27</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>22</td>
<td>Texas</td>
<td>31</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>23</td>
<td>Oklahoma</td>
<td>30</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>24</td>
<td>Kansas</td>
<td>28</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>25</td>
<td>Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming</td>
<td>29</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>26</td>
<td>New Mexico</td>
<td>30</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>27</td>
<td>Colorado</td>
<td>29</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>28</td>
<td>Arizona</td>
<td>29</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>29</td>
<td>Nevada</td>
<td>31</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>30</td>
<td>Oregon, Washington</td>
<td>29</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>31</td>
<td>Idaho, Utah</td>
<td>30</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>32</td>
<td>California</td>
<td>31</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>33</td>
<td>Hawaii</td>
<td>24</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>34</td>
<td>Alaska</td>
<td>23</td>
<td>94%</td>
<td>89%</td>
<td>99%</td>
</tr>
</tbody>
</table>

Source: OIG analysis of formularies’ inclusion of drugs commonly used by dual eligibles, 2015.

*PDP
**MA-PD

Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2015 (OEI-05-15-00120)
Table D-2: MA-PD Formularies’ Inclusion of Commonly Used Drugs, by Region

<table>
<thead>
<tr>
<th>MA-PD Region***</th>
<th>State(s)</th>
<th>Number of MA-PDs</th>
<th>Average Rate of Inclusion by Formularies</th>
<th>Minimum Rate</th>
<th>Maximum Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maine, New Hampshire</td>
<td>37</td>
<td>96%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>Connecticut, Massachusetts, Rhode Island, Vermont</td>
<td>85</td>
<td>96%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>New York</td>
<td>187</td>
<td>95%</td>
<td>90%</td>
<td>99%</td>
</tr>
<tr>
<td>4</td>
<td>New Jersey</td>
<td>37</td>
<td>94%</td>
<td>89%</td>
<td>98%</td>
</tr>
<tr>
<td>5</td>
<td>Delaware, the District of Columbia, Maryland</td>
<td>25</td>
<td>95%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>6</td>
<td>Pennsylvania, West Virginia</td>
<td>129</td>
<td>96%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>7</td>
<td>North Carolina, Virginia</td>
<td>107</td>
<td>96%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>8</td>
<td>Georgia, South Carolina</td>
<td>62</td>
<td>96%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>9</td>
<td>Florida</td>
<td>219</td>
<td>96%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>10</td>
<td>Alabama, Tennessee</td>
<td>83</td>
<td>96%</td>
<td>92%</td>
<td>98%</td>
</tr>
<tr>
<td>11</td>
<td>Michigan</td>
<td>61</td>
<td>96%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
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<td>89%</td>
<td>100%</td>
</tr>
<tr>
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<td>Indiana, Kentucky</td>
<td>79</td>
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<td>89%</td>
<td>98%</td>
</tr>
<tr>
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</tr>
<tr>
<td>15</td>
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<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>16</td>
<td>Louisiana, Mississippi</td>
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<td>93%</td>
<td>98%</td>
</tr>
<tr>
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<td>Texas</td>
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<td>99%</td>
</tr>
<tr>
<td>18</td>
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<td>96%</td>
<td>89%</td>
<td>98%</td>
</tr>
<tr>
<td>19</td>
<td>Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming</td>
<td>79</td>
<td>96%</td>
<td>88%</td>
<td>100%</td>
</tr>
<tr>
<td>20</td>
<td>Colorado, New Mexico</td>
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<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>21</td>
<td>Arizona</td>
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<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>22</td>
<td>Nevada</td>
<td>30</td>
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<td>89%</td>
<td>99%</td>
</tr>
<tr>
<td>23</td>
<td>Idaho, Oregon, Utah, Washington</td>
<td>157</td>
<td>96%</td>
<td>88%</td>
<td>100%</td>
</tr>
<tr>
<td>24</td>
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<td>89%</td>
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</tr>
<tr>
<td>25</td>
<td>Hawaii</td>
<td>17</td>
<td>97%</td>
<td>94%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: OIG analysis of formularies’ inclusion of drugs commonly used by dual eligibles, 2015.

***Region 26, which covers Alaska, had no MA-PDs available for 2015.