

Supporting Statement Part A
Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)
CMS-10142, OMB 0938-0944

Supporting Regulations Contained in 42 Code of Federal Regulation (CFR):

422.250, 422.252, 422.254, 422.256, 422.258, 422.262, 422.264, 422.266, 422.270, 422.300, 422.304, 422.306, 422.308, 422.310, 422.312, 422.314, 422.316, 422.318, 422.320, 422.322, 422.324, 423.251, 423.258, 423.265, 423.272, 423.279, 423.286, 423.293, 423.301, 423.308, 423.315, 423.322, 423.329, 423.336, 423.343, 423.346, 423.350

Background

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and implementing regulations at 42 CFR, Medicare Advantage organizations (MAOs) and Prescription Drug Plans (PDPs) are required to submit an actuarial pricing “bid” for each plan offered to Medicare beneficiaries for approval by the Centers for Medicare & Medicaid Services (CMS).

Title I of the MMA established a program to offer prescription drug benefits to Medicare enrollees through Prescription Drug Plans. MMA Title II revised several aspects of the Medicare+Choice program (renamed Medicare Advantage), including the payment methodology and the introduction of “Regional” MA plans. CMS payments to PDPs and MA plans are on a market-based competitive approach.

MAOs and PDPs use the Bid Pricing Tool (BPT) software to develop their actuarial pricing bid. The information provided in the BPT is the basis for the plan’s enrollee premiums and CMS payments for each contract year. The tool collects data such as medical expense development (from claims data and/or manual rating), administrative expenses, profit levels, and projected plan enrollment information. By statute, completed BPTs are due to CMS by the first Monday of June each year.

CMS reviews and analyzes the information provided on the Bid Pricing Tool. Ultimately, CMS decides whether to approve the plan pricing (i.e., payment and premium) proposed by each organization.

CMS is requesting to continue its use of the BPT for the collection of information for CY2025 through CY2028. This iteration updates labels/parameters and removes/adds input cells to mirror contract year 2025 information. The changes do not impact our currently approved burden estimates.

A. Justification

1. Need and Legal Basis

The MMA was signed into law by President Bush on December 8, 2003. Two key provisions of the MMA were the new prescription drug benefit (Medicare Part D) and enhanced health plan choices of the Medicare Advantage program (which replaced the Medicare+Choice program).

The MMA established a new bidding process. Not later than the first Monday of June of each year, organizations must submit to CMS an actuarial bid for each plan that the organization intends to offer to Medicare beneficiaries in the upcoming year. CMS has the authority to review the bid and conduct negotiations with the submitting organization.

The Act specifies numerous requirements that each bid must contain. The Bid Pricing Tool was designed to facilitate the collection of this information, as well as the actuarial calculation of certain bid requirements (such as payment rates and beneficiary premiums). The submission, review, and approval process for both MA and PD programs has been synchronized.

More specific information can be found in the 42 CFR references listed above. Copies of these references are available at:

Medicare Advantage: <https://www.gpo.gov/fdsys/pkg/FR-2005-01-28/pdf/05-1322.pdf>
Prescription Drug: <https://www.gpo.gov/fdsys/pkg/FR-2005-01-28/pdf/05-1321.pdf>

2. Information Uses

The competitive bidding process defined by the “The Medicare Prescription Drug, Improvement, and Modernization Act” (MMA) applies to both the MA and Part D programs. It was first used for Contract Year 2006. It is an annual process that encompasses the release of the MA rate book in April, the bid’s that plans submit to CMS in June, and the release of the Part D and RPPO benchmarks, which typically occurs in August.

CMS requires that Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) complete the BPT as part of the annual bidding process. During this process, organizations prepare their proposed actuarial bid pricing for the upcoming contract year and submit them to CMS for review and approval.

The purpose of the BPT is to collect the actuarial pricing information for each plan. It is an Excel workbook with multiple worksheets and special functions through which bidders present to CMS their plan pricing information. Bidders enter information, such as plan experience, projected enrollment, and risk profile, and the BPT calculates the plan premiums and other values that drive the bidding process. CMS maintains and updates each BPT file and releases new versions every April.

