WHITE PAPER

Increased ESRD Beneficiary Enrollment Flexibility Presents a Potential Financial Challenge for Medicare Advantage Plans in 2021

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Changes to ESRD Beneficiary Eligibility Creates Increased Financial Risk for Medicare Advantage Organizations

The 2016 21st Century Cures Act enacts a significant change in Medicare Advantage (MA) eligibility for beneficiaries with end stage renal disease (ESRD). Beginning in 2021, ESRD beneficiaries can select a MA plan during open enrollment regardless of previous coverage. Previously, these beneficiaries could generally only obtain MA coverage under limited circumstances. For example, an enrollee could remain in an MA plan if the ESRD diagnosis first occurred after the beneficiary was already enrolled (unless an ESRD-SNP was available in the area).

Currently, about 120,000 ESRD beneficiaries are enrolled in MA plans, which represents about 0.65% of all MA enrollees[1]. While the proportion of ESRD beneficiaries in MA is low, the health expenditures are very high relative to the population size – around 5% of MA spending. Given the upcoming statutory change, a large percentage of the 410,000 ESRD beneficiaries that are in FFS Medicare could switch to MA. If all ESRD beneficiaries enrolled in MA, they would then represent about 2.7% of MA enrollment. Given that the average allowed PMPM for an ESRD beneficiary is almost nine times that of a general enrollment beneficiary, the impact to total average claims would be even more significant. If all ESRD beneficiaries enrolled in MA, we estimate that the proportion of claims attributable to ESRD beneficiaries as a percentage of total would increase from 5% to 20%.

A potential influx of ESRD enrollees in MA creates renewed focus on ESRD payment accuracy.

The potential influx of ESRD beneficiaries into MA plans represents a potential financial challenge to those plans if the Centers for Medicare and Medicaid Services (CMS) does not change the current MA payment structure for ESRD enrollees. If no changes are made, beneficiaries could see an increase in premiums or a decrease in benefits in order for MAO's to maintain their current financial position.

The 21st Century Cures Act requires a number of evaluations of payment model accuracy,

[1] 2019 projection from CMS April 2, 2018 Final Announcement

including ESRD risk adjustment, and how to most accurately measure functional status of ESRD beneficiaries.

This paper provides an overview of the current rules and financial data for ESRD enrollees in MA. This paper also summarizes the changes enacted in the 21st Century Cures Act and highlights the potential impact to plans and beneficiaries if CMS does not modify the ESRD payment methodology

Current Status

ESRD Definition and MA Eligibility

CMS defines those as eligible for Medicare due to ESRD status as individuals with permanently non-functioning kidneys who require either regular dialysis treatments or a kidney transplant to remain alive. Currently any individual with ESRD status is eligible for Medicare, however not all ESRD members are eligible for Medicare Advantage (MA).

Within the broad status of ESRD, there are three subsets of beneficiaries that define how payments are made to Medicare Advantage plans: Dialysis, Transplant, and Functioning Graft. Dialysis status, which includes those currently receiving dialysis treatment, makes up the majority (approximately 85%) of the ESRD population. Transplant status, which comprises less than 1% of the ESRD population, is effective from the date of transplant to three months after. Beginning with the fourth month post-transplant, a member moves to Functioning Graft status (approximately 15% of the population), as long as the member has not returned to dialysis. If the member receives dialysis at any time after the transplant, they revert back to dialysis payment status.

MA Payments for ESRD Beneficiaries

Under Medicare Advantage, MA organizations submit "bids" for non-ESRD beneficiaries - a bid represents the estimated cost to provide Original Medicare benefits. This bid is compared against a benchmark for medical costs in the fee-for-service (FFS) system, adjusted to reflect the expected risk score of the MA organization's non-ESRD population. MA organizations are paid this bid, plus a percentage (50%, 65%, or 70%) of the difference between the risk-adjusted benchmark and the bid, which is called the "rebate". MA organizations must allocate rebate payments to fund additional benefits above and beyond Original Medicare. For example, MA organizations might choose to provide richer Part C and D benefits (above and beyond the Original Medicare benefit of 20 % coinsurance), or offer supplemental dental,hearing, or vision benefits funded through the rebate.

MA organizations are paid differently for ESRD beneficiaries in comparison to the general enrollment population. In general, Medicare Advantage organizations do not submit bids for ESRD beneficiaries. Instead, organizations are paid a risk adjusted benchmark; however the payment varies depending on the type of ESRD status.

For beneficiaries in Dialysis status, MA organizations get paid based on statewide ESRD benchmarks published by CMS, adjusted for an ESRD Dialysis risk adjustment model factor. The ESRD Dialysis benchmark is derived from FFS dialysis cost data for each state and is calculated similarly to the Part C benchmarks for the general risk pool.

For beneficiaries in Transplant status, CMS provides three months of payments to plans to cover the cost of kidney acquisition and costs

surrounding and related to the transplant. CMS develops payments using FFS hospital stay payments for the transplant and professional services provided for the hospital stay and two months after discharge.

