

Issue Brief

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CBO's Approach to Scoring Drug "Rebates" Paints Inaccurate Picture of Savings

Introduction

Quirks in the Congressional Budget Office's (CBO's) approach to scoring legislation can occasionally give a misleading impression about the real-world fiscal impacts associated with a bill. Many times those methods are forced upon them by Congress, such as the rules for constructing the current-law baseline which leads to oddities like the [\\$4 billion in nuclear waste fees](#) that are still included in budget projections even though they have not been collected since 2014.¹ But there are times when CBO's own choices can lead to odd results, such as its take on scoring so-called "rebates" in the prescription drug space.

A prescription drug reform bill in the Senate has been touted as reducing spending, but the details are more complicated than that. A primary driver of the savings in the proposal is a "rebate" that requires drug manufacturers who sell pharmaceuticals through federal programs to pay back a portion of their earnings to the government, if they raise the price of their drugs faster than inflation. A rebate was

¹Brady, Demian. "There's an Extra \$4 Billion Deficit Gap in the Official Current-Law Baseline." National Taxpayers Union Foundation, June 19, 2019. <https://www.ntu.org/foundation/detail/theres-an-extra-4-billion-deficit-gap-in-the-official-current-law-baseline>.

Key Facts:



A bill aiming to reduce the costs of prescription drugs would make reforms to reduce taxpayer liability in the catastrophic phase of Medicare Part D coverage.



However, the majority of the bill's savings result from a "rebate" that requires drug manufacturers who sell through Part D to pay back a portion of their earnings if prices rise faster than inflation.



These rebates are scored as spending reductions, but as they have been increased and expanded, they act much like a tax that leads to price controls and cost-shifting.

originally implemented in Medicaid to ensure that the government pays no more for drugs than can be obtained by private plans through negotiations. But with proposals to increase or extend rebates to Medicare, there are concerns that it could lead to further price controls in federal health programs.

Although the rebates paid to the government are recorded as credits against spending, the proposed expansion, on top of previously imposed rebate clawbacks, in practice acts much like a tax and runs the risks of impeding private research and development in new medications, shifting more costs to private plans, and increasing the prices of newly developed drugs brought to market.

The Prescription Drug Pricing Reduction Act

Finding a solution to the rising costs of prescription drugs has been an ongoing concern. Senate Finance Committee Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR) worked together to develop a bipartisan bill, [S. 2543](#), the Prescription Drug Pricing Reduction Act.² The bill's reforms include changes to the Medicare Part D prescription drug benefit to reduce the out-of-pocket threshold for beneficiaries and eliminate cost-sharing above that catastrophic threshold. It would also increase transparency regarding certain drug discounts and payments between health plans, pharmacies, and pharmacy benefit managers. Additionally, Grassley-Wyden would increase the maximum rebate paid by drug manufacturers under Medicaid, and require drug manufacturers to pay rebates to the federal government for certain drugs through Medicare when the average manufacturer price increases faster than the rate of inflation.

Last September, the Senate Finance Committee approved the bill by a vote of 19 to 9. All the no votes were Republicans. Since then it has been held up in large part due to Republican concerns about the rebate provisions. Despite the COVID-19 pandemic and economic downturn, recent events indicate that the bill's sponsors hope to move on it before the end of the year. On June 1, Bloomberg News [reported](#) that Grassley will push for a vote on the Senate floor this year.³ He added that, as efforts are underway to develop therapies and cures for the COVID-19 virus, "There's no better time to address this issue."

The Bloomberg article also noted that the bill's score includes "big savings," but that might not mean what people would ordinarily think it means.

Budget Score of Grassley-Wyden

Normally when you hear about a reform to save taxpayer dollars, you think it means that outlays are being reduced. The inflation caps on drug prices included in the bill work a bit differently. These caps result in the bill's largest dollar-value "savings," but have also been the most controversial part of the bill.

In March, CBO released a [cost analysis](#) of Division A (which includes the major changes to Medicare Part D and Medicaid) estimating that it would reduce direct spending by over \$93 billion over the next decade.⁴

CBO identified four provisions that would increase outlays by a total of just over \$22 billion, and twelve that would reduce direct spending by over \$115 billion. The vast majority of the savings

² S.2543 - Prescription Drug Pricing Reduction Act of 2019, September 25, 2019. <https://www.congress.gov/116/bills/s2543/BILLS-116s2543rs.pdf>.

³ Griffin, Riley and Court, Emma. "Long-Delayed Drug-Price Bill Not Dead Yet, Grassley Says." Bloomberg, June 1, 2020. <https://www.bloomberg.com/amp/news/articles/2020-06-01/long-delayed-drug-price-legislation-not-dead-yet-grassley-says>.

⁴ Congressional Budget Office. "Division A - Prescription Drug Pricing Reduction Act of 2019." March 13, 2020. <https://www.cbo.gov/system/files/2020-03/PDPRA-SFC.pdf>.

(\$96.3 billion, or 84 percent of the total) resulted from changes in the controversial Medicare and Medicaid drug rebate programs. From the CBO report:

- Medicare Part B rebate by manufacturers for drugs or biologicals with prices increasing faster than inflation: \$12.3 billion in savings;
- Medicare Part D rebate by manufacturers for certain drugs with prices increasing faster than inflation: \$69.7 billion in savings;
- Modification of maximum rebate amount under Medicaid drug rebate program: \$14.2 billion in savings;
- Applying Medicaid drug rebate requirement to drugs provided as part of outpatient hospital services: \$8 million in savings.

