



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

Phillip L. Swagel, Director

July 29, 2026

Honorable Jodey Arrington
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Honorable Brett Guthrie
Chairman
Committee on Energy and
Commerce
U.S. House of Representatives
Washington, DC 20515

Re: Developments in CBO's Projections for Medicare Part D

Dear Chairman Arrington, Chairman Guthrie, and Chairman Smith:

You have asked the Congressional Budget Office to describe and explain updates to spending projections published in *The Budget and Economic Outlook: 2026 to 2036*.¹ In particular, you requested information concerning CBO's original estimates and current projections of the budgetary effects of provisions of the 2022 reconciliation act (Public Law 117-169) that affect Medicare Part D, the prescription drug program.²

The 2022 reconciliation act contains three major provisions affecting prescription drug prices and coverage: drug price negotiation, which requires the Department of Health and Human Services (HHS) to negotiate prices directly with manufacturers for selected high-expenditure drugs; inflation

1. Congressional Budget Office, *The Budget and Economic Outlook: 2026 to 2036* (February 2026), www.cbo.gov/publication/61882.

2. Chairman Jodey C. Arrington, Chairman Jason Smith, and Chairman Brett Guthrie, letter to Phillip Swagel, Director, Congressional Budget Office, concerning CBO's baseline projections for Medicare Part D (May 20, 2026), <https://tinyurl.com/9ub222ny>.

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rebates, which manufacturers must pay if increases in their drug prices outpace inflation; and a redesign of Part D to cap enrollees' annual out-of-pocket costs, limit premium increases, and shift more financial liability to plans and manufacturers.³

In September 2022, following the enactment in August, CBO projected that enacting those provisions would lead to combined deficit reductions of \$129 billion over the 2022–2031 period.⁴ At the time, CBO estimated that by 2026, the reductions in direct spending stemming from the first two provisions would more than offset increases associated with enacting the third.

Since then, on the basis of new information, CBO has revised its projections. Evidence now indicates that the spending reductions attributable to drug price negotiation and inflation rebates have been smaller than CBO originally estimated. The costs of the Part D redesign have been significantly larger because of greater-than-anticipated increases in spending because of greater use of prescription drugs.

As a result, the agency now projects that those provisions will combine to increase deficits over the 2022–2031 period.

This letter provides information about the following topics:

- CBO's original estimate of the 2022 reconciliation act, the evidence used to inform that estimate, and key sources of uncertainty;
- Initial effects of the price negotiation and inflation rebate provisions;
- The effects of the Part D redesign; and
- Ongoing updates to CBO's models, including increases in CBO's projections for Part D to account for recent experience with implementing the act's Part D provisions.

3. The 2022 reconciliation act also requires price negotiation, inflation rebates, and other changes to Medicare Part B, the Medical Insurance program.

4. 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.

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Original Estimate of the Budgetary Effects of Drug Provisions in the 2022 Reconciliation Act

CBO originally estimated that a \$99 billion reduction attributable to new drug price negotiation and a \$63 billion reduction attributable to the inflation rebate provision would combine over 10 years to more than offset the estimated \$30 billion increase in deficits attributable to the Part D redesign. The estimate also included \$3 billion in costs for implementation.

How CBO Estimated the Provisions' Budgetary Effects. In estimating the budgetary effects of drug price negotiation, CBO expected that in some cases, HHS would have sufficient leverage to negotiate prices below the maximum amounts established by law. The new upper limits on prices, combined with that leverage, led CBO to estimate that net prices for drugs selected for negotiation would decline by roughly 50 percent, on average.⁵

CBO estimated that the inflation rebate provision would generate budgetary savings in part through collections of rebates on certain single-source, brand-name drugs whose prices exceeded inflation-adjusted benchmarks and in part through lower spending on drugs whose manufacturers reduced net prices to avoid paying those rebates. CBO expected the effects to vary depending on rebate amounts and whether a drug was already on the market at the time of the law's enactment.

