

# Medicare Advantage market reaction to End-Stage Renal Disease enrollment expansion

How did MA plans react to the 21st Century Cures Act?

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Starting with the 2021 plan year, individuals with end-stage renal disease (ESRD) may enroll in Medicare Advantages plans, made possible by the 21st Century Cures Act.<sup>1</sup>

With the Social Security Amendment of 1972 (P.L. 92-603), Congress enacted legislation that allowed individuals with end-stage renal disease (ESRD) who were less than 65 years of age to enroll in original Medicare. The legislation marked the first time “individuals were allowed to enroll in Medicare based on a specific medical condition rather than on age.”<sup>2</sup> When Medicare Advantage (MA) was signed into law in 1997, this allowance applied to MA plans as well. However, there were enrollment restrictions for these beneficiaries which did not allow them to actively enroll in MA plans.

Historically, there were mainly two ways that beneficiaries with ESRD could enroll with an MA plan. One option was to enroll in an ESRD Special Needs Plan (ESRD SNP), of which there are only nine available in the nationwide 2021 MA market. Another option allowed for a beneficiary already enrolled in an MA plan who later developed ESRD was to stay enrolled in the current plan. The 21<sup>st</sup> Century Cures Act (Cures Act), which passed in December 2016 and came into effect January 1, 2021, requires MA plans to allow active enrollment of beneficiaries with ESRD in their plans.

Prior to 2021, ESRD enrollees comprised about 0.5% of the MA market,<sup>3</sup> but approximately 1% of total Medicare beneficiaries nationwide.<sup>4</sup> Additionally, as of 2018, approximately 40.5% of all ESRD patients in the United States had Medicare fee-for-service (FFS) coverage, while about 24% were covered under MA.<sup>5</sup> By comparison, as of January 2021, just over 42% of all Medicare beneficiaries were enrolled in Medicare Advantage.<sup>6</sup>

As an additional point of comparison, the Office of the Actuary (OACT) reported that in 2021 MA bid pricing tool (BPT) worksheets there were 2,102,000 projected ESRD member months, for an increase of 930,000 projected member months from 2020 to 2021. This 930,000 member month increase included an additional 879,000 member months compared to 2020 BPTs (that is, 51,000 member months were assumed to be due to non-specific enrollment growth) due to MA plans estimating the impact of the new ESRD open enrollment provision.<sup>7</sup> CMS reported in a response to questions submitted for the February 25, 2021 Actuarial User Group Call (UGC), that “based on enrollment through February 2021, we estimate that about 40,000 beneficiaries in ESRD status migrated from Medicare FFS to Medicare Advantage.”<sup>8</sup> It would appear that in the bid projections MA organizations (MAOs) collectively significantly over-projected the increase in ESRD membership for 2021. That is, 930,000 member months divided by a conservative assumption of 12 months per member results in 77,500 additional members, which is significantly higher than the membership which ultimately ended up enrolling.

<sup>1</sup> The full text of the Cures Act is available at <https://www.congress.gov/bill/114th-congress/house-bill/34/text>.

<sup>2</sup> Kirchhoff, S.M. (August 16, 2018). Medicare Coverage of End-Stage Renal Disease (ESRD). Congressional Research Service. Retrieved February 5, 2021, from <https://fas.org/sgp/crs/misc/R45290.pdf>.

<sup>3</sup> Deckert, L. (March 6, 2019). Why Medicare Advantage plans may be losing money on members with ESRD. Discovery Health Partners. Retrieved February 5, 2021, from <https://www.discoveryhealthpartners.com/medicare-advantage-plans-may-losing-money-members-esrd/>.

<sup>4</sup> Kirchhoff, op cit.

<sup>5</sup> U.S. Renal Data System. Healthcare Expenditures for Persons with ESRD. Retrieved February 5, 2021, from <https://adr.usrds.org/2020/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd>.

<sup>6</sup> CMS. MA State/County Penetration 2021 01. Retrieved February 5, 2021, from <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenrolatama-state-county/ma-state-county-penetration-2021-01>.

<sup>7</sup> CMS (November 12, 2020). November 2020 Actuarial User Group Call. Retrieved February 5, 2021, from <https://www.cms.gov/files/document/user-group-call-agenda-2020-11-12.pdf>.

