Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress

How CBO Estimated the Budgetary Impact of Key Prescription Drug Provisions in the 2022 Reconciliation Act

February 2023

Prescription Drug Provisions Are Part of the 2022 Reconciliation Act

The act, which became Public Law 117-169 in August 2022, contains roughly 150 provisions, including ones that:

- Affect prescription drug prices and coverage under Medicare,
- Expand health insurance subsidies established by the Affordable Care Act,
- Establish a new alternative minimum tax on corporations,
- Provide additional funding for the Internal Revenue Service, and
- Create subsidies for renewable energy.

The Congressional Budget Office estimated that the provisions related to prescription drugs would reduce the deficit by $237 billion from 2022 to 2031. Three key policies discussed in this document are responsible for $129 billion of that reduction.

The rest of the deficit reduction largely results from delaying a rule (commonly known as the safe harbor rule) to restrict the ability of manufacturers and insurers to negotiate rebates for prescription drugs. The estimates in this document reflect that delay.

For additional information on the estimate for the 2022 Reconciliation Act, see Congressional Budget Office, Estimated Budgetary Effects of Public Law 117-169, to Provide for Reconciliation Pursuant to Title II of S. Con. Res. 14 (September 7, 2022), www.cbo.gov/publication/58455. Overall, CBO estimated that the law would decrease the deficit by $58 billion over the 2022–2031 period, excluding any additional revenue resulting from an increased appropriation to the Internal Revenue Service. For additional information on the safe harbor rule, see Congressional Budget Office, "Incorporating the Effects of the Proposed Rule on Safe Harbors for Pharmaceutical Rebates in CBO's Budget Projections" (supplemental material for *Updated Budget Projections: 2019 to 2029*, May 2019), www.cbo.gov/system/files/2019-05/55151-SupplementalMaterial.pdf.

Key Prescription Drug Provisions Establish Price Negotiation and Inflation Rebates—and Redesign Part D Benefits

Medicare covers prescription drugs under two parts of the program. Part B covers drugs administered by a physician or other health care professional—primarily injectable and infused drugs—in addition to doctors' visits, outpatient hospital services, and related care. Part D generally covers prescription drugs purchased at a retail pharmacy.

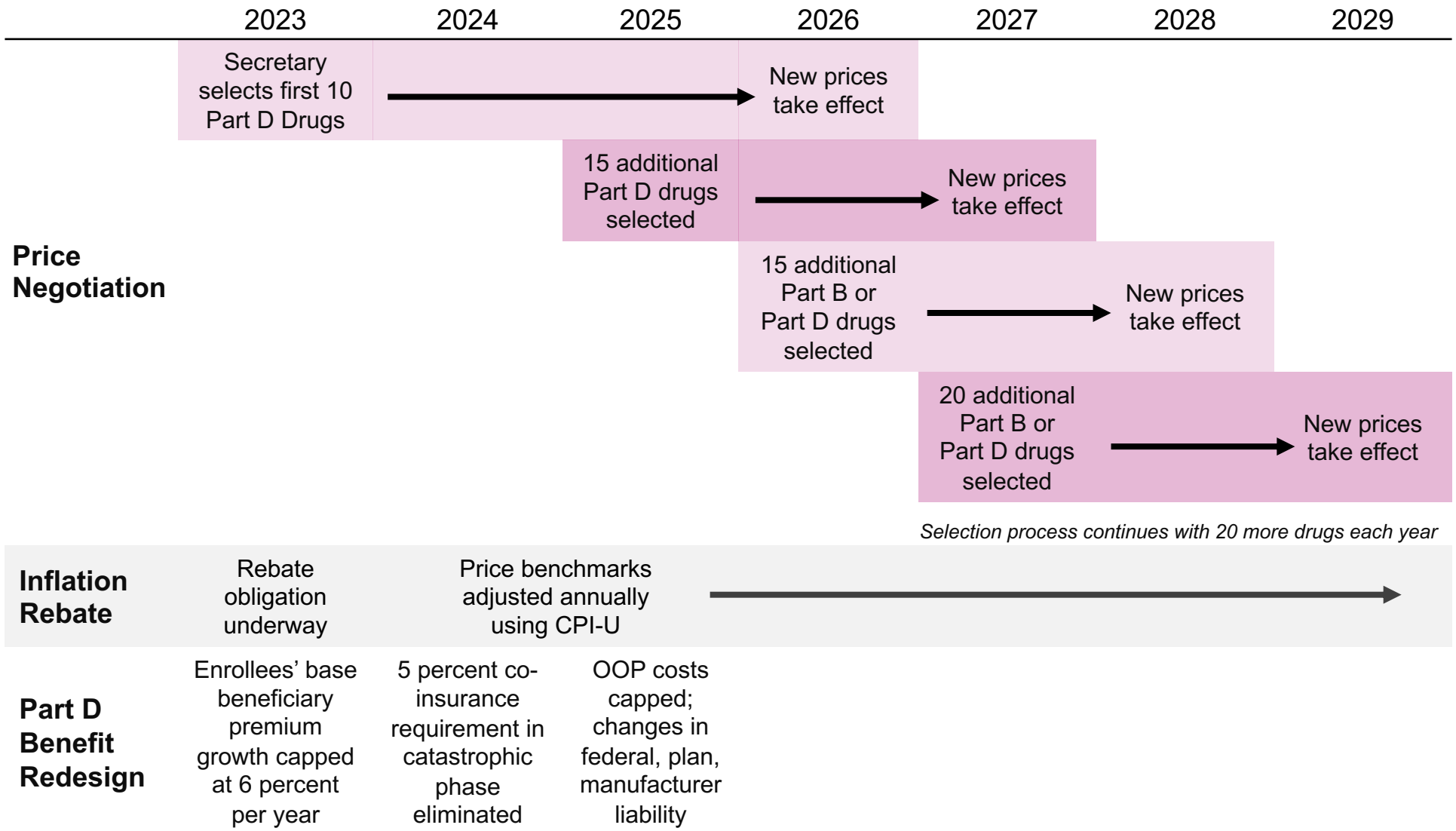
Under the act, the Secretary of Health and Human Services (HHS) will negotiate prices for certain prescription drugs covered under Medicare Part B and Part D.

Manufacturers of drugs covered under Medicare Part B and Part D must pay rebates to Medicare if the prices of brand-name drugs without generic or biosimilar competition exceed an inflation-adjusted benchmark.

The law redesigns the Medicare Part D benefit in numerous ways, including to:

- Cap enrollees' annual out-of-pocket costs and limit their premium increases,
- Reduce Medicare's share of costs beyond the out-of-pocket cap, and
- Require manufacturers to provide new mandatory price discounts.

The Act's Key Prescription Drug Provisions Will Be Phased In Over Time



To be selected for negotiation, a Part D drug must be among the 50 top-selling products without generic or biosimilar competition in Part D. When Part B drugs become eligible in 2026, those selected must be among the top 50 such drugs in Part B. Selected drugs must meet other criteria as well.

A manufacturer's rebate obligation is based on a drug's price in 2021 or its launch year, if launched after 2021.

The cap on OOP costs, set at $2,000 in 2025, increases annually at the rate of growth in Part D costs per capita.

CPI-U = consumer price index for all urban consumers; OOP = out-of-pocket. The inflation rebate obligation for Part D began October 1, 2022; for Part B, it began January 1, 2023.

Three Key Policies Discussed Here Will Reduce the Budget Deficit in 2031 by an Estimated $31 Billion

Price Negotiation: CBO estimated that price negotiation will lower average drug prices paid by Medicare and will reduce the budget deficit by $25 billion in 2031: Part D spending will be $14 billion lower than it would have been, Part B drug spending will be $9 billion lower, and other federal spending will be $1 billion lower on net.

Inflation Rebates: Rebate payments, lower drug prices, and lower health insurance premiums in the commercial market will lower federal spending and increase federal revenues, according to CBO's estimates. Higher prices in Medicaid are expected to offset some of that lowered spending. CBO estimated that, overall, the inflation rebate policy will reduce the federal budget deficit by $8 billion in 2031.

Part D Redesign: Increased federal subsidies, premium stabilization, and increased use of drugs will put upward pressure on the deficit. Other aspects of the benefit redesign will put downward pressure on the deficit. On net, the deficit is estimated to rise by $2 billion in 2031 because of the redesign.

Components do not sum to totals because of rounding. To estimate the incremental effects of each of the key drug provisions discussed in this document, CBO analyzed the three policies in the following sequence: (1) negotiation, (2) inflation rebate, and (3) Part D redesign. CBO estimated the inflation rebate effect relative to a policy scenario that includes negotiation, and estimated the Part D redesign effect relative to a scenario that includes both negotiation and the inflation rebate. All those provisions were estimated relative to a policy scenario that includes the effects of delaying the safe harbor rule.

How the Price Negotiation Provisions Will Affect Medicare's Prices and the Deficit

Before the Reconciliation Act, Drug Prices Were Determined by Statutory Formula in Part B and Private Negotiations in Part D

Prices for drugs have been determined through different mechanisms under Medicare Parts B and D:

- In Part B, prices were determined by a statutory formula. In most cases, Medicare pays providers a drug's average sales price (ASP) plus 6 percent.
- In Part D, prices were determined through negotiations between manufacturers and insurers or their pharmacy benefit managers.