CBO expected several aspects of the Part D redesign to increase deficits. Some elements, including larger federal subsidies for Part D plans, were expected to increase federal spending as those plans assumed a greater portion of drug costs. Other outcomes included increased federal spending associated with limits on growth in base premiums (the average amount paid monthly by enrollees based on expected average benefit costs for all Part D enrollees) and enrollees' increased use of prescription drugs because of reductions in their out-of-pocket costs.

Sources of Uncertainty in the Original Estimates. CBO's original estimates had several important sources of uncertainty, including what price reductions would be achieved through negotiation and how long those prices would apply, how Part D plans would adjust their bids, how drug manufacturers

5. Congressional Budget Office, "How CBO Estimated the Budgetary Impact of Key Prescription Drug Provisions in the 2022 Reconciliation Act" (presentation, February 17, 2023), www.cbo.gov/publication/58850.

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would modify pricing strategies in response to the inflation rebate provision, and how much enrollees would respond to lower out-of-pocket costs. In developing its estimates, CBO relied on academic literature on the effects of similar policies, analyses of administrative and claims data, consultations with subject matter experts, and prior modeling. The list of studies CBO consulted is enclosed with this letter.

Analyses and Evidence Available When the Estimates Were Prepared.

CBO's estimates of the budgetary effects of the provision for drug price negotiation relied on the agency's earlier work on H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act, which included a provision similar to the one enacted in 2022.⁶ The estimates of the effects of the inflation rebate provision relied extensively on the agency's modeling of drug pricing and on prior estimates related to the Medicaid drug rebate. CBO projected how manufacturers would adjust initial prices and apply subsequent increases in response to that policy.

Relatively few analyses of similar policies were publicly available at the time of CBO's original estimate of the reconciliation act. In 2019, the Centers for Medicare & Medicaid Services (CMS) published one such evaluation of H.R. 3.⁷ Although CMS and CBO estimated different budgetary effects for drug price negotiation and inflation rebates, both agencies concluded that those provisions would reduce federal spending. CMS projected smaller savings from negotiation and larger savings from inflation rebates than CBO did. Those differences reflected differing projections of bargaining outcomes under negotiation and manufacturers' responses to inflation rebate penalties. Other independent analyses of the effects of H.R. 3 included estimates that the main drug provisions would, on net, reduce federal spending.⁸

6. For more information, see Congressional Budget Office, letter to the Honorable Frank Pallone Jr., concerning the budgetary effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act (December 10, 2019), www.cbo.gov/publication/55936.

7. Centers for Medicare & Medicaid Services, Office of the Actuary, "Updated Financial Impacts of Titles I and II of H.R. 3, 'Lower Drug Costs Now Act of 2019' " (November 8, 2019), <https://tinyurl.com/4ya6akcu>.

8. Penn Wharton Budget Model, "Inflation Reduction Act: Preliminary Estimates of Budgetary and Macroeconomic Effects" (University of Pennsylvania, July 2022), <https://tinyurl.com/y6d4tsbr>; and Kyle Stengel, Mitchell Cole, and Kelly Brantley, "Insight: Impact of H.R. 3 as Passed by the House on Federal Spending and Drug Manufacturer Revenues" (Avalere Health, June 2020), <https://tinyurl.com/3htar7jc>.

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To estimate the effects of the Part D redesign, CBO relied on earlier analyses of the relationship between cost sharing and health care. Because no prior policy closely resembled the Part D redesign as enacted, CBO relied on evidence drawn from analyses of related but not identical policy changes. The work incorporated evidence from studies that modeled changes in the use of health care among insured people in response to changes in cost sharing.⁹ Taken together, the evidence suggests that people moderately increase their use of health care when their out-of-pocket costs are lower.¹⁰

CBO used that evidence to estimate how changes in out-of-pocket costs affect prescription drug use and incorporated that information into its Part D models. Because enrollees with high prescription drug costs are more likely to use medications that are essential to managing serious or chronic conditions, CBO expected their drug use to be less responsive to reductions in cost sharing. As a result, the agency adjusted the estimated behavioral response downward for enrollees who reached the spending threshold for the catastrophic phase of the standard Part D benefit. Because the Part D redesign mainly affects enrollees whose prescription drug costs are especially high, most of the behavioral response was governed by the downward-adjusted estimate.