<sup>8</sup> CMS (February 25, 2021). February 2021 Actuarial User Group Call. Retrieved February 25, 2021, from <https://www.cms.gov/files/document/cy-2022-actuarial-bid-questions.pdf>.

The focus of this paper is on the various changes to MA plans made in reaction to an expected increase in ESRD enrollment due to the Cures Act, taking advantage of new Centers for Medicare and Medicaid Services (CMS) flexibilities, as described below. We compared various plan characteristics in 2019, 2020, and 2021 to infer market reaction to the Cures Act. We considered the following benefits and plan characteristics in our analysis and comment on different aspects of their changes in the 2021 MA marketplace.

- **Plan maximum out-of-pocket (MOOP):** CMS increased the MOOP to allow plans to mitigate the potential of additional ESRD member costs.
- **Cost sharing for dialysis services:** Though CMS made no changes to regulations regarding cost sharing for kidney dialysis services, we reviewed the cost-sharing trends for these services.
- **Inpatient copay maximum:** As noted below, CMS increased inpatient copay limits to allow plans to mitigate the potential of additional ESRD member costs.
- **Prevalence of ESRD SNP plans:** We review the marketplace impact in 2021 of ESRD SNP plans.

We used changes between 2019 and 2020 as a recent comparison point for how these benefits usually change annually. We note that between 2019 and 2020 the Health Insurance Providers Fee (HIPF) moratorium was lifted (that is, the HIPF tax was not assessed for 2019 plans but was assessed for 2020 plans), which may have imposed an additional cost burden on plans. However, previous research shows that the presence of the HIPF moratorium did not cause plans to significantly alter their benefit designs, presumably in order to remain viable in a competitive market.<sup>9</sup>

## Background

ESRD beneficiaries traditionally have more complex and advanced health concerns than the average non-ESRD, non-hospice Medicare beneficiary. The healthcare claims cost of these members is approximately seven to eight times higher<sup>10</sup> due to the need for routine outpatient dialysis services and other treatments to manage the condition and because these beneficiaries commonly have other comorbidities. It is also important to recognize that CMS requires a bundled prospective payment system (PPS) for the treatment of ESRD in Medicare FFS, so MAOs potentially could have much higher costs than Medicare FFS, as it can be difficult to achieve the much lower ESRD PPS rates when negotiating with dialysis providers.

For benefit year 2021, to address the expected increase in ESRD beneficiary enrollment in MA plans, CMS preemptively took several steps to ease the financial impact of the higher costs associated with these members:<sup>11</sup>

- **Increased the mandatory and voluntary MOOP amounts:** CMS revised the calendar year (CY) 2021 MOOPs to better reflect beneficiary spending across both ESRD and non-ESRD beneficiary groups. The CY 2021 mandatory in-network MOOP is \$7,550, compared to \$6,700 in prior years, an increase of \$850, while the CY 2021 voluntary MOOP received only a \$50 increase, from \$3,400 to \$3,450. Both of these values of the MOOP had been static for many years; these changes to the MOOP limits are therefore significant in mandated benefit plan designs in the MA market. CMS notes that beginning in 2022 it will continue to phase spending patterns of ESRD beneficiaries into MOOP calculations until their costs are fully reflected in the MOOP limits (that is, MAOs should expect increasing MOOP limits in CY 2022 and beyond).
- **Increased the inpatient cost-sharing maximum:** Similar to the MOOP above, CMS also increased this cost-sharing metric for both acute and psychiatric inpatient stays to account for beneficiary spending across both ESRD and non-ESRD beneficiary groups; however, CMS explicitly stated it was not doing so for other service categories. And again, as with the MOOP, CMS indicated it will continue to phase in the spending patterns of ESRD beneficiaries for inpatient cost-sharing maximums. The table in Figure 1 identifies the changes from 2020 to 2021 in the inpatient benefit maximums.<sup>12</sup>

<sup>9</sup> Friedman, J.M., Swanson, B.L., Yeh, M.G., & Cates, J.J. (February 2020). State of the 2020 Medicare Advantage Industry: As Strong as Ever. Milliman Research Report. Retrieved February 5, 2021, from [https://us.milliman.com/-/media/milliman/pdfs/articles/state\\_of\\_the\\_2020\\_medicare\\_advantage\\_industry.ashx](https://us.milliman.com/-/media/milliman/pdfs/articles/state_of_the_2020_medicare_advantage_industry.ashx).