The Secretary was prohibited from interfering or participating in pricing or formulary negotiations between manufacturers and drug plans that deliver the Part D benefit. In CBO's assessment, removing that prohibition without providing the Secretary with additional tools or leverage would not have significantly reduced drug prices or federal spending.

ASP is defined in the Medicare Part B program as the manufacturer's average price paid by all nonfederal purchasers in the United States. It includes all volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under the Medicaid drug rebate program). As described here, the Part B payment formula does not reflect the effects of sequestration arising from the Budget Control Act of 2011, which lowers the effective payment rate to ASP plus 4.3 percent.

For a discussion of the effects of drug price negotiation in Medicare, see Congressional Budget Office, letter to the Honorable Chuck Grassley on negotiation over drug prices in Medicare (May 17, 2019), www.cbo.gov/publication/55270.

The Reconciliation Act Requires the Secretary to Select Part B and Part D Drugs for Price Negotiation

The Secretary must select drugs with the largest expenditures in Medicare Part B or Part D according to the following schedule:

- 10 from Part D in 2023,
- 15 from Part D in 2025,
- 15 from either Part B or Part D (or from both) in 2026, and
- 20 from either Part B or Part D (or from both) in 2027 and later.

Selected drugs must have been on the market for at least:

- 7 years for small-molecule drugs (which are chemically synthesized drugs), or
- 11 years for biologics (which are drugs produced from living organisms).

Drugs cannot be selected if they face competition from one or more approved generic equivalents or biosimilars or if they are not among the 50 drugs with the largest expenditures in Medicare Part B or Part D.

Certain categories of drugs are excluded from selection for price negotiation, including all plasma-derived products, certain orphan drugs, and certain drugs that account for a small share of Medicare spending but a large share of the manufacturers' Medicare revenues. Total expenditures on a drug include spending by all payers and are measured at retail prices (in Part D) or at Medicare's payment rate (in Part B).

Provisions in the Act Set an Upper Limit on Negotiated Prices

Prices determined through negotiations cannot exceed the lower of two values:

- The drug's previous average price in Medicare, or
- A specified percentage of the drug's previous nonfederal average manufacturer price.

For Part B drugs, the previous average price is the average sales price (ASP) in the prior year.

For Part D drugs, the previous average price is the average net price—that is, the price adjusted for any rebates or discounts from the manufacturer—across all Part D plans in the most recent year for which data are available.

Negotiated prices for both Part B and Part D drugs are capped at between 40 percent and 75 percent of the previous nonfederal average manufacturer price, depending on how long the drug has been on the market.

The nonfederal average manufacturer price is the average price paid to manufacturers by wholesalers for drugs distributed to nonfederal purchasers, reflecting discounts. See the glossary of terms in Congressional Budget Office, *A Comparison of Brand-Name Drug Prices Among Selected Federal Programs* (February 2021), www.cbo.gov/publication/56978.
For a small number of drugs, negotiated prices are also constrained by a lower limit equal to 66 percent of the nonfederal average manufacturer price.

The Act Specifies Rules for the Negotiations

In negotiating the price of a drug, the Secretary must consider whether the condition the drug targets can be treated with alternative therapies, how much the drug costs to produce, the costs of research and development (including any federal support), and other factors.

Prices emerging from negotiations take effect beginning the second year after selection, except for the first cohort selected in 2023, whose prices take effect in 2026. Prices are adjusted annually based on the consumer price index for all urban consumers.

Manufacturers that do not comply with the negotiation process must either:

- Withdraw all their drug products from the Medicare and Medicaid programs, or
- Pay an excise tax initially equal to 65 percent of a product's U.S. sales and increasing to a maximum of 95 percent. The combination of that excise tax and corporate income taxes could exceed a manufacturer's profits from that product.

CBO Expects Negotiated Prices to Be Less Than the Upper Limit

CBO expects that drug manufacturers will comply with the negotiation process because the costs of not doing so are greater than the revenue loss from lower, negotiated prices.

Based on the predictions of its bargaining model, CBO expects the Secretary's leverage in negotiations to be sufficient to attain prices below the upper limit established in the act in some cases.

CBO estimates that net prices for selected drugs will decrease by roughly 50 percent, on average, as a result of negotiation. Because those drugs are projected to account for less than one-fifth of total spending net of discounts and rebates in 2031, the estimated overall reduction in net prices in Medicare will be much smaller than 50 percent.

For information about CBO's bargaining model for negotiation, see Christopher Adams and Evan Herrnstadt, *CBO's Model of Drug Price Negotiations Under the Elijah E. Cummings Lower Drug Costs Now Act*, Working Paper 2021-01 (Congressional Budget Office, February 2021), www.cbo.gov/publication/56905.

Negotiation is Expected to Lower Average Drug Prices and Reduce the Deficit

CBO estimated that average drug prices in 2031 will be 9 percent lower in Part B and 8 percent lower in Part D (net of rebates and discounts) because of negotiation. Lower drug prices will put downward pressure on federal spending on drugs in both programs.

With lower drug prices, Medicare enrollees, who pay a portion of drug costs, will probably use more prescription drugs, putting upward pressure on federal Medicare spending. At the same time, they will probably use fewer medical services covered under Medicare Parts A and B, lowering federal spending.

CBO estimated that negotiation will reduce the deficit by $25 billion in 2031 through the following effects:

- Part D spending will be $14 billion lower than it would have been,
- Part B drug spending will be $9 billion lower, and
- Other federal spending will be $1 billion lower on net.

Components do not sum to totals because of rounding. For a discussion of how changes in prescription drug consumption affect use of medical services and health care spending, see Congressional Budget Office, *Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services* (November 2012), www.cbo.gov/publication/43741.

How the Inflation Rebate Provisions Will Affect Drug Prices and the Deficit

Some Manufacturers Could Avoid Owing an Inflation Rebate and Maintain Net Prices by Adjusting Rebates They Pay to Part D Plans

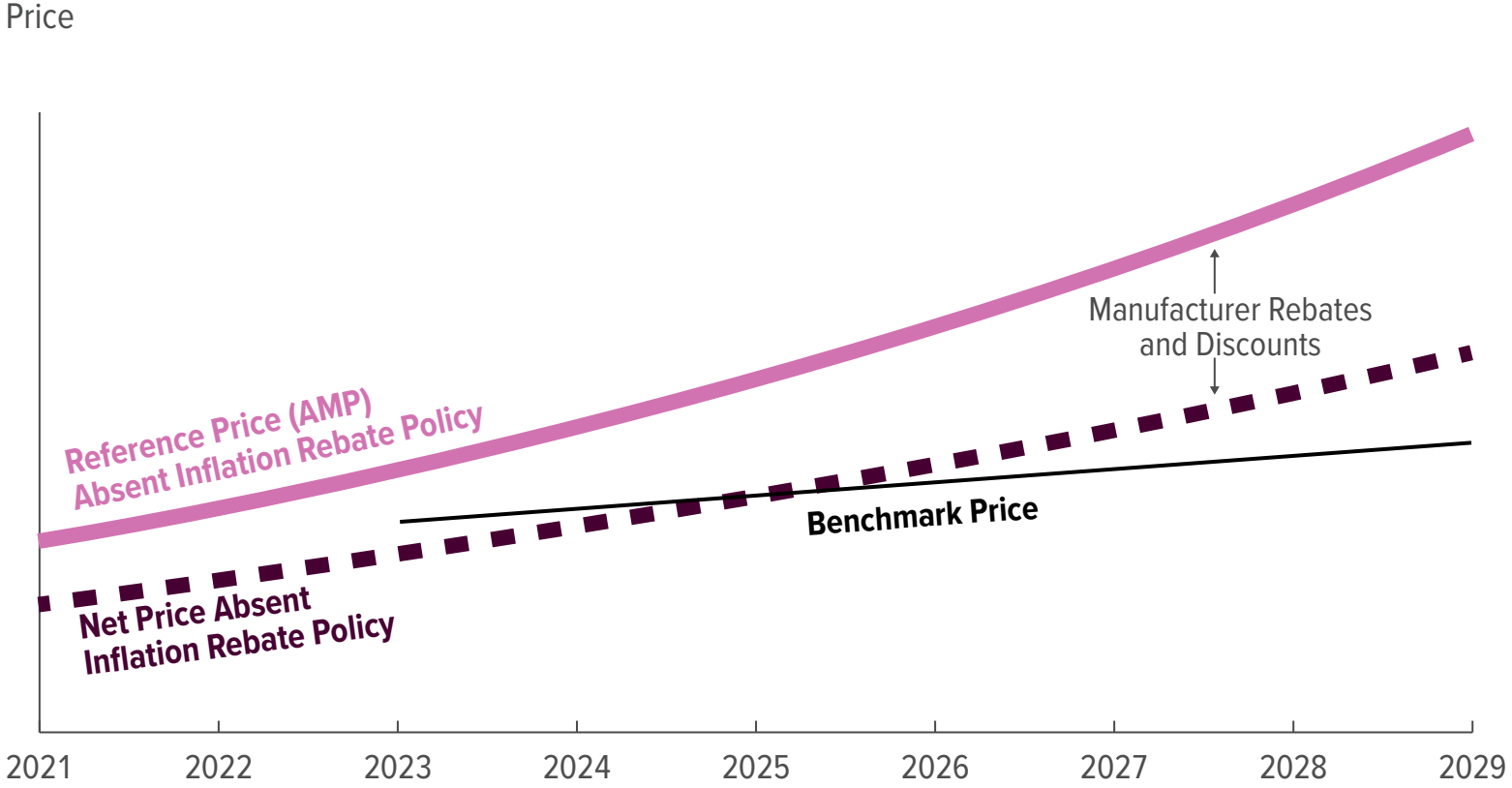
Under the act, if the reference price of a drug covered by Part B or Part D exceeds its inflation-adjusted benchmark in any given year, manufacturers must pay an inflation rebate for each unit sold to a Medicare beneficiary.