For enrollees in Functioning Graft status, MA organizations get paid based on the standard MA benchmark rates. For this population the standard MA benchmark is risk adjusted using the corresponding ESRD HCC model and is not subject to the rebate percentage reduction on savings.

In all cases, since there is not a "bid" amount for ESRD beneficiaries, MA organizations are paid the full benchmark amount, and there is not an adjustment as there is for non-ESRD beneficiaries for a portion of the difference between the plan bid and the CMS benchmark (i.e rebate percentage). Plans must offer the same additional benefits above and beyond Original Medicare that are offered to non-ESRD enrollees.

Current Medicare Advantage Plan Member Premium, MOOP, and Dialysis Benefit Trends

Based on publicly available nationwide 2019 PBP data published by CMS, plans offered by MA organizations generally have relatively low premiums, with attractive cost sharing provisions. Wakely has found that about 49% of MA plans have a $0 premium, and 43% of plans have a premium above $0, but less than $100.

Unlike in Original Medicare, plans offered by MA organizations are required to have a limit on member out of pocket (MOOP) cost that is no greater than $6700 annually. We found that only about 35% of plans have a MOOP this high; 58% have a MOOP between $3,400 and $6,700, and 7% of plans have a MOOP less than $3,400.

Beneficiary cost sharing for dialysis services in plans offered by MA organizations is most commonly 20% coinsurance; however, many plans offer lower coinsurance, or alternatively copays that equate to less than 20% of the average unit cost. About 80% of all plans use coinsurance for dialysis, and 86% of those use the maximum coinsurance value of 20%. The remaining 20% of plans require a copay amount of $30 or less for dialysis services.

Medicare Advantage Financial Experience for ESRD Beneficiaries

MA organizations experience an average medical loss ratio (MLR) of about 86.5%[2]. Wakely client bid data was evaluated to identify the difference in reported MLR experience between ESRD and non-ESRD members. For 2017, the average non-ESRD/non-Hospice MLR was about 86.6%; whereas, the ESRD MLR was about 112%, suggesting that the payments derived from the current ESRD payment model fall well short of covering claim expenses.

We believe one likely cause of the significantly higher MLR for ESRD members is that the MA benchmark calculation is based on the cost of benefits in Original Medicare, which do not include a cap on member out of pocket (MOOP) costs. The Better Medicare Alliance also noted in a November 2016 paper[3] that MA plans often are unable to negotiate dialysis reimbursement rates near 100% of Medicare reimbursement levels.

[2] Based on S&P Market Intelligence for 1Q2018 and 2Q2018 (plans filing orange blanks).

[3] November 23, 2016, "Caring for ESRD Beneficiaries in Medicare & Medicare Advantage", available at https://www.bettermedicarealliance.org/policy-research/resource-library/caring-esrd-beneficiaries-medicare-medicare-advantage

As noted above, MA plans are subject to an out of pocket max which can be no greater than $6700 annually. Given the frequency (as much as three times per week) and cost of dialysis treatment (FFS cost of around $225 per treatment), a beneficiary receiving dialysis treatment is much more likely than a non-ESRD beneficiary to hit a cap on member out of pocket costs.

To estimate the potential impact of adding a MOOP to Original Medicare, we analyzed the 2016 limited data set (LDS) costs pre and post MOOP. For the general enrollment population with an Original Medicare plan design, the impact to plan liability after applying a $6,700 and $3,400 MOOP is 2.7% and 5.4%, respectively. For ESRD Dialysis beneficiaries with an Original Medicare plan design, the comparable MOOP impact is much higher – 8.7% for a $6,700 MOOP and 13.0% for a $3,400 MOOP. Therefore, the difference between the Part C benchmarks and expected costs under an MA plan with a MOOP is much greater for ESRD Dialysis beneficiaries than for non-ESRD beneficiaries.

Table 1 shows the percentage and PMPM impact of these MOOP levels based on 2016 LDS data.

Table 1 - 2016 LDS Costs by MOOP Level

		MOOP Level		
	Population Type	None	$6,700	$3,400
Paid PMPM	Non-ESRD/Non-Hospice	$774	$795	$816
	ESRD Dialysis	$6,891	$7,494	$7,786
% Change vs. No MOOP	Non-ESRD/Non-Hospice	-	2.7%	5.4%
	ESRD Dialysis	-	8.7%	13.0%
PMPM Change vs. No MOOP	Non-ESRD/Non-Hospice	-	$21	$42
	ESRD Dialysis	-	$602	$894

21st Century Cures Act

Section 17006 of the 2016 21st Century Cures Act amends the Social Security Act to allow enrollees with end stage renal disease to enroll in Medicare Advantage plans. This change is effective as of January 1, 2021.

Beyond this core change, the Act also prescribed that organ acquisition costs for kidney transplants are to be excluded from the determination of the MA benchmark. MA plans will not be responsible for kidney acquisition costs nor expenses related to an organ donor.