<sup>10</sup> Based on the 2018 CMS 5% sample.

<sup>11</sup> CMS (April 8, 2020). Final Contract Year 2021 Part C Benefits Review and Evaluation. Retrieved February 5, 2021, from [https://mabenefitsmailbox.fhi.gov/MABenefitsMailbox/Documents/2021%2FFinal%20CY%202021%20Part%20C%20Bid%20Review%20Memorandum\\_4-8-2020.pdf](https://mabenefitsmailbox.fhi.gov/MABenefitsMailbox/Documents/2021%2FFinal%20CY%202021%20Part%20C%20Bid%20Review%20Memorandum_4-8-2020.pdf).

<sup>12</sup> 2021 values from <https://www.cms.gov/httpseditcmgovresearch-statistics-data-and-systemscomputer-data-and-systemshpms-hpms-memos-archive/hpms-memo-7>, CY 2021 Part C Bid Review Memorandum\_Final 2.6.2020.pdf. 2020 values from <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf>.

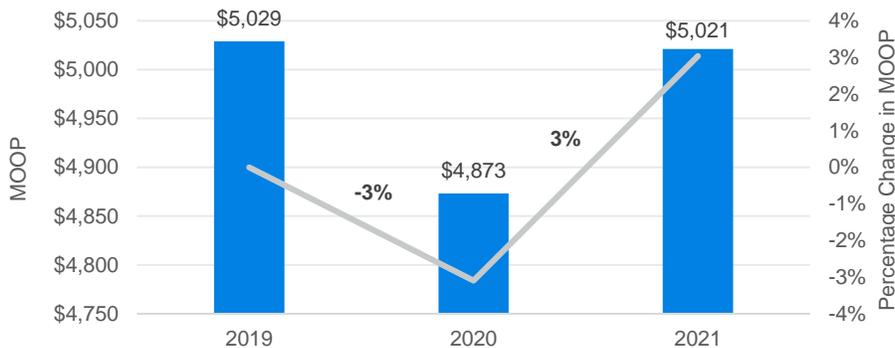
**FIGURE 1: CY 2020 AND CY 2021 INPATIENT IN-NETWORK SERVICE CATEGORY COPAY MAXIMUM CHANGES**

BENEFIT	DAY LIMIT	VOLUNTARY MOOP		MANDATORY MOOP	
		CY 2020	CY 2021	CY 2020	CY 2021
<b>INPATIENT HOSPITAL – ACUTE</b>					
	60 days	N/A	N/A	\$4,777	\$4,816
	10 days	\$2,721	\$2,783	\$2,177	\$2,226
	6 days	\$2,461	\$2,524	\$1,969	\$2,019
<b>INPATIENT HOSPITAL PSYCHIATRIC</b>					
	60 days	\$3,408	\$3,408	\$2,438	\$2,726
	15 days	\$2,204	\$2,339	\$1,763	\$1,871

- Increased the total beneficiary cost (TBC) limit:** The TBC limit represents the maximum permissible amount a plan can reduce benefits or increase premium year over year in order to limit beneficiary exposure to significant total cost changes between those two years. The TBC limit increased from \$36 to \$39.<sup>13</sup> CMS stated the TBC limit increase was due to the additional program costs associated with enrolling beneficiaries with ESRD and related MOOP limit changes.

## Results

**FIGURE 2: CHANGE IN THE NATIONWIDE AVERAGE MOOP FOR NON-SNP PLANS BETWEEN 2019 AND 2021**



As detailed in Figure 2, between 2020 and 2021, there was an approximately 3% nationwide increase in average MOOP<sup>14</sup> for non-dual-eligible, Medicare Advantage and Prescription Drug (MAPD) plans, from \$4,873 in 2020 to \$5,021 in 2021. This is in contrast to a 3% decrease in MOOP between 2019 and 2020, despite the lifting of the HIPF moratorium between 2019 and 2020 (causing many MA plans to incur an additional expense). For plans at the voluntary MOOP of \$3,400 or less in 2020, the change in nationwide MOOP was a 7% increase from 2020 to 2021. In contrast, plans at the voluntary MOOP saw a 10% decrease in MOOP between 2019 and 2020. The additional TBC allowance may have aided plans in making this upward change in MOOP into 2021. Despite the Cures Act being passed in December 2016, the average nationwide non-SNP MOOP has seen consistent decreases since then, as shown in Figure 3, pointing to the reactionary nature of many MAO organizations to the allowed CMS MOOP increase in 2021.