For Part D drugs, the reference price is the average manufacturer price (AMP), which is often higher than the net price because it does not reflect negotiated rebates that manufacturers pay to Part D plans. A drug's AMP is typically close to its retail price, which is the price paid to the pharmacy. For Part B drugs, the reference price is the ASP, which does reflect rebates. Because of that difference, CBO expects that manufacturers will respond to the policy for Part D drugs differently than for Part B drugs.

In Part D, the gap between the reference and net prices means that manufacturers could avoid paying the inflation rebate without reducing net prices, which determine federal insurance subsidies and manufacturers' profits. If the rebates they have been paying are large enough, manufacturers can, at least initially, reduce rebates so that the reference price remains below the benchmark without affecting net prices.

The AMP is the average price paid to a manufacturer for a drug distributed to retail pharmacies, either through wholesalers or through sales directly from manufacturers to pharmacies (not including prices for drugs dispensed primarily through the mail). Neither the AMP nor the retail price reflect rebates or other price concessions manufacturers extend to insurers.

Without the Inflation Rebate Policy, Both Reference and Net Prices of Brand-Name Part D Drugs Typically Rise Faster Than Inflation

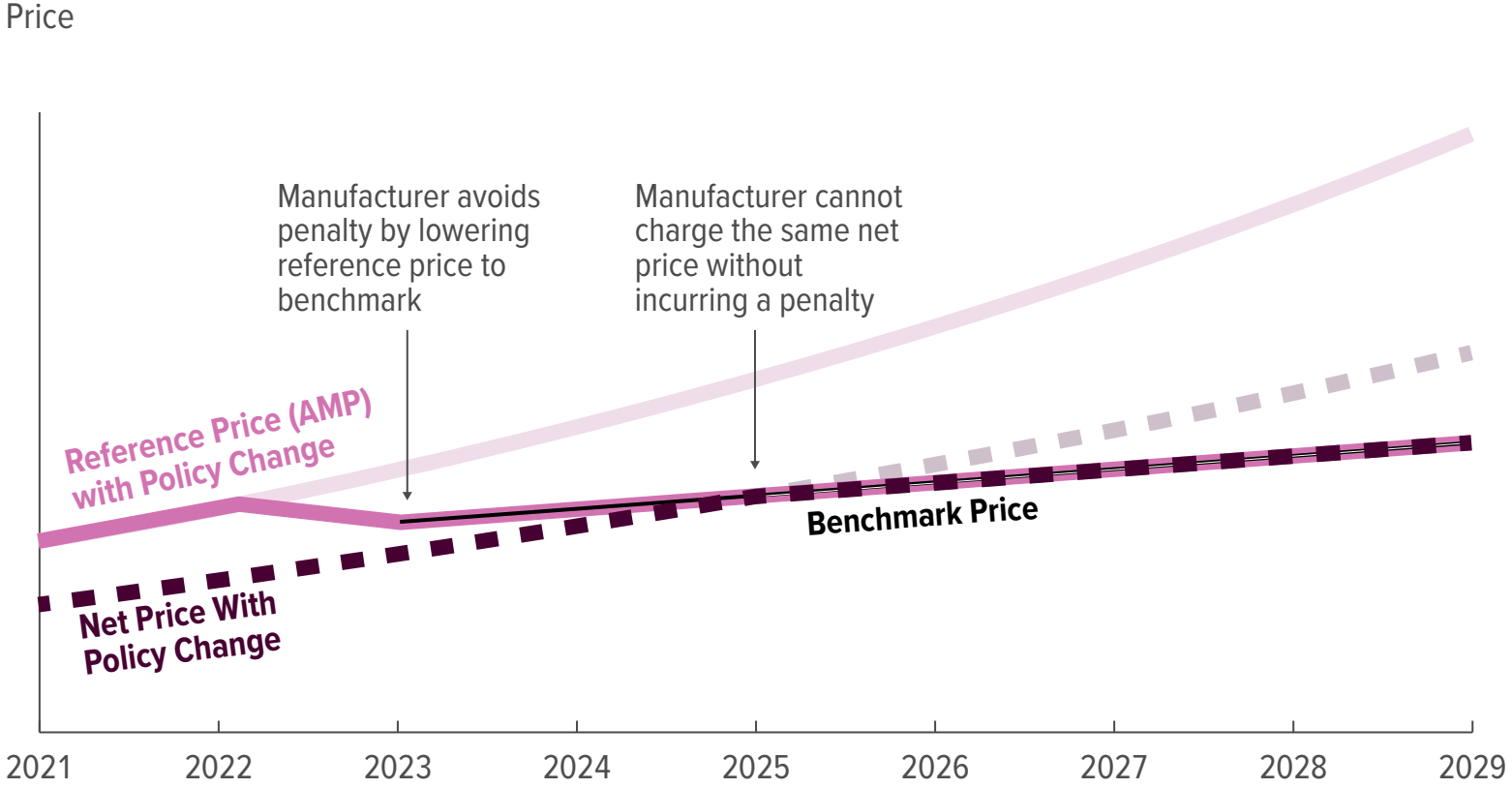


This illustrative figure compares prices of a hypothetical drug covered by Medicare Part D without the inflation rebate policy with the benchmark price set by the policy. The benchmark is based on the drug's 2021 price and is adjusted for inflation using the CPI-U in later years.

Starting in 2023, the manufacturer owes a penalty if the reference price exceeds the benchmark.

AMP = average manufacturer price; CPI-U = consumer price index for all urban consumers.

Under Inflation Rebate Provisions, CBO Expects Lower Reference Prices for Many Drugs and Lower Net Prices for Some Drugs