For CMS, the BPT is an organizational tool that is used to structure bid information into a common, standardized format, which helps to automate important tasks such as—bid review, bid audit, and even plan payment. The BPT calculates the plan’s bid, enrollee premiums, and payment rates. CMS publishes this beneficiary premium information using a variety of formats (<https://www.medicare.gov/>, the *Medicare & You* handbook, Summary of Benefits marketing information) for the purpose of beneficiary education and enrollment.

All other data collected on the worksheets of the BPT follows the rules described in Section 10: Confidentiality.

The BPT files may be downloaded from the Health Plan Management System website (or HPMS), which is a restricted-access website, so users must obtain approval from CMS before using it. From HPMS, the BPT files may be downloaded as part of the Plan Benefit Package (or

PBP) software, or they may be downloaded as stand-alone blank files. These files are made available to users on the first Monday of April every year and an HPMS memo is released announcing the software availability. Plan sponsors are required to upload the completed BPTs to HPMS by the first Monday in June each year.

There are multiple resources that offer guidance on completing the BPTs, these include—the BPT Technical Instructions; the two Bid Instructions documents: one for PD plans and one for MA, ESRD-SNP, and MSA plans; the annual bidders training available on the CMS website; and the Weekly User Group Calls that are held on Thursdays between the release of the BPT files in April and the bid submission deadline in early June. The Instructions documents are required reading for preparing BPTs.

To complete the MA BPT, organizations enter data about the plan including—actual plan experience, projected allowed costs based on that experience, the plan’s cost-sharing values, and much more. Based on that input, the BPT calculates the plan’s revenue requirement, compares that amount to a benchmark—and ultimately—calculates the plan premium or MA rebate.

MA BPT Overview

In Worksheet 1, report the plan’s actual, PMPM cost and utilization experience (in Section III) as well as the assumptions (in Section IV) that will be used to project that experience into the contract year. The general information entered in Section I—such as plan ID, contract number, and plan type—will automatically display in Section I of Worksheets 2 through 7. In section II enter incurred and paid dates for the plan experience, enrollment information, risk scores and a completion factor. Enter other summary base period experience in Section VI.

Worksheet 2 develops the PROJECTED ALLOWED COSTS PMPM using the experience and projection assumptions entered in WS1. If plan experience is less than fully credible, you may enter credibility factors and manual rates in WS2. The worksheet calculates the Projected Allowed Cost as a blend of the experience rates and the manual rates. Note that WS2 contains Projected Allowed Costs for two populations: one is Dual Eligible beneficiaries WITHOUT full Medicare cost-sharing liability (which is called the “D-E-pound” population) and the other is everyone else, which includes Dual Eligible beneficiaries WITH full Medicare cost-sharing liability and non-Dual Eligible beneficiaries (this is called the non-D-E-pound population).

In Worksheet 3 enter the plan’s cost-sharing information. Enter out-of-pocket maximums in Section II on a PMPY basis. All other cost-sharing information must be entered in Section III on a PMPM basis. In Section III enter “effective” cost-sharing values that reflect the impact of services or circumstances for which cost sharing is waived.

Worksheet 4 combines Allowed Costs from WS2 and Cost Sharing information from WS3 to calculate the plan’s Projected Revenue Requirement, which includes non-benefit expenses and gain/loss margin entered directly in WS4. WS4 also allocates the projected revenue requirement between Medicare covered and non-covered services. The benefit expense component of required revenue is developed separately for the DE# and Non-DE# populations. WS4 also contains sections that address the ESRD population, and Medicaid data for the DE# population.

