CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Peter R. Orszag, Director

March 12, 2007

The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20510

The Honorable Jim McCrery
Ranking Member
House Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20510

Dear Congressmen:

I am writing in response to your request to have the Congressional Budget Office (CBO) analyze the potential effects on the Medicare drug benefit if information on price rebates that have been negotiated by the prescription drugs plans (PDPs) administering that benefit was publicly disclosed.

As your letter noted, Chairman Waxman has asked several PDPs to submit to the Committee on Oversight and Government Reform information that they were required to report to the Centers for Medicare and Medicaid Services (CMS), including information on negotiated price discounts, rebates, and other price concessions that they obtained from drug manufacturers. Currently, much of the information submitted to CMS is protected from disclosure. It is not clear, however, exactly what information those drug plans have submitted or will submit in response to Chairman Waxman's request, nor is it clear to what extent any information submitted would be disclosed publicly.

In this letter, CBO analyzes the broader issue of the disclosure of information on drug rebates and provides the reasons why the agency would currently estimate a much smaller financial impact on Medicare from legislative provisions that would require detailed disclosure (or would be likely to result in such disclosure) than had been estimated prior to the implementation of the Medicare drug benefit.

General Effects of the Disclosure of Drug Rebates

The disclosure of drug rebates could affect Medicare spending through two principal mechanisms. First, disclosure would probably make rebates less varied among purchasers, with large rebates and small rebates tending to converge toward some average rebate. Such compression, for reasons discussed below, would tend to reduce the rebates that PDPs received and thus would raise Medicare costs. Second, for a range of medical conditions, drugs appropriate for treatment are available from only a few manufacturers; disclosure of drug-by-drug rebate data in those cases would facilitate tacit collusion among those manufacturers, which would tend to raise drug prices.

To explain how those two effects from the disclosure of rebates can arise, it is useful to briefly review the basis for drug rebates, the reasons they differ among purchasers, and the rules and incentives affecting rebates under the Medicare benefit. Rebate payments from drug manufacturers to insurers (or their intermediaries) are most common for brand-name drugs with patent protection that face some competition from potential substitute drugs to treat the same medical condition.[1] In such cases, insurers typically designate a limited number of the competing products as preferred drugs and encourage enrollees and their doctors to shift use to those drugs. The primary mechanism for encouraging such a shift is a tiered formulary, which is a list of the medications that the insurer will cover and the cost-sharing requirements for each type—typically the lowest for generic drugs, higher for preferred brand-name drugs, and highest for nonpreferred brand-name drugs. Manufacturers of preferred drugs generally pay a rebate in return for inclusion on the insurer's formulary, plus additional rebates that are tied to the increase in their drug's market share that results from having preferred status.[2] The forces of competition will thus tend to result in larger rebates and lower net prices (that is, prices net of the rebates) for drugs that have closer available substitutes and for insurers that establish narrower lists of preferred drugs or are more effective in steering doctors and patients toward those drugs.

Under the Medicare drug benefit, PDPs are required to pass along the rebates they receive either through lower retail prices or reductions of premiums, and enrollees

1. For a more complete discussion, see Congressional Budget Office, *Prescription Drug Pricing in the Private Sector* (January 2007).

2. The reason prices concessions usually come in the form of rebates rather than as direct price cuts reflects the way that drugs are distributed. Pharmacies purchase drugs from manufacturers and fill prescriptions, but they pay the same price regardless of who ends up receiving the drugs. Health insurers (or their intermediaries) arrange to reimburse pharmacies for their acquisition costs—but to receive a targeted price reduction from a drug's manufacturer that accounts for an insurer's own formulary design and success in shifting use to the given drug, the simplest mechanism is a rebate from the manufacturer to the insurer.

can compare their expected total costs—including payments of premiums and cost-sharing requirements for the drugs they use—among the available plans.[3] As a result, PDPs have strong incentives to negotiate the best deal they can get from manufacturers so that they can compete for enrollees. At the same time, some PDPs have chosen to attract enrollees by offering broader coverage of drugs (even though the broader coverage tends to translate into somewhat higher drug prices, because a less restrictive formulary generates less substantial rebates). Some component of the differences in rebates among insurers thus reflects different formulary design choices. Another component, though, may reflect differences in bargaining skill or other idiosyncratic factors. Disclosure of data on drug rebates would not affect the first cause of variation in rebates (that is, differences in formulary design) but would probably affect the second (other differences among insurers).