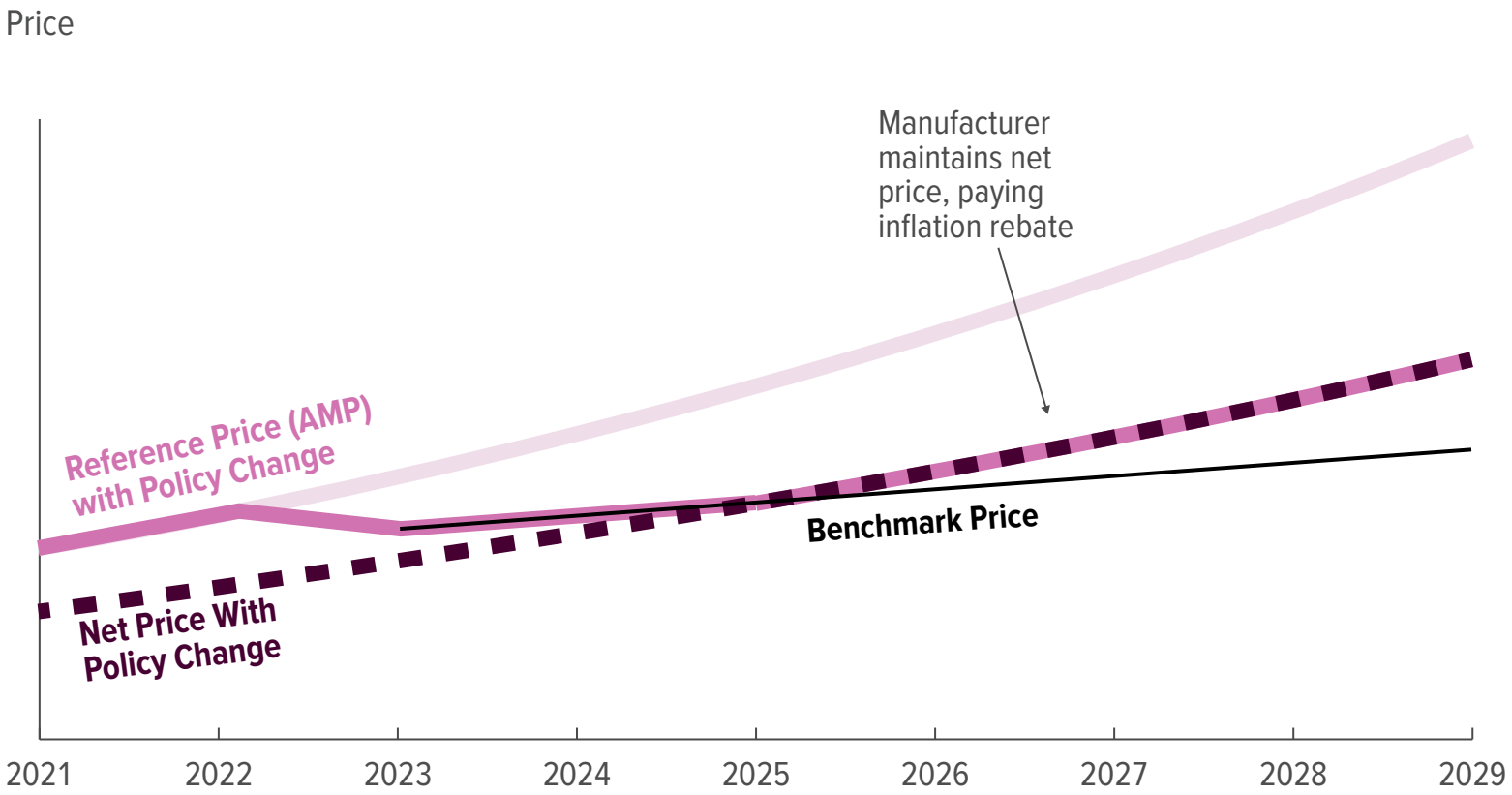


When the policy takes effect, the drug's reference price falls to avoid a penalty, but the net price is unaffected if the manufacturer can reduce rebates and discounts.

In this example, the manufacturer later chooses to constrain reference and net prices to avoid penalties. As a result, the drug's net price is lower in Medicare and commercial sectors after 2025.

The figure displays prices of a hypothetical drug to convey how a manufacturer's response to the inflation rebate policy could lead to lower net prices for a drug. The manufacturer cannot directly set the reference price of a drug but can exert considerable influence on it by changing the prices at which it sells the drug to wholesalers and pharmacies.

CBO Expects That Other Manufacturers Will Pay Inflation Rebate to Avoid Constraining Net Prices



As in the previous example, the manufacturer initially lowers the drug's reference price to the benchmark until depleting rebates and discounts.

In this case, the manufacturer then raises prices above the benchmark to avoid constraining the net price. The manufacturer then owes an inflation rebate penalty on units sold in Medicare.

The figure displays prices of a hypothetical drug to convey how a manufacturer's response to the inflation rebate policy could lead to inflation rebates paid to Medicare. The manufacturer cannot directly set the reference price of a drug but can exert considerable influence on it by changing the prices at which it sells the drug to wholesalers and pharmacies.

CBO Projects that Retail Prices and Manufacturer Rebates Will Be Lower for Part D Drugs on the Market in 2022 and Higher for New Drugs Under the Inflation Rebate Provisions

For drugs on the market in 2022, as illustrated in the previous two charts, the inflation rebate policy tends to lower reference prices and manufacturer rebates in Part D. CBO expects that net prices will decrease for some of those drugs in both Part D and commercial markets.

For drugs brought to the market in 2023 or later, CBO expects that manufacturers will set higher initial prices to allow for slower price growth over time and that they will rebate a portion of those higher launch prices back to Part D plans to remain competitive and maintain their preferred net prices.

Changes in prices and rebates affect enrollees' spending. CBO estimates that retail prices and manufacturer rebates in Part D overall will be lower between 2023 and 2031, which will:

- Reduce payments that decrease when retail prices are lower, such as cost-sharing amounts paid by enrollees; and
- Raise payments that increase when manufacturers' rebates are lower, such as premiums paid by enrollees in Part D.

For more details, see Congressional Budget Office, *Additional Information About Prescription Drug Legislation* (August 2022), www.cbo.gov/publication/58355.

CBO Expects That the Inflation Rebate Policy Will Reduce Medicare Drug Prices

CBO estimates that average net drug prices in Part B and Part D will both be 2 percent lower in 2031 than they would have been without the inflation rebate provisions.

In Part D, that overall price decline will largely be driven by brand-name drugs whose prices have not been negotiated and that were already on the market by 2022. CBO projects that, by 2031, those drugs will account for about one-third of Part D spending.

Overall, CBO estimates that average net prices of that set of Part D drugs will be about 6 percent lower in 2031 than they would have been without the inflation rebate policy. Although the AMP for those drugs will need to be about 40 percent lower to avoid triggering inflation rebate penalties, manufacturers will offset most of those reductions by reducing rebates paid to Part D plans, the agency estimates.

CBO Expects the Inflation Rebate Policy to Affect the Deficit Through Several Channels

Price reductions and the inflation rebate payments to the federal government are expected to reduce the budget deficit.

As with the negotiation provision, lower prices under the rebate provision tend to lower drug costs for Medicare enrollees. CBO expects Medicare enrollees to respond by increasing their use of, and spending on, prescription drugs. Spending on other Medicare-covered services will decline as a result.

CBO projects that commercial drug prices, and therefore health insurance premiums, will be lower than they would have been absent the policy. Lower premiums tend to shift some of employees' compensation from nontaxable health insurance to taxable wages, increasing tax revenues.

CBO estimates that net prices for drugs covered by Medicaid will increase because of smaller rebates under Medicaid's statutory drug rebate formula and higher prices for newly launched drugs (see next slide).

Lower drug prices and health insurance premiums tend to reduce spending on other federal health care programs such as the Federal Employees Health Benefits Program.

CBO Projects That the Inflation Rebate Policy Will Increase Medicaid Spending

Drug manufacturers already pay rebates on prescription drugs covered by Medicaid. The rebate amount per unit in Medicaid, set by a statutory formula, is the sum of:

- The Basic Rebate (the greater of 23.1 percent of AMP or the difference between AMP and the Best Price), and
- The inflation-based rebate (the growth in AMP in excess of growth in the CPI-U).

Reductions in AMP therefore reduce both components of Medicaid's rebate. To the extent that the new *Medicare* inflation rebates reduce prices for drugs already on the market, net *Medicaid* spending will rise because the reduction in retail prices will be more than offset by reductions in *Medicaid* rebates collected.

Net Medicaid spending is also expected to rise for some drugs launched in 2023 or later as manufacturers respond to the new Medicare provisions by setting higher launch prices for those drugs.

A drug's Best Price is the lowest price available to any purchaser excluding participating Part D plans and certain government entities. It reflects discounts, rebates, and other pricing adjustments, and is used to calculate a manufacturer's rebate to the Medicaid program.

CBO Projects That, on Net, the Inflation Rebate Policy Will Lower the Deficit

Rebate payments, lower drug prices, and lower health insurance premiums in the commercial market will lower federal spending and increase federal revenues, according to CBO's estimates.

Higher prices in Medicaid are expected to offset some of that lowered spending.

CBO estimates that, overall, the inflation rebate policy will reduce the federal budget deficit by $8 billion in 2031 through the following effects:

- Part D spending will be $7 billion lower and Part B spending will be $3 billion lower than spending would have been without the policy.
- Lower commercial health insurance premiums will increase revenues and reduce spending by a combined $2 billion.
- Higher Medicaid spending and, to a lesser extent, higher spending by the Department of Defense will increase the deficit by $4 billion.

How the Redesign of the Part D Benefit Will Affect Medicare's Prices and the Deficit

Before Redesign, the Standard Part D Benefit Had Four Coverage Phases

Deductible and initial coverage phases

- In the first phase, enrollees paid 100 percent of their drug costs up to the deductible set by statute.
- When enrollees' spending exceeded the deductible, enrollees entered the initial coverage phase and paid 25 percent of costs and their Part D plan paid 75 percent.

Coverage gap phase (for enrollees who did not receive the low-income subsidy)

- Enrollees whose total spending (by themselves and on their behalf by all payers) exceeded the initial coverage limit set by statute continued to pay 25 percent of drug costs; plans and manufacturers combined to pay the remainder.
- For brand-name drugs, the manufacturer provided a mandatory discount of 70 percent, and the Part D plan paid 5 percent.
- For generic drugs, the Part D plan paid 75 percent.

Catastrophic phase

- Enrollees whose out-of-pocket costs (including discounts received) exceeded the catastrophic threshold set by statute paid 5 percent of drug costs.
- Part D plans paid 15 percent and the federal government's share of drug costs (referred to as reinsurance) was 80 percent.

For a description of the Part D benefit design prior to enactment of the law and how it interacted with the incentives of market participants, see Congressional Budget Office, "Paying for Drugs in Medicare Part D Under Current Law and Under Proposals to Redesign the Program" (November 2021), www.cbo.gov/publication/57461.

Part D Redesign Eliminates the Coverage Gap and Places Greater Liability for Part D Spending on Plans

The deductible phase of the benefit remains the same.

Enrollees entering the initial coverage phase still pay 25 percent of drug costs. But, starting in 2025, the plans' share falls to 65 percent of costs for brand-name drugs (other than those subject to negotiation), and the manufacturers provide a discount of 10 percent of total costs.

