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General Comment

Dear CMS,

Thank you for the opportunity to comment on the proposed revisions to the Medicare Advantage (MA) and Part D Bid Pricing Tool (BPT). I am a Master of Public Health student focused on drug affordability, PBM influence, and community-level access. I appreciate CMS's push for more accurate bid submissions and stronger oversight, but I believe this rule needs clearer guardrails to protect beneficiaries and independent pharmacies, two groups that often absorb the consequences of plan-level financial decisions. Below are the areas where I believe the rule can be strengthened, based on evidence and recent analyses of MA/Part D practices.

1. Transparent bid assumptions must lead to actual savings for patients, not merely plan compliance

The intent of the BPT updates is good, but transparency only matters if it translates into lower out-of-pocket costs for Medicare beneficiaries. Historically, savings from rebates or negotiated prices do not reliably reach patients. Kaiser Family Foundation reported in 2023 that Part D plans pass through only a portion of manufacturer rebates, and in many cases, higher rebates lead to higher patient cost sharing because coinsurance is based on list price. In other words: plans save money, but patients may still face high costs at the pharmacy counter.

Recommendation: CMS should require MA/Part D plans to report:

- How bid pricing assumptions affect beneficiary cost sharing
- The percentage of rebate savings passed directly to enrollees
- Transparency on negotiated vs. list prices at the point of sale

Why this matters: Cost-related non-adherence remains widespread. According to a 2022 Commonwealth Fund survey, one in three Medicare beneficiaries struggled to afford their prescriptions. Transparency that does not translate to patient savings does not improve access. CMS has the authority, and now the opportunity, to ensure that beneficiaries actually feel the impact.

2. The rule must explicitly protect independent pharmacies from reimbursement cuts and network exclusion

Independent pharmacies play an essential role in rural communities, low-income urban neighborhoods, and areas with limited chain-pharmacy presence. However, they operate on tight margins and have been repeatedly harmed by PBM practices like:

- Below-cost reimbursement
- Clawbacks and retroactive fees
- Mandatory mail-order steering
- Narrow networks

The Government Accountability Office's 2023 report on PBM reimbursement found that independent pharmacies are consistently reimbursed less and face higher administrative burdens than chain pharmacies (GAO-23-105452). Changes to BPT assumptions may unintentionally give plans incentives to tighten reimbursement even further.

Recommendation: CMS should require:

- MA/Part D plans to reimburse pharmacies at or above NADAC, plus a reasonable dispensing fee
- Public reporting of pharmacy network adequacy, including urban/rural disparities
- Disclosure of PBM payment practices to CMS for oversight

Why this matters: If independent pharmacies close, Medicare beneficiaries lose access, particularly those with transportation barriers, disabilities, or chronic conditions. Protecting independent pharmacies is not a convenience issue; it is a public health equity issue.

3. CMS must prevent formulary incentives that favor high-cost brand drugs over generics/biosimilars

One persistent issue in Medicare Part D is the incentive structure that encourages plans and PBMs to place high-rebate brand-name drugs on preferred tiers, even when cheaper generics or biosimilars exist. This is well documented in multiple analyses, including a 2024 MedPAC report showing that rebates often distort formularies and increase spending for both Medicare and beneficiaries.

Recommendation: CMS should:

- Require plans to document clinical and economic justification when a high-cost brand is placed above a lower-cost equivalent
- Audit formulary decisions for rebate-driven distortions
- Increase reporting around biosimilar uptake and barriers to use

Why this matters: If generics and biosimilars remain underutilized, both Medicare and its beneficiaries will continue paying more than necessary. This undermines CMS's long-term cost and access goals.

Conclusion

I strongly support CMS's intention to increase transparency and oversight in MA and Part D bidding. But to ensure these reforms actually improve affordability and access, CMS must go further. Transparency needs to directly benefit patients; independent pharmacies must be protected from downstream financial harm; and rebate-driven formulary manipulation must be addressed head-on. These changes would strengthen the Medicare program, reduce inequities, and make sure the Part D benefit functions as intended, to help older adults and people with disabilities afford the medications they need.
Thank you for considering my comment.

Sincerely,
Natalie Aponte