Although the evidence available at the time generally supported CBO's conclusion that the provisions concerning drug price negotiation and inflation rebates would reduce federal spending and that the Part D redesign would increase it, the magnitude of those effects was highly uncertain: No prior circumstances precisely resembled the specific combination of enacted provisions.

CBO is not aware of any analyses that had been published at the time of enactment, other than its own estimate, that projected the combined budgetary effects of the three provisions. The agency also is not aware of any analysis that anticipated the subsequently observed increase in projected spending under Part D after the enactment of the 2022 reconciliation act.

9. Willard G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence From a Randomized Experiment," *American Economic Review*, vol. 77, no. 3 (June 1987), pp. 251–277, www.jstor.org/stable/1804094.

10. CBO's Single-Payer Health Care Systems Team, *How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-For-Service Program*, Working Paper 2020-08 (Congressional Budget Office, December 2020), pp. 56–59, www.cbo.gov/publication/56811.

Initial Effects of Drug Price Negotiation and Inflation Rebates

CBO has gathered information since 2022 that has provided some insights into the initial effects of those provisions.

Effects of Drug Price Negotiation. In September 2022, CBO estimated that drug price negotiation under the 2022 reconciliation act would reduce deficits by \$99 billion through 2031. That estimate, which incorporated Part B effects, reflected uncertainty regarding the extent to which net price reductions could be achieved. CBO estimated that, on average, net prices for selected drugs would decline by 50 percent.

Since that estimate, CMS has negotiated prices for the first two groups of drugs that are subject to negotiation under the act. The prices announced in August 2024 for the first group were 22 percent below the average net prices for those drugs in 2023.¹¹ In response, CBO revised its projection of a 50 percent net reduction and now anticipates net reductions between 25 and 50 percent (using the midpoint of 37.5 percent) for prices of drugs that are subject to negotiation.¹² CBO increased its February 2024 Part D baseline projection by \$34 billion through 2034 to account for smaller-than-expected price reductions from negotiation.¹³ The prices CMS announced for the second group in November 2025 were 44 percent below the average net prices for those drugs in 2024, consistent with CBO’s updated expectation of a 25 to 50 percent reduction.¹⁴

Since CBO’s original estimate for the negotiation provision, Part D spending has grown faster than the agency expected following the enactment of the

11. For the comparison between net prices in 2023 and the negotiated prices announced in August 2024, see Centers for Medicare & Medicaid Services, “Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2026” (fact sheet, August 2024), <https://tinyurl.com/44upxx3b>.

12. Congressional Budget Office, *Alternative Approaches to Reducing Prescription Drug Prices* (October 2024), www.cbo.gov/publication/58793.

13. Austin Barselau and Scott Laughery, Congressional Budget Office, “Effects of the 2022 Reconciliation Act’s Drug Provisions: What We Have Learned So Far and What Questions Remain?” (presentation to CBO’s Panel of Health Advisers, September 12, 2025), www.cbo.gov/publication/61547; and Congressional Budget Office, *The Budget and Economic Outlook: 2024 to 2034* (February 2024), Table 1-4, www.cbo.gov/publication/59710.

14. Centers for Medicare & Medicaid Services, “Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2027” (fact sheet, November 2025), <https://tinyurl.com/bd4pte7f>.

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2022 reconciliation act. That growth reflects higher spending for certain drugs, some of which CBO projects will be subject to negotiation within the next 10 years. As a result, CBO has increased its projections both for spending on drugs expected to be chosen for negotiation and for potential savings from negotiated price reductions, even after accounting for smaller price reductions.

Effects of Inflation Rebates. CBO originally estimated that the inflation rebate provision, including Part B effects, would reduce deficits by \$63 billion through 2031. Since it prepared the 2022 estimate, CBO has reduced its projections of Part D savings attributable to the inflation rebates. Overall price inflation has increased more rapidly than CBO anticipated in 2022, which raised the benchmarks CMS uses to calculate manufacturers' inflation rebates. That, in turn, lowered the amount of inflation rebates owed to Medicare and curtailed manufacturers' incentives to limit price increases. CMS has issued invoices informing manufacturers of the inflation rebates they owe for the first two periods of the program.