The coverage gap phase is eliminated.

The catastrophic phase starts when enrollees' out-of-pocket costs reach $2,000 and in this phase enrollees pay nothing:

- The federal government's share of drug costs falls from 80 percent to either 20 percent (for brand-name drugs) or to 40 percent (for generics).
- Manufacturers provide discounts of 20 percent for brand-name drugs, except drugs whose prices have been negotiated with the Secretary.
- Part D plans' share of drug costs increases from 15 percent to 60 percent.

The elimination of the 5 percent co-insurance requirement in the catastrophic phase occurs in 2024. Enrollees' out-of-pocket costs are capped at $2,000 per year beginning in 2025; that cap is adjusted annually thereafter at the projected rate of growth in Part D costs per enrollee.

Premium Stabilization Limits Premium Growth From 2024 to 2029 and Permanently Lowers Premiums in Subsequent Years

Part D premiums are determined in part by a policy benchmark known as the base beneficiary premium, which is based on expected average benefit costs for all Part D enrollees. Although premiums that enrollees pay vary by plan, they tend to increase when the base beneficiary premium rises.

Under the new premium stabilization policy for Part D, growth in the base beneficiary premium is capped at 6 percent per year from 2024 through 2029. Although CBO expects that cap to slow premium growth on average, during those years some enrollees could still experience annual premium growth greater than 6 percent depending on their plan choices.

In 2030, the Secretary is required to permanently adjust the formula for the base beneficiary premium if its level in 2030 would otherwise be more than 6 percent higher than in 2029.

For additional information about how CBO analyzed the effects of the premium stabilization mechanism, see Congressional Budget Office, letter to the Honorable Jason Smith providing additional information about prescription drug legislation (August 4, 2022), https://www.cbo.gov/publication/58355.

Eliminating the Coverage Gap Changes How Costs for Low-Income Enrollees Are Covered

In Part D, enrollees whose incomes and assets fall below specified thresholds are eligible for the low-income subsidy. That subsidy consists of two parts: a premium subsidy and a cost-sharing subsidy.

Under the previous standard benefit, the coverage gap phase for low-income enrollees differed from that for enrollees who did not receive the subsidy. For low-income enrollees in the coverage gap phase, all drug costs were assigned to the enrollee and were largely covered by the cost-sharing subsidy.

Under the Part D redesign, low-income enrollees have the same standard benefit as other enrollees, and the coverage gap is eliminated. As a result, the share of costs assigned to the enrollee and covered by the federal government decreases, while the shares covered by plans and manufacturers increase.

CBO Projects That Certain Elements of Part D Redesign Will Reduce the Deficit

Reallocated Part D spending and reduced spending on Parts A and B are expected to put downward pressure on the deficit:

- The federal contribution to the cost-sharing subsidy and to spending in the catastrophic phase will decrease.
- Manufacturers will bear a greater share of total Part D costs through statutory discounts, which reduces subsidies from the federal government.
- Plans will have a stronger incentive to control costs because they will be responsible for a greater percentage of costs.
- Lower out-of-pocket costs for enrollees will lead to greater use of Part D drugs, which will reduce spending in Medicare Part A and Part B.

Other Elements of Part D Redesign Will More Than Offset the Reductions, Leading to an Overall Deficit Increase, CBO Estimates

Increased federal subsidies, premium stabilization, and increased use of drugs put upward pressure on the deficit:

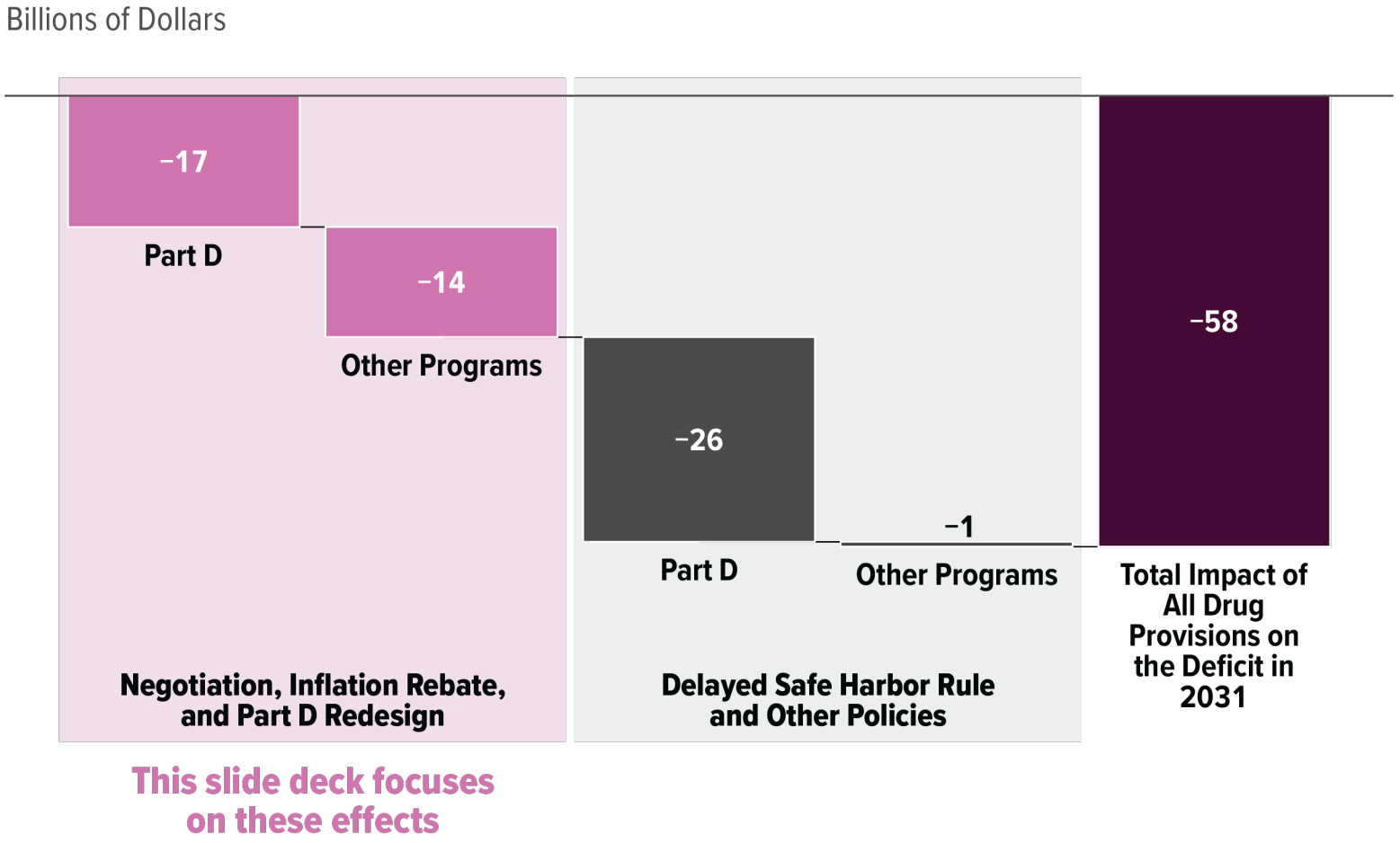
- Federal subsidies to Part D plans will rise as plans face greater liability for drug costs.
- The premium stabilization mechanism will increase federal spending.
- Part D enrollees will use more drugs because their out-of-pocket costs will be lower.

CBO projects an overall increase in the federal budget deficit of $2 billion in 2031:

- Part D spending will increase by $4 billion.
- Part A and Part B spending will decrease by $2 billion because of increased use of prescription drugs.

How the Combined Effects of Negotiation, Inflation Rebates, and Part D Redesign Will Affect the Federal Budget

CBO Estimates That Drug-Related Provisions Combined Will Reduce the Deficit by $58 Billion in 2031