In light of those considerations, the disclosure of rebate data would probably cause the variation in rebates among purchasers to decline—but the effect of that compression in rebates on Medicare spending would depend on where rebates to PDPs lie in the overall distribution of rebates and on which rebates were disclosed. Hypothetically, if full transparency of all rebates were implemented nationwide, purchasers who had not been obtaining large rebates (other things being equal) could use the revealed pricing information to bargain harder; by the same token, however, manufacturers would probably reduce their largest rebates because of the pressure that disclosure of such large rebates would place on their arrangements with other customers.[4] In other words, one would expect (all else being equal) that compression would occur as small rebates were increased and large rebates were reduced. A key question is therefore the current magnitude of rebates to PDPs relative to rebates to others in the overall drug market. Although full information is not available, CBO's understanding is that PDPs have secured rebates somewhat larger than the average rebates observed in commercial health plans. As a result, the revelation of rebates to PDPs would create pressure to reduce those rebates, which would tend to increase costs for both the Medicare program and, on average, for enrollees.

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3. The flexibility that PDPs have to pass on rebates though premium reductions means that they do not have to reveal the rebates they receive in the posted drug prices that enrollees can observe. Apparently, some PDPs have chosen to emphasize reductions in drug prices, while others have used rebates primarily to reduce premiums.

4. A vivid example is the Medicaid "best price" provision, which essentially requires manufacturers to give the Medicaid program rebates that are at least equal to the largest private rebates they provide. After those provisions were enacted, private purchasers who had been receiving the largest price concessions saw their rebates decline. See Congressional Budget Office, *How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry* (January 1996).

In addition to pressure from purchasers, a second reason that the disclosure of rebates would be expected to reduce the rebates to PDPs (and thus increase net drug prices) is that it would facilitate tacit collusion among the manufacturers of competing brand-name drugs. Tacit collusion is difficult to impossible in highly competitive markets with large numbers of suppliers. Because of patent protections, however, the number of sellers that make drugs to treat a given medical condition is generally limited—which is a prerequisite for such collusion. The current secrecy of rebate negotiations makes it difficult for manufacturers to monitor one another's behavior and thus impedes collusive activity: When rebates are confidential, manufacturers can pursue their self-interest in increasing their drug sales at the expense of their competitors by offering rebates without fear of retaliation.[5] For those reasons, the Federal Trade Commission has indicated that several recent state-level legislative proposals, which would have revealed drug rebates, could have resulted in reductions in those rebates and thus higher net drug prices.[6] In the context of the Medicare program, the revelation of rebates would also facilitate tacit collusion among producers; to the extent that such collusion did arise, the effect would be to reduce average rebates for the PDPs and to raise net prices.

Updated Estimate Regarding Section 133 of S. 1

The two effects described above suggest that the disclosure of rebates received by Medicare drug plans would tend to raise program costs, but developments since the Medicare benefit was enacted indicate that the effect of such disclosure would be substantially smaller than CBO previously estimated. In July 2003, CBO estimated that disclosure provisions included in S. 1 as passed by the Senate (which would have established a Medicare drug benefit) would increase the cost of that legislation by $40 billion over 10 years.[7] The disclosure provisions, contained in Section 133 of that bill, would have required each drug plan participating in the Medicare benefit to provide a report annually to the Department of Health and Human Services and the Justice Department specifying the rebates and other payments it had received from each pharmaceutical

5. For a general discussion of price secrecy and other factors affecting the prospects for tacit collusion in markets that have a limited number of suppliers, see F. M. Scherer, *Industrial Market Structure and Economic Performance*, 2nd ed. (Boston, Mass.: Houghton Mifflin, 1980), pp. 199–227. For a discussion focused on health care markets, see the statement of Paul B. Ginsburg, President, Center for Studying Health System Change, *Consumer Price Shopping in Health Care*, before the Subcommittee on Health of the House Energy and Commerce Committee, March 15, 2006, available at www.hschange.com/CONTENT/823/823.pdf.