Although CBO currently projects smaller rebate collections, recent growth in Part D spending could increase the amount of rebates if that spending occurs for drugs that are subject to the provision. CBO will continue to revise its projections as information becomes available.

CMS has published some information on amounts manufacturers are required to pay in rebates for drugs covered by Part B.¹⁵ The data indicate that manufacturers owe \$14 million for 2023 and \$122 million for 2024. CBO estimated that inflation rebates for drugs covered by Part B would reduce direct spending by about \$23 billion over the 2022–2031 period, with \$2.3 billion of that amount accruing in 2023 and 2024. CBO's estimate did not distinguish cash rebates from price reductions in lieu of rebates. Therefore, it is difficult to measure the accuracy of the agency's rebate estimates against actual experience. CBO's assessment of the types of drugs likely to be subject to the Part B rebate is roughly in line with the CMS data released so far.

Effects of the Part D Redesign

In projecting the budgetary effects of the redesign, CBO significantly underestimated the increase in per-enrollee costs when the policy was implemented. CBO expected the redesign to shift some of the costs of

15. Centers for Medicare & Medicaid Services, "Medicare Part B Inflation Rebates for Calendar Years 2023 & 2024" (fact sheet, October 2025), <https://tinyurl.com/2z5jbu9n>.

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prescription drugs from Part D enrollees to their prescription drug plans, resulting in higher bids from private insurers.¹⁶ The agency originally estimated that the Part D redesign would increase deficits by \$30 billion through 2031.

Bids from Part D prescription drug plans have been higher than CBO expected earlier and the budgetary costs have been much larger than originally estimated. Plans' 2025 bids were higher than expected partly because of greater-than-expected use of certain classes of medication, such as antidiabetics, in 2023. (Plans used that 2023 information to project costs for their 2025 bids.) Although the 2025 bids were higher than CBO had expected, the spending projections underlying those bids suggested that Part D plan sponsors expected benefit spending to grow at a pace that largely mirrored CBO's projections of the redesign's effects for 2025.¹⁷

For 2026, Part D plans anticipated a 35 percent increase in annual costs per enrollee. Before the plans submitted their bids, CBO had expected costs to increase by roughly 5 percent, about the program's average annual growth rate. CBO did not anticipate the large increase in the projected costs underlying the plans' 2026 bids. Instead, the agency expected that most of the effect of the redesign would already have been reflected in 2025 and that drug price negotiation would help to moderate spending growth afterwards.

To better understand the unexpected increase in projected costs, in November 2025 CBO issued a call for research that brought in new information about enrollees' responses to lower out-of-pocket costs.¹⁸ The evidence does not

16. Before the start of the calendar year, Part D plans generally submit a bid to CMS with their expected costs to provide coverage to a typical Part D enrollee.

17. Austin Barselau and Scott Laughery, Congressional Budget Office, "Effects of the 2022 Reconciliation Act's Drug Provisions: What We Have Learned So Far and What Questions Remain?" (presentation to CBO's Panel of Health Advisers, September 12, 2025), www.cbo.gov/publication/61547.

18. Congressional Budget Office, "A Call for New Research in the Area of Spending on Medicare Part D," *CBO Blog* (November 21, 2025), www.cbo.gov/publication/61824.

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fully explain the higher bids, but it suggests that enrollees' increased use of prescription drugs contributed to higher costs.¹⁹

In its February 2026 baseline, CBO added about \$700 billion to the projection of Part D outlays over the 2026–2035 period compared with the prior baseline.²⁰ Roughly \$550 billion of that increase reflected new information concerning the 2026 Part D bids. In CBO's assessment, the redesign was the leading driver of those higher bids. Other contributing factors include underlying growth in spending on drugs and changes in rebates and other payments from manufacturers.²¹

CBO has not produced an updated point estimate of the overall budgetary effects of the redesign because changes in Part D spending reflect the combined effects of the redesign, administrative actions, marketwide trends in prescription drug spending, and other factors, making it difficult to estimate the redesign's contribution separately.