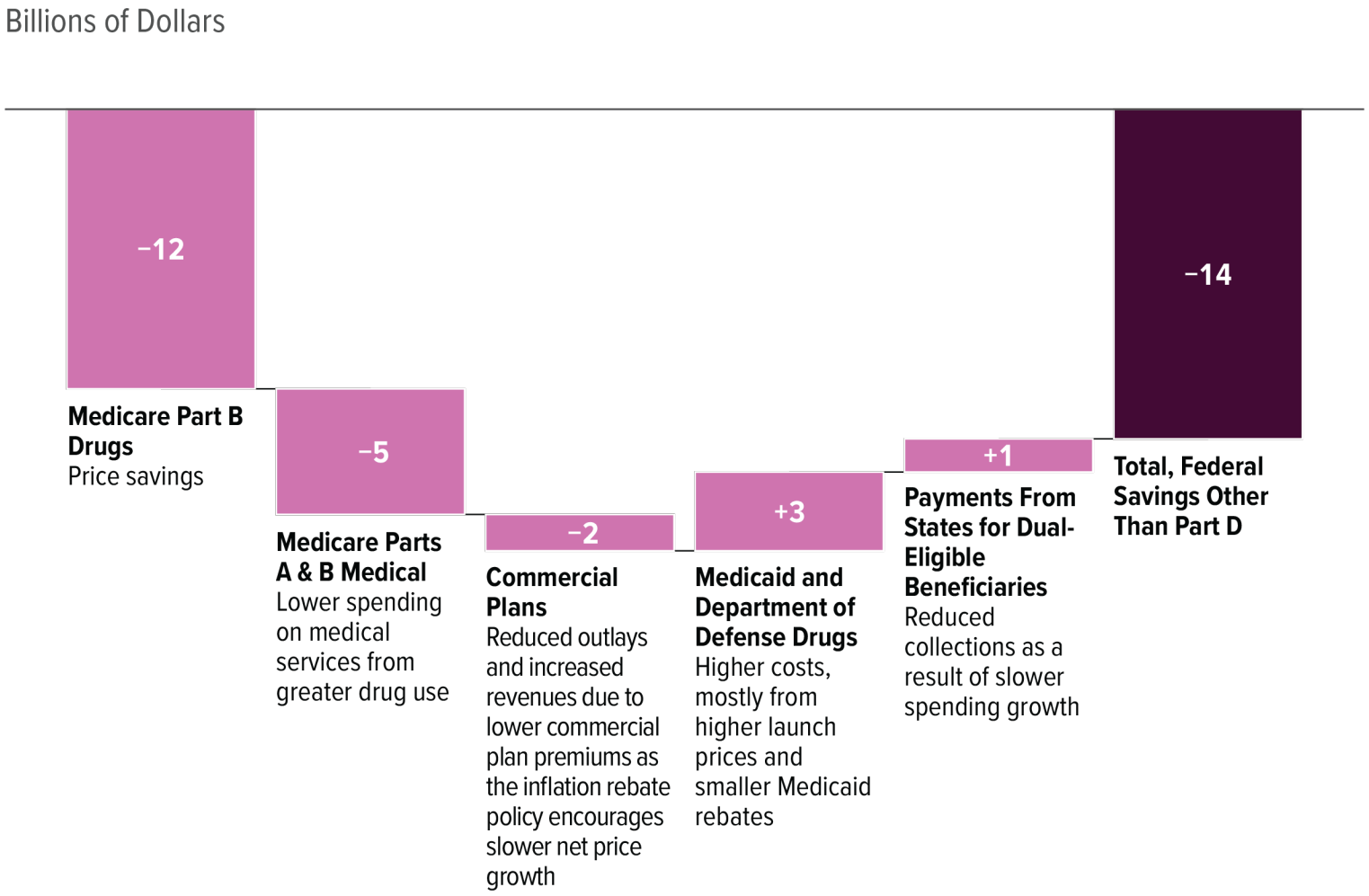


Taken together, all drug-related provisions in the 2022 Reconciliation Act will reduce the federal deficit by an estimated **$58 billion** in fiscal year 2031.

About half ($31 billion) of that reduction is attributable to the negotiation, inflation rebate, and Part D redesign provisions discussed in this slide deck, including **$17 billion** in Part D and **$14 billion** in other programs.

Nearly all of the remaining $27 billion is accounted for by reduced Part D spending from delaying implementation of the safe harbor rule.

$14 Billion of the Deficit Reduction from the Three Key Drug Policies Comes From Outside of Part D



The **$14 billion** in other federal savings expected from the three key policies in 2031 are mostly driven by **$12 billion** in savings on Medicare Part B drugs. That includes $9 billion from the negotiation policy and $3 billion from the inflation rebate policy.

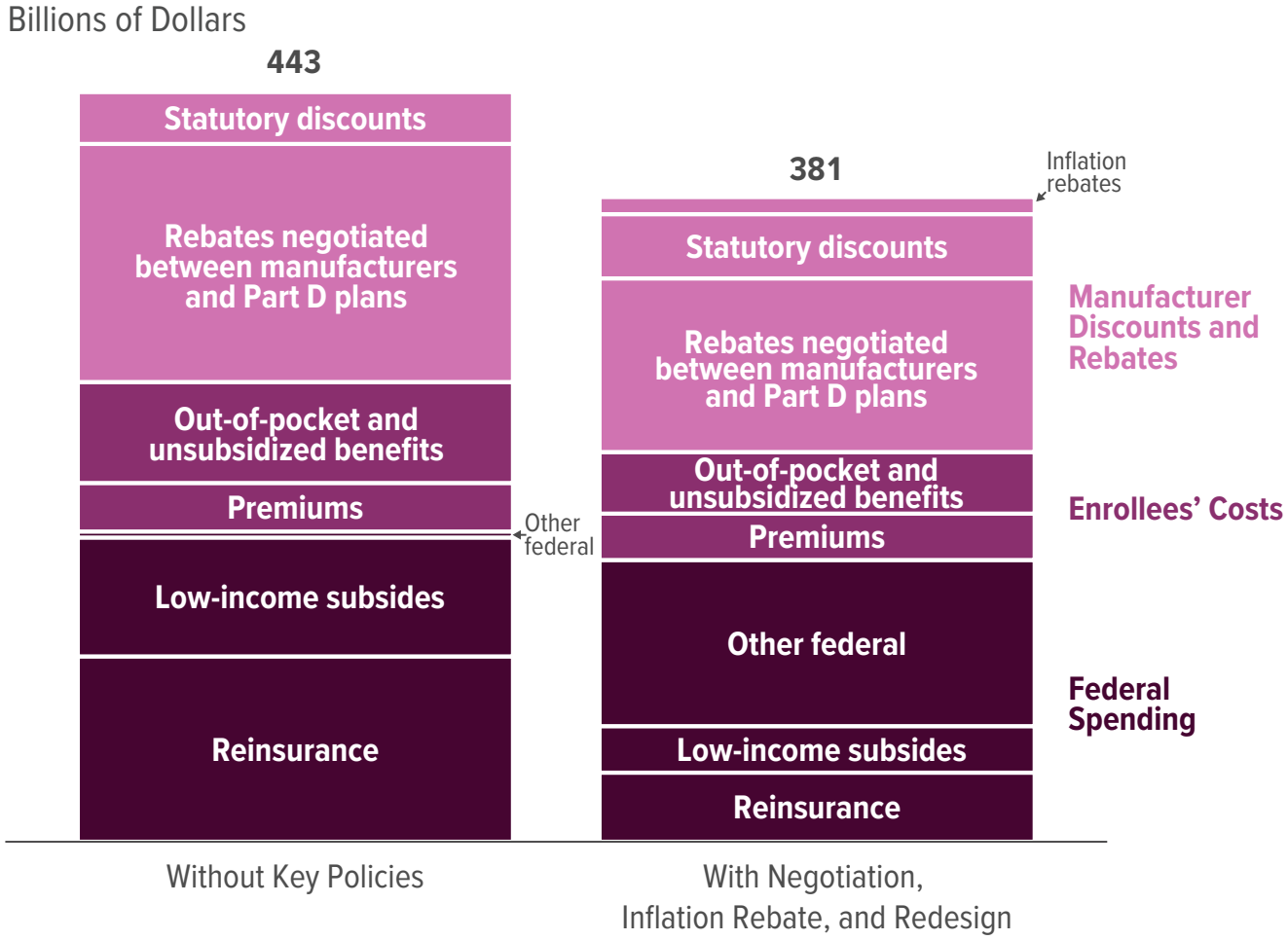
CBO estimates that spending on medical services covered under Medicare Parts A and B will decrease by **$5 billion** as a result of increased use of prescription drugs.

Lastly, changes in overall drug spending growth will increase tax revenues and interact with other federal programs. Taken together, those effects will increase the deficit by $3 billion. (Components do not sum to the total because of rounding.)

Dual-eligible beneficiaries are people who are enrolled in both Medicare and Medicaid.

How the Combined Effects of Negotiation, Inflation Rebates, and Part D Redesign Will Affect Spending by All Payers in Medicare Part D

CBO Projects That the Three Key Drug Policies Will Lower Total Part D Spending by $62 Billion in 2031



Total Part D drug spending at retail prices is projected to decrease by $62 billion (14 percent) in 2031, from **$443 billion** to **$381 billion**, because of price reductions for negotiated drugs and slower price growth from the inflation rebate policy.