<sup>13</sup> From <https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpms-hpms-memos-archive/hpms-memo-12>, CY 2021 Part C Bid Review Memorandum\_Final 2.6.2020.pdf and Final CY 2021 Part C Bid Review Memorandum\_4-8-2020.pdf.

<sup>14</sup> Plan-specific MOOP-weighted average weighted by September 2020 crosswalked enrollment.

**FIGURE 3: NON-SNP AVERAGE NATIONWIDE MOOP FOR 2017 THROUGH 2021**

YEAR	MOOP	PERCENT CHANGE
2017	\$5,273	N/A
2018	\$5,246	-0.5%
2019	\$5,029	-4.1%
2020	\$4,873	-3.1%
2021	\$5,021	3.0%

ESRD prevalence historically varied by geographic area. We analyzed the top 10 metropolitan statistical areas (MSAs) by overall 2018 ESRD prevalence in the MA market.<sup>15</sup> The top two MSAs are El Paso and McAllen-Edinburg-Mission, Texas, both with just over 1% ESRD penetration in the MA market. These MSAs saw 14% and 8% increases in average MOOP for 2021, respectively. In contrast, between 2019 and 2020, the average MOOP decreased by 0 to 2% for these two MSAs. Among the rest of the top 10, two MSAs were outliers: Los Angeles-Long Beach, and Riverside-San Bernardino, California. In these MSAs, the average MOOP decreased by 11% to 12% from 2020 to 2021, and between 14% and 22% between 2019 and 2020. We note there are several ESRD SNPs in these MSAs, which may have reduced the need for MA plans to redesign their general enrollment plans. In the remaining six MSAs, the average increase in MOOP in 2021 was approximately 5%, in contrast to almost no change between 2019 and 2020.

Among the top 10 carriers of non-SNP plans as determined by September 2020 enrollment, six carriers increased average MOOP overall for their MAPD non-SNP plans from 2020 to 2021. The top ten carriers reviewed comprise over 75% of the non-SNP MA enrollment. For most of these carriers, the increase was not significant (on average a 2% increase over these carriers), suggesting that plans considered more than just the eligibility of ESRD members when designing benefits. One large nationwide carrier increased its average MOOP significantly, but its 2021 average nationwide MOOP remained below the 2020 mandatory MOOP of \$6,700. Another regional carrier elected to move all of its non-SNP plans to the \$7,550 MOOP maximum in 2021, despite having an average MOOP in 2020 of about \$4,000.

**FIGURE 4: CHANGE IN THE NATIONWIDE AVERAGE MOOP FOR D-SNP PLANS BETWEEN 2019 AND 2021**

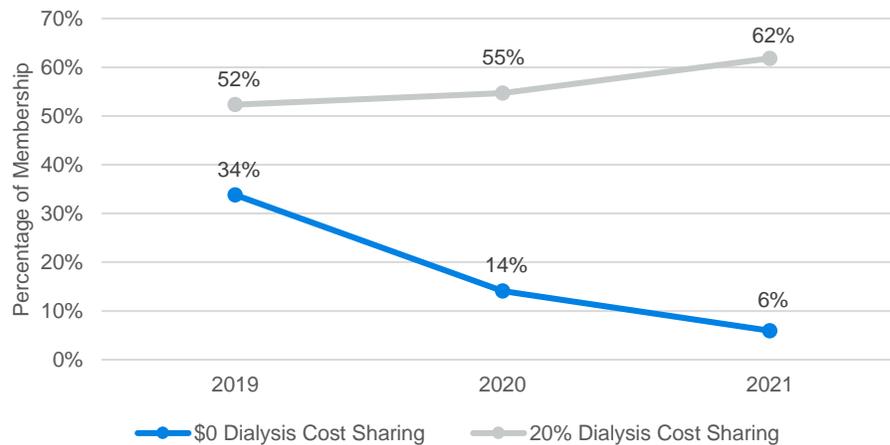
Because members requiring dialysis are disproportionately low-income,<sup>16</sup> we analyzed dual-eligible SNPs (D-SNPs) separately. As shown in Figure 4, for D-SNPs the increase in MOOP between 2020 and 2021 was 7% (from \$5,200 to \$5,555), relative to a 1% decrease from 2019 to 2020 (\$5,254 to \$5,200). Most members enrolled in D-SNPs pay little to no cost sharing and therefore are not sensitive to plan changes in either cost sharing or the MOOP. Because about 40% of those

<sup>15</sup> Based on the 2018 CMS 100% sample.