The Act did not mandate any specific changes to the calculation of the ESRD Dialysis benchmark rates or to non-ESRD Part C benchmark rates, beyond the exclusion of organ acquisition costs.

The Act also requires the Health and Human Services Secretary to consider incorporating a quality measure specific to ESRD coverage into the Star Rating system, revise the Medicare Advantage risk adjustment model to include additional factors regarding chronic kidney disease, and evaluate the ESRD risk adjustment model.

Impact Analysis for Medicare Advantage Organizations (MAOs)

Enrollment

Given that ESRD members will have the opportunity to voluntarily enroll in general enrollment MA plans, ESRD members will now almost certainly be a higher percentage of the total MA population.

Estimating how much of the current FFS ESRD population will be attracted to MA plans will be significantly influenced by the expected out-of-pocket difference between MA plan offerings and

Original Medicare (potentially with a Medicare Supplement policy attached).

As highlighted in the *Member Premium, MOOP, and Dialysis Benefits* section, there are a number of MA plans that offer richer dialysis benefits than FFS as well as a high proportion of plans with a $0 premium. These plans must offer a MOOP no higher than $6,700, and many offer a lower MOOP amount. The low premiums and MOOP protections will likely be attractive to ESRD enrollees in FFS. In particular, ESRD beneficiaries with dialysis status have very high, consistent monthly expenses. It will be relatively straightforward for them to analyze whether the monthly premiums and annual cost sharing expenses in an MA plan are likely to result in lower out-of-pocket expenses than FFS, or FFS with a Medicare Supplement plan.

We would expect that any current ESRD beneficiary with a Medicare Supplement plan covering Part B coinsurance will experience lower out-of-pocket expenses than most MA plan offerings, unless the MA plan has very low premiums combined with low dialysis cost sharing.

It is important to note, however, that the availability and affordability of Medicare Supplement policies varies by State. Not all ESRD beneficiaries will be able to purchase a Medicare Supplement policy as there are varying rules with respect to guaranteed issuance of policies. Also, many states allow significant "rate-up" of premium levels for disabled beneficiaries.

It will be important for MA organizations to assess current Medicare Supplement enrollment in the states in which they operate in order to determine the potential for significant increase in ESRD enrollment.

Financial Impact to MAOs if there are No Changes to the ESRD Payment System

As noted at the beginning of this paper, the ESRD penetration in MA plans could move from the current 0.65% to as high as 2.7%. If average ESRD penetration in MA plans moved to our estimated maximum of 2.7%, we calculate that plan profits could decrease by 1.72%. Put another way, if plans wanted to maintain their current profit levels, member premiums would have to increase by about $16 PMPM, or benefits would have to be pared back by a similar magnitude.

Table 2 displays a few scenarios of the impact of increased ESRD MA enrollment on member premium, using 2017 Wakely client data. We found that the total MLR increased about 0.8% each time we increased the assumed ESRD mix percent by 0.5%. We also found that the total premium would have to increase about $4 PMPM in each scenario iteration to remain at the current MLR.

Table 2 – Required Premium Change

ESRD Mix %	Premium Increase Required to Remain at Current MLR
0.65%	$0.00
1.15%	$3.96
1.66%	$7.96
2.16%	$11.98
2.67%	$15.95

If no changes are made to the current ESRD payment calculation, even a small increase in ERSD members as a percent of total will have a material impact on benefits and/or premiums for MA plans' total population.

In the 2019 Final Announcement, CMS implemented a revised ESRD risk adjustment model that reflected a recalibration using more recent FFS cost data. The core structure of the ESRD risk adjustment did not change, so it is unclear whether the change will have any impact on the losses that MA plans have experienced for ESRD members. While the new model may improve predictive accuracy of the relative costs of ESRD members, it will not correct the apparent shortfalls in payment if the underlying MA benchmarks are inadequate.

Conclusion

In summary, there is evidence which suggests the current ESRD payment system is not adequate to cover the high costs generated by ESRD members. The change in eligibility rules and MOOP requirements under Medicare Advantage are likely to make MA plans attractive to the nearly 80% of total ESRD beneficiaries who are not currently enrolled in an MA plan. Due to the high costs of ESRD beneficiaries, even a small increase in ESRD enrollment will create financial challenges for MAOs. While the financial impact may vary for different MAOs and in different parts of the country, we believe that many MAOs will be forced to increase member premiums, decrease benefit offerings, or both if no changes are made to ESRD payment.

We strongly encourage CMS to investigate this issue further and consider adjustments to the ESRD payment system that will allow MAOs to continue to offer attractive benefits at reasonable premium levels to all beneficiaries, including new ESRD enrollees.

Caveats and Limitations

Tim Courtney is a member of the American Academy of Actuaries and meets the qualification standards for sharing the information in this paper. To the best of our knowledge and belief, this information is complete and accurate. This paper was sponsored by Humana, Inc.

Please contact one of the authors directly with any questions or to follow up on any of the concepts presented here.