Ongoing Updates to CBO's Modeling for Part D Spending

In CBO's February 2026 baseline projections for the 2026–2035 period, Medicare Part D outlays total \$2.1 trillion, up from \$1.5 trillion in the January 2025 baseline.²²

Projected outlays for Medicare Part D are now substantially larger than CBO had projected in the May 2022 baseline, which predated the 2022 reconciliation act. At that time, CBO projected total Part D outlays of \$1.2 trillion over the 2026–2032 period—\$0.2 trillion less than the current

19. Christopher L. Cai and others, "Changes in Medication Use After Medicare Part D Annual Out-of-Pocket Spending Caps," *JAMA Health Forum*, vol. 7, no. 6, e2615452026 (June 2026), <https://doi.org/10.1001/jamahealthforum.2026.1545>; and Lucas X. Marinacci and others, "Cost-Related Medication Nonadherence After the Inflation Reduction Act," *JAMA Internal Medicine*, vol. 186, no. 5 (March 2026), pp. 609–617, <https://doi.org/10.1001/jamainternmed.2026.0012>.

20. Congressional Budget Office, *The Budget and Economic Outlook: 2026 to 2036* (February 2026), www.cbo.gov/publication/61882; and *The Budget and Economic Outlook: 2025 to 2035* (January 2025), www.cbo.gov/publication/60870.

21. Betty Fout and Shinobu Suzuki, Medicare Payment Advisory Commission, "Analyzing Recent Increases in Part D Bids" (presentation, January 15, 2026), <https://tinyurl.com/d85sz49y>.

22. Congressional Budget Office, *The Budget and Economic Outlook: 2026 to 2036* (February 2026), www.cbo.gov/publication/61882; and *The Budget and Economic Outlook: 2025 to 2035* (January 2025), www.cbo.gov/publication/60870.

projection for that period.²³ (At that time, 2032 was the final year of the 10-year projection period.)

In that 2022 baseline, CBO projected that Part D spending per enrollee in 2032 would reach about \$3,500 (or \$293 per month). The February 2023 projection, incorporating the effects of the 2022 reconciliation act, declined to \$2,600 (or \$217 per month).²⁴ For 2032, CBO currently projects average spending per enrollee to rise again to \$3,500.

CBO continues to incorporate new evidence into its regular updates to baseline projections, including the effects of faster-than-expected growth in spending for Part D. In particular, the agency is revising assessments of enrollees' responses to reductions in out-of-pocket costs under the Part D redesign. The original estimate relied on the available literature and historical experience, which suggested that lower cost sharing would lead to modest increases in the use of prescription drugs. More recent evidence indicates that prescription drug use, particularly for certain high-cost, specialty prescription drugs, has increased more than initially expected because enrollees' out-of-pocket costs have declined.²⁵

CBO also has undertaken new modeling of premiums for different types of Part D plans, including Medicare Advantage and stand-alone prescription drug plans. That work informed CBO's estimate of the budgetary effects of CMS's temporary premium subsidies for stand-alone plans through 2027 and will inform CBO's future projections for the Part D program.²⁶

23. Congressional Budget Office, Details About Baseline Projections for Selected Programs, "Medicare Baseline" (May 2022), <https://tinyurl.com/bdd4a8sy>.

24. Congressional Budget Office, *The Budget and Economic Outlook: 2023 to 2033* (February 2023), www.cbo.gov/publication/58848.

25. Christopher L. Cai and others, "Changes in Medication Use After Medicare Part D Annual Out-of-Pocket Spending Caps," *JAMA Health Forum*, vol. 7, no. 6, e2615452026 (June 2026), <https://doi.org/10.1001/jamahealthforum.2026.1545>; and Lucas X. Marinacci and others, "Cost-Related Medication Nonadherence After the Inflation Reduction Act," *JAMA Internal Medicine*, vol. 186, no. 5 (March 2026), pp. 609–617, <https://doi.org/10.1001/jamainternmed.2026.0012>.