In Worksheet 5, enter county-level data in Section VI to support the development of the benchmark; the data include projected member months and projected risk scores. FFS county-level information is displayed in Section VII. In Section II, the worksheet compares the bid amount from WS4 to the benchmark developed in WS5; Section III displays the results of that comparison as follows: if the bid amount is greater than the benchmark, the difference is the basic MA premium. If the benchmark is greater than the bid, the difference is considered a savings; the rebate amount is a percent of the savings and the percentage depends on the plan's quality rating. Section IV contains benchmark information for Regional Plans. Section V captures quality bonus information. Enter additional projected member month details in Section VIII.

In Worksheet 6, indicate (in Section IIIB) how the rebate from WS5 will be allocated; the worksheet then applies the rebate in order to develop (in Section IIIC) the resulting plan premium. WS6 requires input of information from the Part D BPT if the plan includes prescription drug benefits. The Other information in Section II is included to support the allocation of the rebate. In section IV, provide contact information for CMS.

Worksheet 7 addresses Optional Supplemental benefits, which are additional benefits that plan members choose by paying a separate premium. Bids may include up to 5 Optional Supplemental Benefit packages; the premium for each package must cover its benefit expenses, non-benefit expenses, and gain/loss margin.

PD BPT Overview

The Part D BPT comprises seven worksheets. On Worksheet 1 report (in Sections II and III) base period plan experience including—member months, number of scripts, allowed amounts, and cost sharing. Enter non-benefit expenses in Section IV.

Worksheet 2 develops the projected allowed PMPM benefit and non-benefit expenses. Enter the utilization per thousand and allowed costs PMPM that underlie the information on WS1; report this information separately—for retail and mail-order drugs as well as for preferred brand, non-preferred brand, generic, and specialty drugs. On this worksheet, also enter the following information for both benefit and non-benefit expenses: manual rates, credibility factors, and assumptions that will be used to project the base period data into the contract year. Worksheet 2 also allocates non-benefit expenses and the gain/loss margin between Basic and Supplemental benefit categories; however, only Enhanced Alternative plan benefit types are affected.

Worksheet 3 is filled out for all Part D bids, regardless of the plan benefit type. Enter the Projected Membership, and risk scores. The worksheet develops the bid amount for Part D Defined Standard Coverage. For plan benefit types other than Defined Standard, the bid amount is used for actuarial equivalence testing purposes.

Worksheet 4 is filled out only for Actuarial Equivalent plan benefit types. It calculates the bid amount and performs one actuarial equivalence test, using data entered on Worksheet 6.

Worksheet 5 is filled out only for Basic Alternative and Enhanced Alternative plan benefit types. It calculates the plan bid amount and performs four actuarial equivalence tests, using data entered on Worksheet 6. In section IV, enter information that describes the type and cost of the following items: the deductible, and non-Part D covered drugs. In section VII—the BPT calculates the supplemental premium. The supplemental premium is zero for Basic Alternative

plans; Enhanced Alternative plans have a supplemental premium greater than zero. In section VIII, enter—for Enhanced Alternative plans—the induced utilization, i.e., the impact that a different benefit type is expected to have on plan utilization.

Worksheet 6 is filled out for all Part D bids, regardless of plan benefit type. Enter the number of scripts, total allowed dollars, and total standard cost sharing by drug tier using the cost-sharing structure of the Defined Standard plan and for the plan benefit type being submitted in the bid (if other than Defined Standard).

Worksheet 6 is specially designed to support the actuarial equivalence tests in worksheets 4 and 5. Enter the number of scripts, allowed costs, and cost-sharing amounts for a variety of claim intervals and drug types. This information is entered for a Defined Standard Benefit and for the plan benefit type being submitted in the bid (if other than Defined Standard).

In Worksheet 7 Section III, enter the National Average Monthly Bid Amount and the Base Beneficiary Premium, and the worksheet calculates the Part D Basic and Supplemental premiums. These premiums will not reflect the impact of the MA rebate allocation. In Section IV enter contact information.

3. Improved Information Technology

The BPT is programmed in an off-the-shelf software package called Microsoft Excel. This software has been used by CMS for numerous other pricing activities and builds on the knowledge of the organizations' users regarding this common business software. Excel's design is a user-friendly format, and used commonly in business applications. These factors limit the time required by organization users to gain experience and familiarity with the BPT software.

