Comment on the Centers for Medicare & Medicaid Services Notice CMS-2024-0317-000

I am commenting in response to the Centers for Medicare & Medicaid services notice on proposed updates to the Bid Pricing Tool (BPT) for Medicare Advantage (MA) and Prescription Drug plans (PDP). Firstly I would like to voice my support BPT, which is crucial for transparency and efficiency in the bidding process. While I believe this initiative has and will continue to help MA recipients, there is always room to improve with health equity and prioritizing marginalized and vulnerable populations. As a public health student, I would like to offer my perspectives and comment through an equity lens, focusing on public health impacts and improving healthcare for vulnerable populations.

Firstly, it is important to discuss the BPT in the context of the Inflation Reduction Act of 2022, a bipartisan act which may significantly reduce prescription drug costs for Medicare recipients. Enrollment in MA has been rising in the last two decades, with a large growth in the last five years especially, making efficiency and affordability even more important. While the IRA aims to improve affordability for beneficiaries, the provision that Medicare Advantage organizations (MAOs) and PDPs can now negotiate drug prices with pharmaceutical companies directly has also introduced new factors for MAOs and PDPs to consider when calculating bid pricing. The bidding process, as outlined in this notice is estimated to have an increased updated annual burden of 406,000 total annual hours and 11,700 total annual responses for MAOs preparing and submitting bids. While this updated increase in time investment for the BPT by MAOs may be fruitful to increase competition and benefit the end user, it is important to consider indirect impacts as well as its accuracy in reflecting the burden done by organizations of different size. CMS could clarify the burden estimates for larger MAOs versus small organizations to see where the largest burden falls as well as investigate the impact of the updated burden.

This increased annual burden may pose to be a significant administrative burden to non-profit organizations who need to use the same resources to meet compliance standards as lager private for-profit companies. This may have negative consequences for health equity. One consequence is that smaller non-profit organizations who may be servicing a vulnerable group, or a region specific group such as rural communities, may struggle to compete with larger private MAOs during the bidding process due to limited resources. This could reduce the variety of

plans available to Medicare recipients in vulnerable communities due to market consolidation. The main concern would be that the increased burden would disproportionally impact smaller MAOs or non-profit organizations that are catered to vulnerable populations, which would in turn lead to reduced competition and affordability for beneficiaries as well as reduced plan availability for certain markets. Overtime, it may affect innovation as well. To address this, CMS could consider allowing for flexibility for smaller MAOs and non-profit organizations until they are able to adjust to the BPT changes under the IRA. This may include extending deadlines or providing technical guidance to help with administrative burden and ensure that smaller organizations that benefit underserved communities will be able to stabilize and compete with larger companies.

Furthermore, another consideration would be around transparency from larger MAOs on any changes in BPT rebates and calculations under the IRA which may impact beneficiaries. While the BPT will require MAOs to be more transparent with manufacturer rebates, encouraging more fair pricing for drugs, it could still potentially lead to increased costs in other ways. Even though BPT overall can foster a competitive bidding process and lower drug costs, there may be tradeoffs that affect consumers. For example, MAOs may submit competitive bids for drug pricing but increase premiums in following years to maintain profits, thus increasing cost for consumers. MAOs could also implement higher deductibles, restrict provider networks, or increase cost-sharing for services to make up deficits from competitive bids, essentially increasing costs for beneficiaries in other ways. This could affect many vulnerable populations, especially those with chronic conditions and those who have lower literacy to understand changes in their coverage and plan. CMS could issue guidance on increasing transparency from all MAOs about changes in plans and service alongside BPT considerations.

As CMS is navigating implementation and process of the BPT with the rollout of the IRA, it is critical to continue considering the impact of any changes on access and affordability for the most vulnerable populations. I urge CMS to prioritize health equity and support for smaller MAOs and non-profit organizations to ensure underserved and marginalized communities do not get disproportionately affected my any BPT complexities.