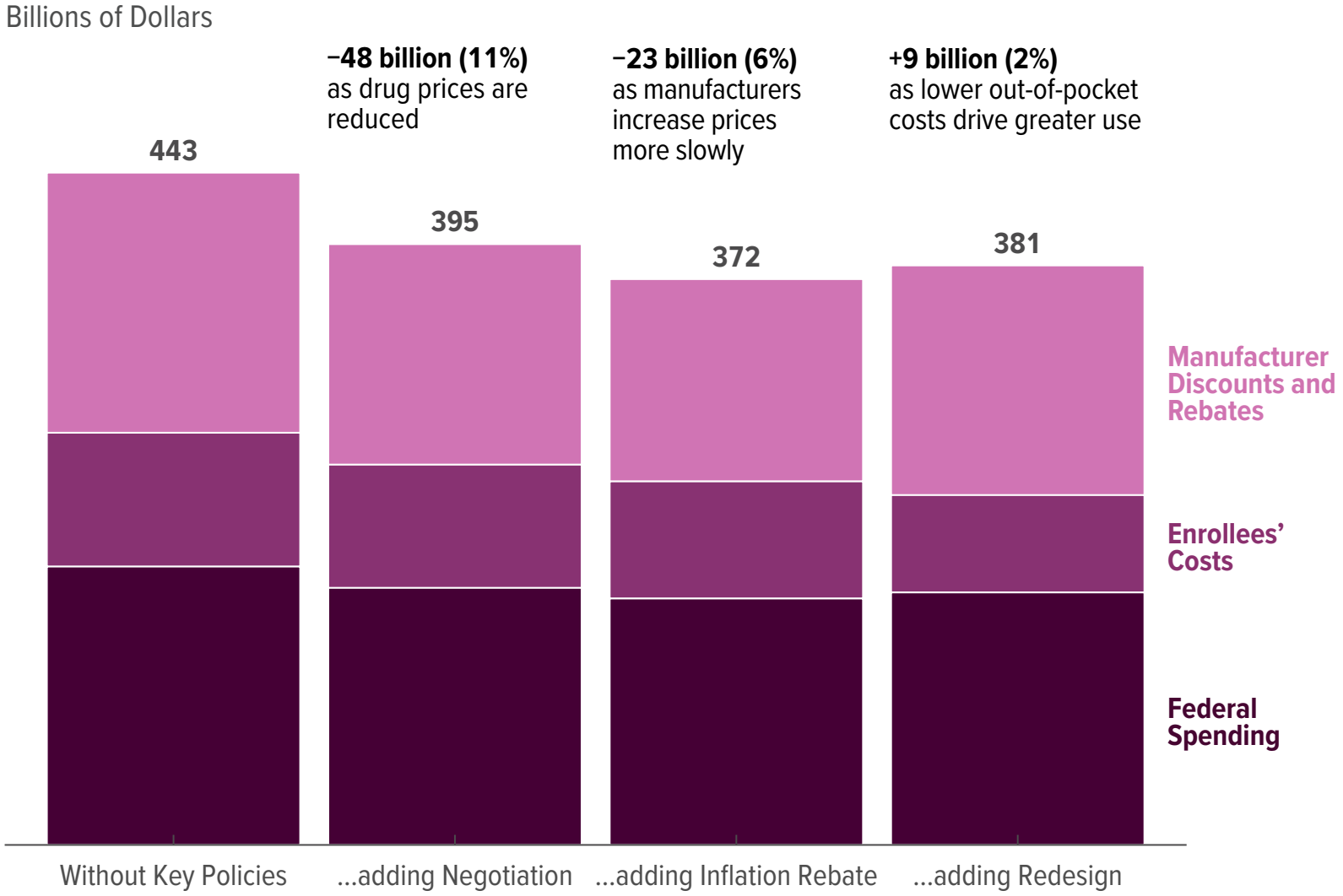
Total Part D drug spending net of manufacturer discounts and rebates, which consists of enrollees' costs plus federal spending, is projected to decrease by $42 billion (15 percent), from $272 billion to $230 billion. Factors behind that decline include price reductions, slower price growth, and increased statutory discounts included in the Part D redesign.

Federal spending, net of premiums and inflation rebate receipts, accounts for $17 billion of that decrease. It is projected to decrease by 9 percent, from $183 billion to $166 billion. The percentage decline in federal spending is less than the percentage decline in overall drug spending because some of the decline in drug spending reduces enrollees' cost sharing.

Low-income subsidies and reinsurance together are projected to decline from 98 percent to 41 percent of federal spending.

The "Without Key Policies" scenario reflects the delay of the safe harbor rule. "Other federal" includes the direct subsidy to Part D plans, subsidies to employers that provide drug coverage to Medicare enrollees, and new subsidies created by the Part D redesign.

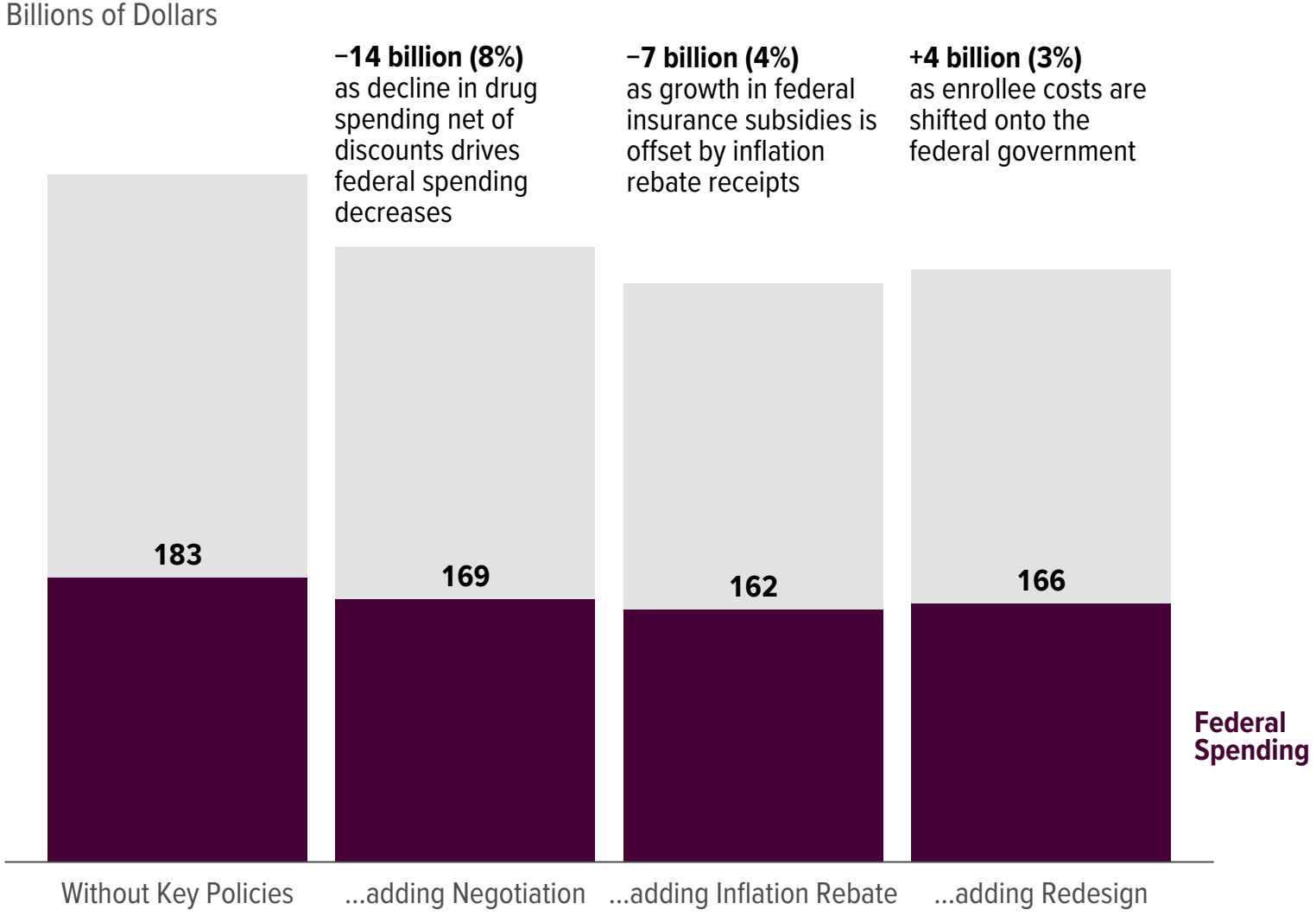
How Each of the Key Drug Policies Contributes to an Estimated $62 Billion Decline in Total Part D Spending



Responsible for an estimated **$48 billion** decrease in drug spending, the negotiation policy accounts for most of the overall $62 billion decrease in drug spending in 2031.

"Total Part D spending" is spending on Part D drugs at retail prices. The "Without Key Policies" scenario reflects the delay of the safe harbor rule.