Understanding Prescription Drug Rebates

The Medicaid rebate was established in 1990. The policy requires that any pharmaceutical company that participates in Medicaid must pay a rebate back to the states (which is also shared with the federal government) for covered outpatient drugs (drugs provided in hospitals or other medical settings are excluded). In a 1996 analysis, CBO [wrote](#) that “The basic rebate ensures that Medicaid pays manufacturers no more—and sometimes less—than any private purchaser in the United States for outpatient prescription drugs.”⁵

However, the basic rebate was subsequently expanded. Under the Affordable Care Act, the basic Medicaid rebate was increased for most outpatient drugs from 15.1 to 23.1 percent of the Average Manufacturers Price (AMP) for brand drugs and from 11 to 13 percent for generic drugs. For an example of how this works, if a private sector purchaser is able to obtain a price that is lower than 23.1 percent off of the AMP, then the manufacturer would have to pay a larger rebate to the government. There is also an additional rebate for brand-name drugs so that when prices rise faster than inflation, manufacturers pay a larger rebate.

Grassley-Wyden would expand the rebates and add a new requirement that manufacturers in Medicare Parts B and D pay inflation rebates. The justification for creating the new Medicare rebates is that the bill’s other provisions remove cost-sharing for beneficiaries whose out-of-pocket expenses reach a certain level. Costs above this threshold are paid by the federal government. Thus, there is a concern that this would give drug companies an incentive to increase prices.

Like Taxes, Rebates Can Lead to Cost-Shifting

In cases where money collected by a federal agency is the result of “businesslike or market-oriented transactions,” CBO [records the amounts](#) as credits against spending, or essentially as negative spending.⁶ Since the manufacturers have the option on paper of not participating in Medicaid or Part D, the rebates are scored as offsetting receipts rather than as tax receipts, which are “collected from the public that arise from the government’s exercise of its sovereign or governmental powers.” Given the market share under Medicaid and Medicare Part D, this raises a methodological question regarding whether pharmaceutical manufacturers’ participation is truly optional. But as the government is increasing and expanding its clawback mandates, it is arguably more proper to consider the rebates as a tax.

⁵ Congressional Budget Office. “How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry.” January 1, 1996. <https://www.cbo.gov/sites/default/files/104th-congress-1995-1996/reports/1996doc20.pdf>.

⁶ Congressional Budget Office. “Glossary.” January, 2012. <https://www.cbo.gov/sites/default/files/cbofiles/attachments/glossary.pdf>.

Because the rebates are added on top of existing input costs, they have the same economic impacts as a tax or a price control. Like taxes, the added burden will result in cost shifting. This could include some combination of higher prices charged to private sector plans, less research and development of new groundbreaking drugs, and higher prices for new drugs that are launched on the market.

Senator Pat Toomey (R-PA) along with co-sponsors Pat Roberts (R-KS) and James Lankford (R-OK) offered an amendment that would have removed the inflation cap rebate because of the cost-shifting concerns noted above. During the debate, Toomey added:

In 1990, Congress built a very small rebate into the Medicaid drug program. That is how it started. Today in this underlying bill, the bill contemplates modifying the cap on that rebate such that there are scenarios in which a drug manufacturer could be forced to actually pay the government to have a consumer use their drugs.

The amendment narrowly failed to pass on a tie 14-14 vote.

If it does indeed turn out that the rebates will lead to higher prices for new drugs, beware of further government interference. During the Finance Committee hearing on Grassley-Wyden, Senator Mark Warner (D-VA) urged Congress to regulate the release price points of medication. He suggested a proposal whereby, after a new drug is released and has been on the market for a period of time, an independent committee would review the drug and have the authority to dictate a new, lower price point. If the manufacturer disagreed with the decision, they could make an appeal to another committee. This would be a disastrous mode of government control over prices.

Conclusion

NTU's Policy and Government Affairs Manager Andrew Lautz has [written favorably of certain reforms in Grassley-Wyden](#) to reduce taxpayers' liability in the catastrophic phase of Part D coverage.⁷ However, the rebate's inflation cap could work to undermine the market-oriented forces that have worked well in the program since its inception.

Any attempt to address the rising costs of prescription drug costs must carefully thread the needle to not end up squashing innovation in new life-saving remedies. Relying so heavily on savings from rebates could lead to unintended consequences that drive up the cost of development and release prices of new medical innovations.

CBO serves a vital role as official scorekeeper for Congress, but its approach to scoring the rebates as savings gives a misleading impression about the policy's ability to reduce the size and scope of the federal government. Approaching rebates in a manner more like a tax would arguably give a more accurate picture of the true fiscal impact of bills like Grassley-Wyden.

About the Author

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⁷ Lautz, Andrew. "Ranking Members Brady and Walden Are Right: This Is the Time to Reform Part D." National Taxpayers Union, January 29, 2020. <https://www.ntu.org/publications/detail/ranking-members-brady-and-walden-are-right-this-is-the-time-to-reform-part-d>.



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