The hardcopy screen prints in Attachment D present an overview of the tool that may not fully capture the streamlining effect of the BPT software on the bid submission and review process. The actuarial pricing bid involves many complex calculations to develop the plan's bid, enrollee premiums, and payment rates. The use of Excel greatly reduces the burden on the organizations to calculate each item by using standard formulas. Also, in the case where an organization offers more than one plan (and therefore, submits more than one bid), the Excel format allows for plans to easily "copy" information into multiple bid forms and to use other automation techniques.

The submission process for the BPTs is entirely automated (electronically) through CMS's Health Plan Management System (HPMS). No paper/hardcopy submissions are required/accepted.

In addition, CMS has maximized the usability of the BPT by using standardized formats, intelligently pre-filled data fields, and instructions. These features enable the user to complete the BPT fields in a timely manner. In cases where the standardized format or pre-filled items do not describe an organization's specific pricing adequately, the BPT has included free-flow text fields where plans can describe their individual pricing in a custom fashion. Also, plans have the flexibility to provide supporting documentation to CMS in order to further describe any aspects of the bid that they would like to expand on, beyond the bid pricing tool elements.

CMS continues to improve the BPT with suggestions from its users (CMS employees, bid

reviewers, and industry). The BPT allows for the consolidation of data reporting, to use the information to perform numerous activities (beneficiary premium, plan payment) without placing additional burden on the organization.

4. Duplication of Similar Information

There is no similar information collected through any other CMS effort.

5. Small Businesses

Part D Sponsors and MA plans, entities that will be affected by this collection, are not generally considered small business entities. We have determined that there are very few MA plans and Part D sponsors that fall below the size thresholds for “small” business established by the Small Business Administration (SBA). While a very small rural plan could fall below the threshold, we do not believe there are more than a handful of such plans. As stated earlier, the Excel format of the BPT is a common business application among businesses both large and small. As stated in #13 below, no capital costs are required for this effort. The electronic submission of bids eases burden among all plans.

6. Less Frequent Collection

CMS must collect this information annually, as required by the Social Security Act. This collection is part of the annual bidding process, where organizations are required to submit their proposed actuarial pricing bid (premiums and payment rates) for the upcoming contract year.

Legislation indicates that the collection must occur annually in early June. Plans may need to resubmit bids after the initial June submission based on annually calculated national averages and to inform CMS of any rebate re-allocations.

If this collection were not conducted, or were conducted less frequently than described above, there would be adverse consequences to the Medicare Advantage and Prescription Drug programs, including but not limited to, the following:

- CMS would not be able to effectively review and approve plan marketing materials.
- CMS would not be able to effectively review and approve the plan’s bid submission, as required by statute.
- CMS would not be able to accurately or effectively educate Medicare beneficiaries regarding plan premiums.

7. Special Circumstances

Organizations may be required to submit data more often than quarterly under certain special circumstances. As stated above, each organization must submit a BPT on an annual basis as part of the contract renewal process. Under certain circumstances, new legislation may require that an organization make another submission in mid-year.

Organizations may be required to submit data in a written response to an information collection request/ requirement in fewer than 30 days after receipt under certain special circumstances. Each bid contains detailed pricing information that is unique to that organization and plan. If some of the information contained in the bid is deemed by CMS to be outside the norm, CMS

has reserved the right to request additional supporting documentation, as part of the bid review process.

Otherwise, this information collection request does not include any other special circumstances. More specifically, this information collection does not do any of the following:

- Require respondents to submit more than an original and two copies of any document;
- Require respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years.;
- Is connected with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Require the use of a statistical data classification that has not been reviewed and approved by OMB;
- Includes a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Require respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultation

The 60-day notice published in the Federal Register on 09/29/2023 (88 FR 67298).

The collection received comments from one plan sponsor. CMS/ responses to these comments can be found in "CY2025 Public Comments Received for 60 Day.docx"

The 30-day notice published in the Federal Register on TBD (88 FR).