26. Centers for Medicare & Medicaid Services, "CMS Releases 2025 Medicare Part D Bid Information and Announces Premium Stabilization Demonstration" (press release, July 29, 2024), <https://tinyurl.com/y2ykvzps>; and Congressional Budget Office, letter to the Honorable Jodey Arrington, the Honorable Charles E. Grassley, the Honorable Cathy McMorris Rodgers, the Honorable Mike Crapo, and the Honorable Jason Smith concerning developments in Medicare's prescription drug benefit (October 2, 2024), www.cbo.gov/publication/60804.

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CBO also is monitoring changes in the structure of the Part D market, notably the decline in the number of stand-alone plans since the enactment of the 2022 reconciliation act. According to CMS data analyzed by KFF, 360 stand-alone plans are being offered in 2026, compared with 766 such plans in 2022.²⁷ Over the same period, access to Medicare Advantage prescription drug plans has remained relatively stable but the share of Medicare enrollees receiving prescription drug coverage through Medicare Advantage has increased.²⁸ Those trends indicate that the Part D market continues to adjust to the redesign. CBO will continue to assess the implications for plan competition and federal spending.

Although CBO does not model plan availability or access to benefits in its projections of Part D spending, the agency continues to assess changes in plan participation and market structure for insights that will be relevant for future estimates. CBO is monitoring how administrative actions, such as the temporary subsidy program for stand-alone plans and reduced competition among such plans, affect Part D plans' bidding and profit margins.

CBO also continues to seek and assess new information, including preliminary analyses submitted in response to its call for research, and will incorporate those findings into future projections.

27. Juliette Cubanski, *A Current Snapshot of the Medicare Part D Prescription Drug Benefit* (KFF, October 2025), <https://tinyurl.com/4vkfvfex>.

28. Jeannie Fuglesten Biniek and others, *Medicare Beneficiaries Have 32 Medicare Advantage Prescription Drug Plans Available, on Average, for 2026* (KFF, October 2025), <https://tinyurl.com/3cur8kwd>.

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I hope you find this information useful. Please contact me directly if you have further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Phillip L. Swagel", with a long, sweeping horizontal line extending to the right.

Phillip L. Swagel
Director

cc: Honorable Brendan F. Boyle
Ranking Member
House Committee on the Budget

Honorable Richard E. Neal
Ranking Member
House Committee on Ways and Means

Honorable Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce

Enclosure:
Works Consulted

Works Consulted

CBO used the following studies to inform the agency’s estimates for the major drug provisions in the 2022 reconciliation act (P.L. 117-169).

Drug Price Negotiation

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.

Ken Binmore, Ariel Rubinstein, and Asher Wolinsky, “The Nash Bargaining Solution in Economic Modelling,” *RAND Journal of Economics*, vol. 17, no. 2 (Summer 1986), pp. 176–188, <https://www.jstor.org/stable/2555382>.

Sharat Ganapati and Rebecca McKibbin, “Non-Tariff Barriers and Bargaining in Generic and Off-Patent Pharmaceuticals,” (draft, Georgetown University, March 2019), <http://dx.doi.org/10.2139/ssrn.3313630>.

Darius Lakdawalla and Wesley Yin, “Insurers’ Negotiating Leverage and the External Effects of Medicare Part D,” *Review of Economics and Statistics*, vol. 97, no. 2 (May 2015), pp. 314–331, https://doi.org/10.1162/REST_a_00463.

Ariel Rubinstein, “Perfect Equilibrium in a Bargaining Model,” *Econometrica*, vol. 50, no. 1 (January 1982), pp. 97–110, <https://doi.org/10.2307/1912531>.

Inflation Rebates

Anna Anderson-Cook and others, “How a Medicare Part D Inflation Penalty Would Lower Drug Spending for Patients, Taxpayers, and Employers,” *Health Affairs Forefront* (February 2020), <https://doi.org/10.1377/forefront.20200204.864372>.

Congressional Budget Office, *A Comparison of Brand-Name Drug Prices Among Selected Federal Programs* (February 2021), www.cbo.gov/publication/56978.

Congressional Budget Office, *Prescription Drugs: Spending, Use, and Prices* (January 2022), www.cbo.gov/publication/57050.