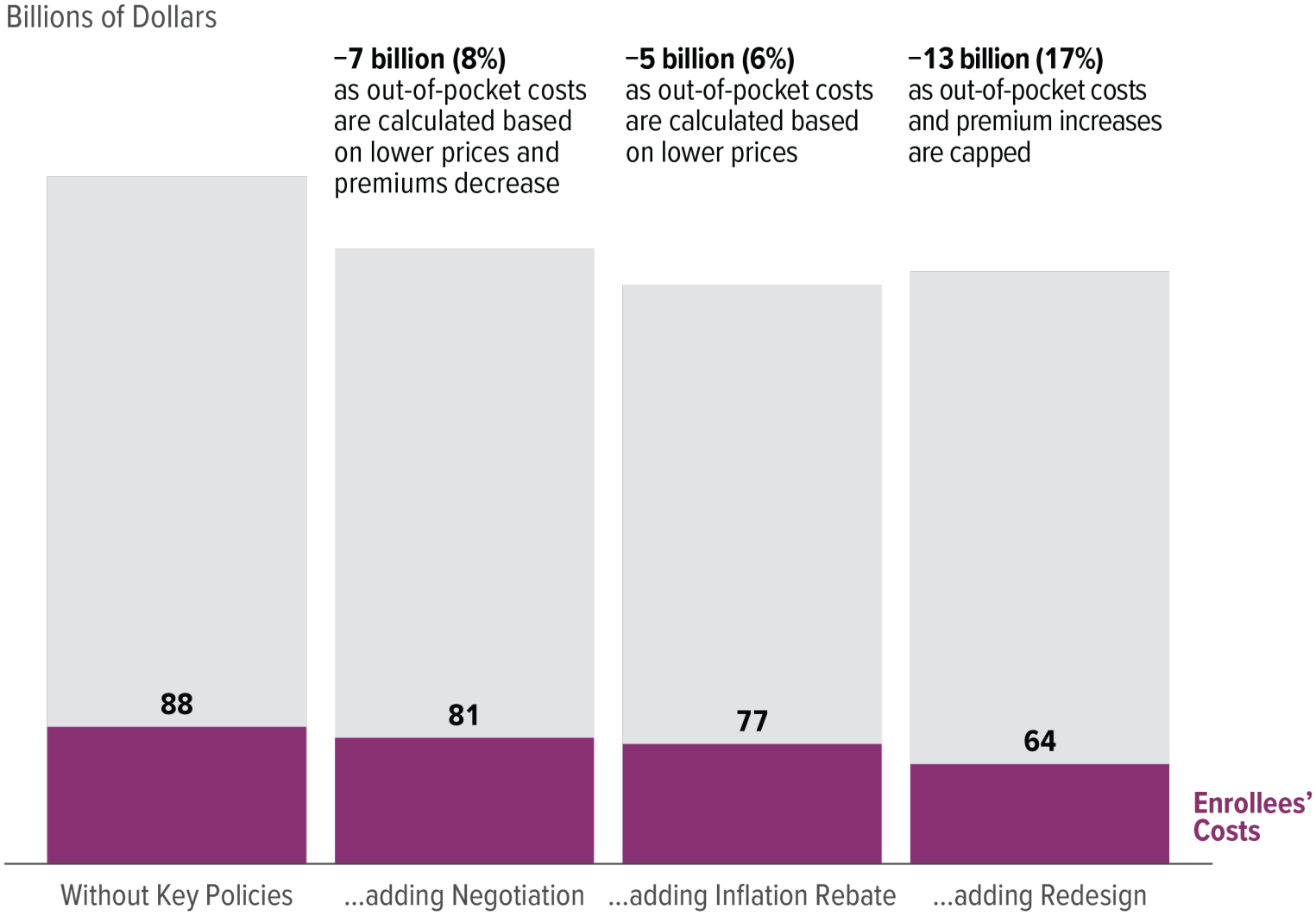
How Each of the Key Drug Policies Contributes to an Estimated $17 Billion Decline in Federal Part D Spending



By lowering federal spending from **$183 billion** to **$169 billion**, the negotiation policy drives most of the $17 billion decrease in federal spending in 2031.

The “Without Key Policies” scenario reflects the delay of the safe harbor rule. “Federal spending” is drug spending at retail prices. Components do not sum to totals because of rounding.

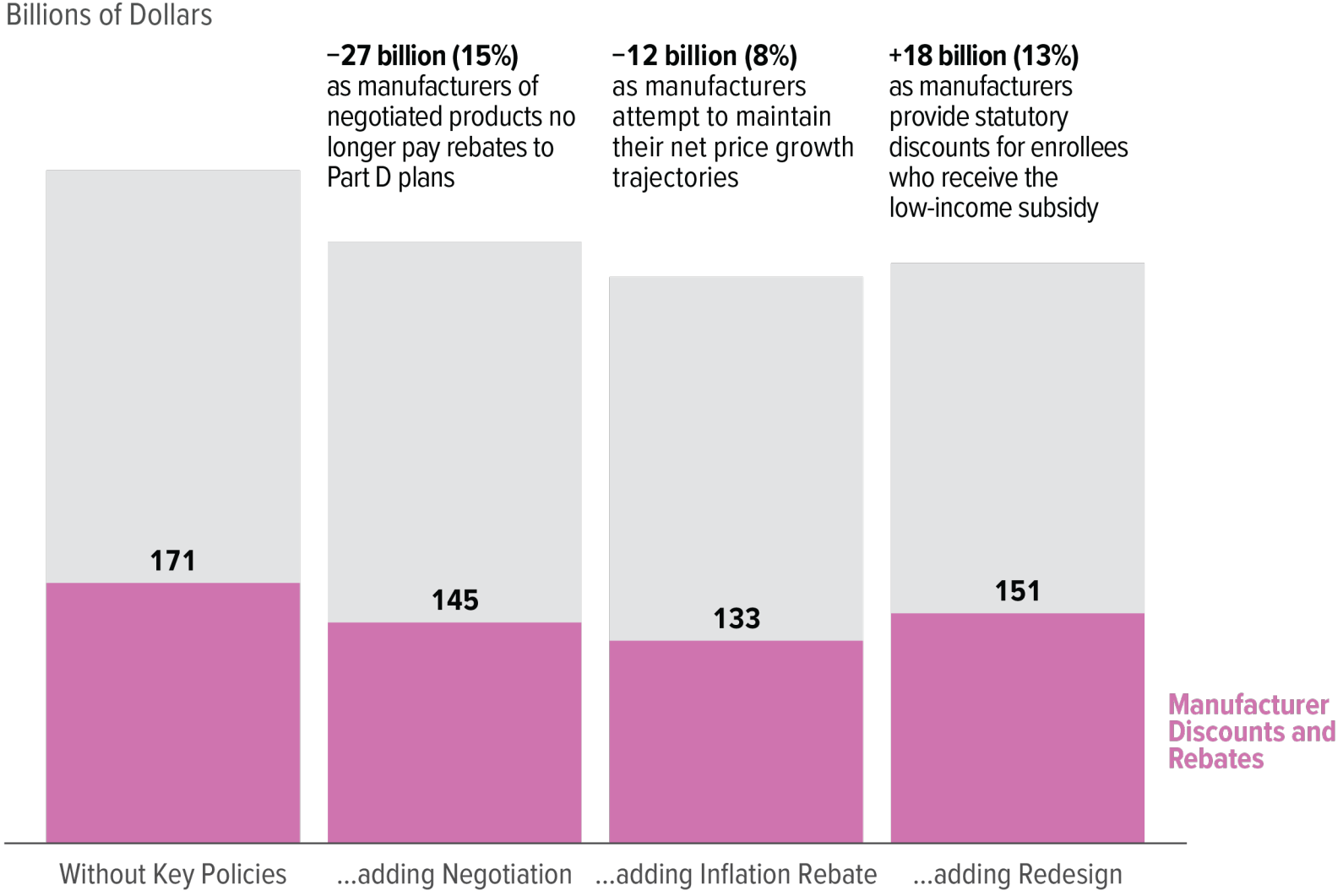
How Each of the Key Drug Policies Contributes to an Estimated $25 Billion Decline in Part D Enrollees' Costs



Lower costs for enrollees account for about 40 percent of the estimated $62 billion decrease in total Part D spending in 2031. By reducing enrollees' costs by **$13 billion**, the Part D redesign policy drives more than half of the $25 billion decrease in those costs in 2031.

The "Without Key Policies" scenario reflects the delay of the safe harbor rule. "Enrollees' Costs" comprise enrollee drug spending at retail prices. Components do not sum to totals because of rounding.

How Each of the Key Drug Policies Contributes to an Estimated $20 Billion Decline in Manufacturer Discounts and Rebates



A decline of $20 billion in manufacturer discounts and rebates accounts for the rest of the estimated $62 billion decrease in total Part D spending in 2031. CBO estimates that the negotiation provision is the largest contributor to that $20 billion decline.

The “Without Key Policies” scenario reflects the delay of the safe harbor rule. Components do not sum to totals because of rounding.

About This Document

This document was prepared to enhance the transparency of CBO's work and to encourage external review of that work. In keeping with CBO's mandate to provide objective, impartial analysis, the document makes no recommendations.

Colin Baker, Scott Laughery, and Asha Saavoss prepared the document with guidance from Tamara Hayford and Paul Masi. Elizabeth Bass, Ezra Cohn, Carrie H. Colla, Ryan Greenfield, Stuart Hammond, Leo Lex (formerly of CBO), R. L. Rebach, Lara Robillard, Matt Schmit, Joshua Varcie, Chapin White, and Kate Young provided comments.

Jeffrey Kling, Robert Sunshine, and Phillip Swagel reviewed the document. Lora Engdahl edited it and Casey Labrack created the graphics. The document is available at www.cbo.gov/publication/58850.

CBO seeks feedback to make its work as useful as possible. Please send comments to communications@cbo.gov.