<sup>16</sup> MedPAC (March 2020). Chapter 6: Outpatient Dialysis Services. Report to the Congress: Medicare Payment Policy. Retrieved February 5, 2021, from [http://www.medpac.gov/docs/default-source/reports/mar20\\_medpac\\_ch6\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch6_sec.pdf?sfvrsn=0).

beneficiaries indicated as qualifying as ESRD are dual-eligible members,<sup>17</sup> MAOs may have reacted more aggressively in raising the MOOPs on these plans relative to their non-SNP counterparts. Additionally, many D-SNPs opted to offer the maximum MOOP in 2020, and some (but not all) of those increased their MOOPs to remain at the maximum in 2021.

**FIGURE 5: NON-SNP MEMBERSHIP ENROLLED IN PLANS WITH OUTPATIENT DIALYSIS COST SHARING FOR TOP 10 ESRD PREVALENCE MSAS**



Outpatient dialysis benefits, a benefit that is crucial for ESRD beneficiaries,<sup>18</sup> historically are set at the traditional Medicare equivalent of 20% coinsurance by the majority of plans. However, a number of plans have offered lower coinsurances or copays, or tiered copays or coinsurances, for this service. When analyzing the top 10 metropolitan statistical areas (MSA) by ESRD prevalence, the proportion of members in plans in 2020 with the standard 20% coinsurance was 55%, whereas 14% of members enrolled in MA-PD non-SNP plans with \$0 dialysis cost sharing, as shown in Figure 5. In 2021, 62% of beneficiaries were in plans with a 20% coinsurance, while only 6% of members remained in plans with \$0 dialysis cost sharing. These findings are in significant contrast to 2019, when 34% of members were in plans with \$0 dialysis cost sharing, suggesting that MA-PD plans began planning for this change specific to the dialysis cost-sharing metric beginning as early as the 2020 benefit year.

We reviewed the change in inpatient copays in the top 10 MSAs by ESRD prevalence. We did not observe a pattern in inpatient benefit changes across these MSAs, or nationwide. We note the inpatient benefit is an impactful benefit to beneficiaries who utilize it, with much more significant financial implications, suggesting plans considered more factors than just the change in ESRD enrollment when making benefit change determinations.

Lastly, there was a small reduction in the number of ESRD SNPs, or ESRD chronic condition SNPs (C-SNPs),<sup>19</sup> targeting enrollees who rely upon dialysis services—there were 10 plans available in 2020 but only nine in 2021 (the Humana’s Kidney Care plan in Nevada exited the market). Additionally, these nine current ESRD C-SNPs are operated by three broad health maintenance organizations (HMOs)—Anthem, SCAN Health Plan, and Humana—with coverage for about 5,300 members. The ESRD C-SNP plans are concentrated mainly in California and have been in the market for a number of years. The lack of expansion for these specialized ESRD C-SNP plans may be due to the lack of ESRD care coordination resources or a provider network to successfully implement such a specific plan.

<sup>17</sup> Based on the 2018 CMS 100% sample.

<sup>18</sup> See <https://www.modernhealthcare.com/article/20141011/MAGAZINE/310119932/home-dialysis-grows-despite-cost-and-logistical-hurdles>. Only 8% of dialysis patients in the United States are on home dialysis, compared to other countries where the rate is at or above 20%.

<sup>19</sup> CMS. Chronic Condition Special Needs Plans (C-SNPs). Retrieved February 5, 2021, from <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/C-SNPs>.

## Methodology and assumptions

The costs of ESRD members relative to non-ESRD members are approximately seven to eight times higher, which was determined by a review of the 2018 CMS 5% sample. In particular, the 2018 CMS 5% sample was used to determine the average Medicare Part A and Part B utilization and cost metrics per member per month (PMPM) for an ESRD beneficiary and a non-ESRD beneficiary. This database includes the final claims data for a 5% sample of Medicare FFS beneficiaries.