Enrollees' Responses to Changes in Cost Sharing Under Part D

Jason Abaluck, Jonathan Gruber, and Ashley Swanson, "Prescription Drug Use Under Medicare Part D: A Linear Model of Nonlinear Budget Sets," *Journal of Public Economics*, vol. 164 (August 2018), pp. 106–138, <https://doi.org/10.1016/j.jpubeco.2018.05.005>.

Abby Alpert, "The Anticipatory Effects of Medicare Part D on Drug Utilization," *Journal of Health Economics*, vol. 49 (September 2016), pp. 28–45, <https://doi.org/10.1016/j.jhealeco.2016.06.004>.

Michael Anderson, Carlos Dobkin, and Tal Gross, "The Effect of Health Insurance Coverage on the Use of Medical Services," *American Economic Journal: Economic Policy*, vol. 4, no. 1 (February 2012), pp. 1–27, <https://doi.org/10.1257/pol.4.1.1>.

Aviva Aron-Dine, Liran Einav, and Amy Finkelstein, "The RAND Health Insurance Experiment, Three Decades Later," *Journal of Economic Perspectives*, vol. 27, no. 1 (Winter 2013), pp. 197–222, <https://doi.org/10.1257/jep.27.1.197>.

Katherine Baicker and others, "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine*, vol. 368, no. 18 (May 2013), pp. 1713–1722, <https://doi.org/10.1056/NEJMsa1212321>.

Katherine Baicker and others, "The Effect of Medicaid on Medication Use Among Poor Adults: Evidence From Oregon," *Health Affairs*, vol. 36, no. 12 (December 2017), pp. 2110–2114, <https://doi.org/10.1377/hlthaff.2017.0925>.

Zarek C. Brot-Goldberg and others, "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," *Quarterly Journal of Economics*, vol. 132, no. 3 (August 2017), pp. 1261–1318, <https://doi.org/10.1093/qje/qjx013>.

Thomas C. Buchmueller and others, "Book Review: The Effect of Health Insurance on Medical Care Utilization and Implications for Insurance Expansion: A Review of the Literature," *Medical Care Research and Review*, vol. 62, no. 1 (February 2005), pp. 3–30, <https://doi.org/10.1177/1077558704271718>.

David Card, Carlos Dobkin, and Nicole Maestas, "The Impact of Nearly Universal Insurance Coverage on Health Care Utilization: Evidence From Medicare," *American Economic Review*, vol. 98, no. 5 (December 2008), pp. 2242–2258, <https://doi.org/10.1257/aer.98.5.2242>.

Mary K. Catlin, John A. Poisal, and Cathy A. Cowan, “Out-of-Pocket Health Care Expenditures, by Insurance Status, 2007–10,” *Health Affairs*, vol. 34, no. 1 (January 2015), pp. 111–116, <https://doi.org/10.1377/hlthaff.2014.0422>.

Amitabh Chandra, Jonathan Gruber, and Robin McKnight, “The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence From Massachusetts,” *Journal of Health Economics*, vol. 33 (January 2014), pp. 57–66, <https://doi.org/10.1016/j.jhealeco.2013.10.008>.

CBO’s Single-Payer Health Care Systems Team, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare’s Fee-for-Service Program, Working Paper 2020-08 (Congressional Budget Office, December 2020), www.cbo.gov/publication/56811.

Congressional Budget Office, *A Detailed Description of CBO’s Cost Estimate for the Medicare Prescription Drug Benefit* (July 2004), www.cbo.gov/publication/15841.

Christina M. Dalton, Gautam Gowrisankaran, and Robert Town, *Salience, Myopia, and Complex Dynamic Incentives: Evidence From Medicare Part D*, Working Paper 21104 (National Bureau of Economic Research, April 2015, revised April 2019), <https://doi.org/10.3386/w21104>.

Abe Dunn, “Health Insurance and the Demand for Medical Care: Instrumental Variable Estimates Using Health Insurer Claims Data,” *Journal of Health Economics*, vol. 48 (July 2016), pp. 74–88, <https://doi.org/10.1016/j.jhealeco.2016.03.001>.

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