Outside Consultation

Each year, CMS solicits industry consultation via the following avenues:

- beta testing of the BPTs in February, including solicitation of user feedback,
- annual bidders training, in early April, conducted by CMS,
- weekly CMS user group calls with BPT users, between mid-April and early-June,
- a CMS resource mailbox available for correspondence regarding the BPT,
- an online industry feedback/ comment forum following the bid review season, and
- informal discussions between CMS and BPT users (phone, email, etc.) as part of our daily business operations.

These consultations, and the resulting feedback, are then considered and incorporated into the BPT each year. As a result of this year's consultations, minor clarifications and revisions were made to the bid pricing tools. Please see Attachment C submitted with this package for the description of all changes made to the BPTs.

To summarize, industry input assists CMS to create a tool that is entirely automated, data driven, and responsive to the needs of BPT users.

9. Payments/Gifts to Respondents

There are no payments/gifts to respondents for their participation in the bidding process, however, Bid/Contract approval and publication is a possible incentive.

10. Confidentiality

Information collected through the BPT may contain proprietary information, trade secret, commercial and/or financial information, therefore it is privileged, private to the extent permitted by law, and protected from disclosure. This information is protected to the extent permitted by the Freedom of Information Act (5 U.S.C.552).

Information collected through the BPT will be published pursuant to the authority at §422.272.

11. Sensitive Questions

There are no sensitive questions included in this collection effort.

12. Burden Estimate

Assumptions

In the CY 2011 Terms of Clearance, CMS was instructed to survey a subset of plans regarding their burden estimates. CMS requested participation in the survey from nine organizations representing a meaningful sampling of MA and PDP organizations. Seven organizations completed the PRA burden survey while two of the organizations declined participation in the survey process. Estimates for the “average hours per response” and “wages per hour” for the occupation title “Actuary” are based on the survey results. The figures represent the organization’s best estimate of total cost required to complete the bid forms.

The estimates for “number of respondents” and “average number of responses per respondent” are based on the previous years’ bid submissions.

Annual Burden Estimates

The estimated annual burden for the BPT is as follows:

Type of Respondent	Number of Respondents	Average Number of Responses per Respondent	Number of Responses	Average Hours per Response	Time (hr)
PDP	160	9	1,440 PD	12 PD	17,280
MAO: MA-only, MA-PD	395	9	3,555: 1,395 MA-only, 2,160 MA-PD	30 MA 30 MA + 12 PD	41,850 90,720
Total	555	9	4,995	30	149,850

Note that the number of respondents for the BPT does not exactly match the number of

respondents for the Plan Benefit Package (PBP), even though these two instruments are often viewed as one submission. The difference in the number of respondents between the BPT and PBP is due to the fact that some respondents only submit the PBP, and some other respondents only submit the BPT.

We are adjusting the employee hourly wage estimate by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. We believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

An estimate of the cost to respondents in burden hours for the submission of information is approximately \$22,477,500 (149,850 hours x \$150 per hour) for each contract year.

Collection of Information Instruments and Instruction/Guidance Documents

- Medicare Advantage BPT Worksheets
- Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2025

To complete the MA BPT, organizations must provide a series of data entries on the appropriate form pages. The MA BPT is organized as outlined below:

- Worksheet 1 – MA Base Period Experience and Projection Assumptions
 - Worksheet 2 – MA Projected Allowed Costs PMPM
 - Worksheet 3 – MA Projected Cost Sharing PMPM
 - Worksheet 4 – MA Projected Revenue Requirement PMPM
 - Worksheet 5 – MA Benchmark PMPM
 - Worksheet 6 – MA Bid Summary
 - Worksheet 7 – Optional Supplemental Benefits
- Prescription Drug BPT Worksheets
 - Instructions for Completing the Prescription Drug Plan Bid Pricing Tool for Contract Year 2025