We summarize the methodology used in the analysis described above in the following steps:

- We identified member types as those being ESRD or non-ESRD, non-dual-eligible. We excluded all other members (hospice, dual-eligible, or institutionalized) from this analysis, including those who would be identified as ESRD and one of these statuses (e.g., ESRD-hospice, ESRD-SNP, etc.).
- We focused only on members who are enrolled under both Part A and Part B.
- We excluded data that did not pass our data quality guidelines.

To aggregate ESRD prevalence by ESRD status, we used the 2018 CMS 100% sample to summarize the count of MA ESRD members within each county. We summarized each county into the appropriate MSA and ranked them by ESRD prevalence as a percentage of total MA members. We used the top 10 MSAs by this metric in our analysis.

In performing the analyses contained in this report, we relied on detailed MA plan benefit offerings for 2019 through 2021 as released by CMS. We also used publicly available MA enrollment information for February of each year (with the exception of 2021, which uses September 2020 enrollment, taking into account any plans which applied a crosswalk into 2021, because February 2021 enrollment was not yet available) to develop member-weighted averages by year from the plan-level detail released by CMS. The values presented reflect plans available in each respective year. The information released by CMS includes detailed cost-sharing information by service category, member premium, service area, supplemental benefits covered, star rating, and enrollment by plan and was summarized from each respective year of the Milliman MACVAT®.

We summarized the data as described above for a non-SNP population, with the exception of Figure 4, which focuses on a D-SNP population. Except when otherwise noted, we included all individual, i.e., non-employer group waiver plan (EGWP) Medicare Advantage plans, excluding Prescription Drug Plan (PDP), Medicare Set-Aside Arrangement (MSA), Medicare-Medicaid Plan (MMP), Program of All-Inclusive Care for the Elderly (PACE), Part B-only, and Cost plans.

## Looking ahead

Organizations and plan types reacted differently in the benefit allowances afforded them by CMS due to the Cures Act. MAOs should consider different initiatives, data analyses, and care management opportunities<sup>20</sup> to provide the best care for these beneficiaries while remaining financially stable. To address some of the cost issues that are inherent in providing care to ESRD beneficiaries, the Centers for Medicare and Medicaid Innovation (CMMI) has started a number of innovation models addressing both the cost and quality of life for ESRD beneficiaries. The Kidney Care Choices (KCC) Model<sup>21</sup> will run from 2020 through 2023 and is designed to help healthcare providers reduce the cost and improve the quality of care of patients with late-stage chronic kidney disease (CKD, stages 4 and 5). The model also aims to delay the need for dialysis and encourage kidney transplants. The ESRD Treatment Choices (ETC) Model<sup>22</sup> went live on January 1, 2021, which is a value-based payment model. The ETC will impact about 30% of kidney care providers, with the aim to incentivize home dialysis and kidney transplants.

<sup>20</sup> Backes, K.S., Kroening, K.N., Rodriguez, D., & Yilmaz, G.S. (December 2019). Medicare Advantage: Eight Critical Considerations for Every Organization as ESRD Eligibility Expands in 2021. Milliman White Paper. Retrieved February 5, 2021, from <https://www.milliman.com/-/media/milliman/pdfs/articles/medicare-advantage-eight-critical-considerations.ashx>.

<sup>21</sup> CMS. Kidney Care Choices (KCC) Model. Retrieved February 5, 2021, from <https://innovation.cms.gov/innovation-models/kidney-care-choices-kcc-model>.

<sup>22</sup> CMS. ESRD Treatment Choices (ETC) Model. Retrieved February 5, 2021, from <https://innovation.cms.gov/innovation-models/esrd-treatment-choices-model>.

## Caveats, Limitations, and Qualifications

Julia M. Friedman is a consulting actuary for Milliman, a member of the American Academy of Actuaries, and meets the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of my knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The material in this report represents the opinion of the author and is not representative of the view of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views contained in this report related to the Medicare Advantage program.

The information in this report is designed to provide an overview of market reactions to the Cures Act for various Medicare Advantage benefits. This information may not be appropriate, and should not be used, for other purposes. I do not intend this information to benefit any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this report to a third party should be in its entirety.

The credibility of certain comparisons provided in this report may be limited, particularly where the number of plans in certain groupings is low. Some metrics may also be distorted by premium and benefit changes in a few plans with particularly high enrollment.

In preparing our analysis, I relied upon public information from CMS, which I accepted without audit. However, I did review it for general reasonableness. If this information is inaccurate or incomplete, conclusions drawn from it may change.



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