6. See Federal Trade Commission, *Letter to California Assembly Member Greg Aghazarian* (September 7, 2004), available at www.ftc.gov/be/V040027.pdf; and *Letter to Virginia Delegate Terry G. Kilgore* (October 2, 2006), available at www.ftc.gov/be/V060018.pdf.

7. See Congressional Budget Office, *Cost Estimate for H.R. 1 and S. 1* (July 22, 2003), pp. 14–15.

manufacturer—both in the aggregate and for each of the top 50 drugs. The provision specified that it was not intended to prevent disclosure of the information to either House of the Congress or to any duly authorized committee or subcommittee of the Congress. CBO expected that if those provisions were enacted, private firms would have perceived a significant risk of public disclosure of detailed information on rebates, in part because it would have been provided in a readily accessible form on an ongoing basis.

For two reasons, CBO would now estimate a substantially smaller impact of such provisions if they were applied to the current drug benefit. First, before the program began, CBO estimated that the disclosure provisions would reduce the chances that risk-bearing insurers would participate at all (about which there was debate at that time). As a result, CMS would have faced an increased likelihood of having to contract with a "fallback" drug plan to deliver the benefit in each region, and that fallback plan would have borne little financial risk and (by definition) would have faced little competition. CBO estimated that fallback plans would be less effective in controlling drug spending than risk-bearing plans—so an increase in the probability that fallback plans would be used resulted in higher expected costs for the drug benefit.[8] Experience under the program, however, shows that a large number of insurers are participating. CBO would not currently expect the disclosure provisions that were contained in S. 1 (if enacted today) to lead all plans to cease their participation—so the provisions regarding fallback plans would not be triggered.

In addition, although CBO still expects that disclosure provisions would reduce the rebates that risk-bearing PDPs obtain, the impact would be smaller than assumed in the earlier estimate. CBO had expected that the combination of financial incentives and management tools that were provided by the legislation would lead PDPs to establish relatively narrow formularies and to limit drug spending by encouraging enrollees to use lower-cost drugs and by securing substantial rebates for the limited number of drugs that they designated as preferred. For a variety of reasons, however, plans are offering formularies under Medicare that more closely resemble commercial formularies. (The reasons include restrictions imposed by CMS on the use of narrow formularies and decisions by PDPs about the types of products they wanted to market.) As a result, although PDPs appear to have obtained somewhat larger rebates than the average commercial plan, the difference is not as substantial as CBO had anticipated.[9] Correspondingly, the disclosure of Medicare rebate data would have

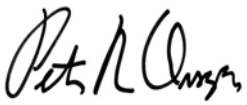
8. For additional discussion of provisions governing fallback plans, see Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (July 2004), pp. 10–11.

9. At the same time, PDPs have been able to limit program spending though their management of the benefit (as evident in relatively high rates of dispensing generic drugs), which is one reason program costs have been lower than previously expected.

a smaller impact on drug spending than was assumed in CBO's earlier estimate. Overall, CBO now estimates that the expected impact of such disclosure provisions on Medicare spending over 10 years would very likely be less than $10 billion and could be significantly less.

I hope this analysis is helpful to you. If you would like additional information on this subject, CBO would be pleased to provide it. The staff contacts for this analysis are Tom Bradley and Philip Ellis.

Sincerely,



Peter R. Orszag
Director

cc: Honorable John D. Dingell
Chairman
House Committee on Energy and Commerce

Honorable Charles B. Rangel
Chairman
House Committee on Ways and Means

Honorable Henry A. Waxman
Chairman
House Committee on Oversight and Government Reform

Honorable Tom Davis
Ranking Member
House Committee on Oversight and Government Reform

Honorable Max Baucus
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Senate Committee on Finance

Honorable Chuck Grassley
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