To complete the Part D bid form, Part D sponsors must provide a series of data entries on the appropriate BPT worksheets. The number of inputs depends on the type of plan being offered and the length of time it has had a contract with CMS, among other factors. The Part D bid form is organized as outlined below:

- Worksheet 1 – Rx Base Period Experience
- Worksheet 2 – PDP Projection of Allowed/Non-Benefit
- Worksheet 3 – Rx Contract Period Projection for Defined Standard Coverage
- Worksheet 4– Rx Standard Coverage with Actuarially Equivalent Cost Sharing
- Worksheet 5 – Rx Alternative Coverage
- Worksheet 6 – Rx Script Projections for Defined Standard, Actuarially Equivalent or Alternative Coverage

- Worksheet 7 – Summary of Key Bid Elements

All Part D sponsors must complete Section I of Worksheet 1; completion of subsequent sections of the BPT is based on the plan benefit type being offered.

13. Capital Costs

No capital costs are needed for this collection effort.

14. Cost to the Federal Government

The initial burden to the Federal government for the collection of the BPT was borne through the initial development cycle, as a one-time cost. The BPT is now in maintenance mode with regard to development and enhancements. The maintenance cost and the cost for enhancements are estimated in the table below. (The CMS employees' hourly wage schedule can be obtained <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/> under the Washington-Baltimore-Northern Virginia locality. Effective January 2019.)

Maintenance and Enhancements	\$300,000.00
Defining Requirements	
2 GS-15 (Step 10): 2 x \$79.78/hr x 20 hours	\$3,191.20
1 GS-15 (Step 10): 1 x \$79.78/hr x 40 hours	\$3,191.20
2 GS-14 (Step 10): 2 x \$73.00/hr x 80 hours	\$11,680.00
5 GS-14 (Step 10): 5 x \$73.00/hr x 20 hours	\$7,300.00
2 GS-13 (Step 10): 2 x \$61.77/hr x 20 hours	\$2,470.80
<i>Subtotal</i>	<i>\$27,833.20</i>
Total Cost to the Government	\$327,833.20

Additional costs to the government to prepare these files for release are already accounted for in current estimates (existing staff assignments and contracts), and therefore the cost impact is zero.

15. Program Changes/Adjustments

While there are no changes to our burden estimates, we have made the following changes in response to contract year 2025 effective provisions of the Medicare Advantage and Prescription Drug Program and industry feedback. None of the changes result in any burden adjustments.

See Attachment C for a list of all CY 2025 changes.

16. Publication and Tabulation Dates

Plan premium information in the BPT is utilized, in conjunction with the PBP, for beneficiary education and enrollment (the SB marketing material, the <https://www.medicare.gov/> website, and the *Medicare & You* handbook). This release of premium and benefit information occurs annually in September or early October.

The remainder of the BPT collection will be published under the authority at §422.272. As noted in §422.272, CMS will release to the public, MA bid pricing data for MA plan bids

accepted or approved by CMS for a contract year under §422.256. The annual release will contain MA bid pricing data from the final list of MA plan bids accepted or approved by CMS for a contract year that is **at least 5 years prior to the upcoming calendar year**. For the purpose of this section, the following information is excluded from the data released:

- (1) For an MA plan bid that includes Part D benefits, the information described at §422.254(b)(1)(ii), (c)(3)(ii), and (c)(7).
- (2) Additional information that CMS requires to verify the actuarial bases of the bids for MA plans for the annual bid submission, as follows:
 - (i) Narrative information on base period factors, manual rates, cost-sharing methodology, optional supplement benefits, and other required narratives.
 - (ii) Supporting documentation.
- (3) Any information that could be used to identify Medicare beneficiaries or other individuals.
- (4) Bid review correspondence and reports.

CMS will release MA bid pricing data as provided in paragraph (b) of this section on an annual basis after the first Monday in October.

17. Expiration Date

CMS will display the expiration date on Worksheet 1 of all BPTs and on both instruction documents.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

Not applicable. No statistical methods will be used in this collection effort.