Wakely
An HMA Company

Wakely.com

WHITE PAPER

ESRD Patients: The Forgotten Group

Yucheng Feng, FSA, MAAA, PhD
Mike Krentzman, FSA, MAAA

January 5, 2026

EXECUTIVE SUMMARY

People with end-stage renal disease (ESRD) are among Medicare's most medically complex and financially costly populations, yet they have historically been underserved. Despite representing less than 1 percent of total beneficiaries, ESRD accounts for a disproportionately large share of Medicare expenditures. Traditional Medicare Advantage (MA) plans often lack the specialized networks, care coordination, and benefit designs required to address ESRD patients' intensive needs. Although ESRD Chronic Condition Special Needs Plans (C-SNPs) have begun to fill this gap, their adoption remains extremely limited nationwide.

In 2026, the Centers for Medicare & Medicaid Services (CMS) is expanding the C-SNP category from ESRD to chronic kidney disease (CKD), allowing plans to serve beneficiaries across the full kidney disease continuum—from earlier-stage CKD to dialysis-dependent ESRD. This policy shift enables MA plans to intervene sooner, coordinate care more effectively, and help patients avoid or delay kidney failure, yielding improved quality of life and lower long-term costs. Integrating CKD and ESRD into a single SNP also aligns with CMS's value-based care strategy and addresses significant equity gaps. This paper outlines the challenges ESRD patients face, the limitations of current MA benefits, the unique requirements of ESRD C-SNPs, and the potential impact of the upcoming CKD-ESRD SNP model.

What Is ESRD?

End-stage renal disease (ESRD) is the final, irreversible stage of chronic kidney disease (CKD), occurring when kidney function drops below 10–15 percent of normal capacity. At this point, the kidneys can no longer sustain life without treatment. Without dialysis or a kidney transplant, ESRD is fatal.

Epidemiology and Key Drivers

ESRD incidence is largely driven by diabetes and hypertension, which together account for approximately 70 percent of cases. Significant disparities exist, with Black Americans developing ESRD at three to four times the rate of White Americans because of APOL1 gene variants. While ESRD incidence has stabilized in recent years, CKD prevalence continues to rise, increasing the future pipeline of ESRD patients.

Lifestyle Impact of ESRD

ESRD patients rely on either kidney transplantation or dialysis to survive. Due primarily to an insufficient supply of donor kidneys, only a small, single-digit percentage of ESRD patients receive transplants. As a result, most remain on dialysis for the rest of their lives.

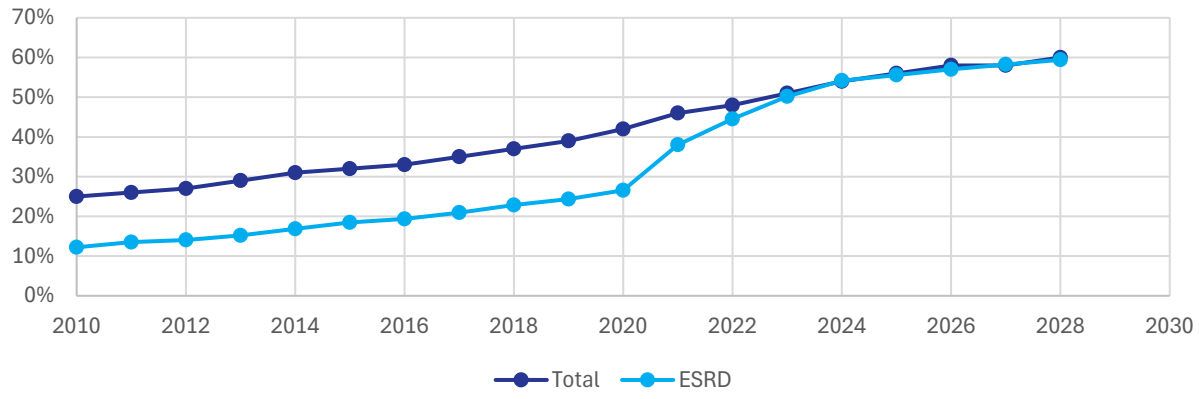
Hemodialysis, the most common treatment, replaces essential kidney functions through a machine that filters and cleans the patient's blood. Treatments occur three times per week, with each session lasting three to five hours. When travel and recovery time are included, these sessions often consume six to eight hours of a patient's day. Although the Centers for Medicare & Medicaid Services (CMS) has policies in place that support home dialysis (e.g., peritoneal dialysis), adoption remains limited because of caregiver constraints, training needs, and housing challenges.

The physical and emotional toll of dialysis is substantial. Many patients experience profound fatigue after treatments. Dialysis patients must also follow strict dietary restrictions, limit fluid intake, and take multiple daily medications. This regimented lifestyle significantly affects daily routines, energy levels, employment, travel, and mental well-being. ESRD patients typically have high rates of hospitalization and emergency department utilization.

ESRD in Medicare and Medicare Advantage

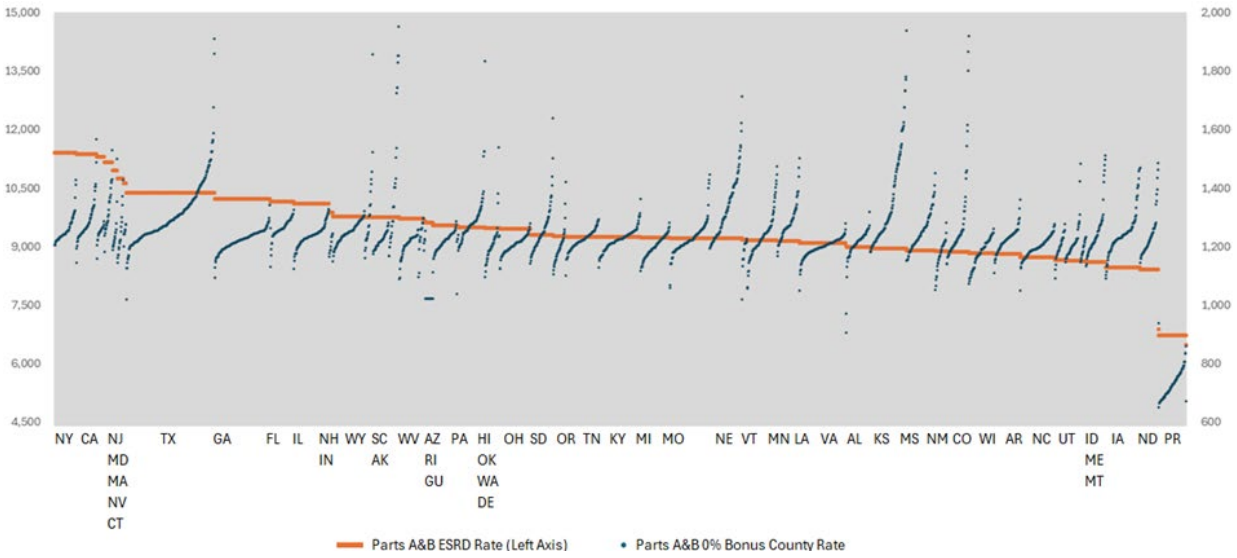
Despite representing less than 1 percent of all Medicare beneficiaries, ESRD patients account for a disproportionately large share of Medicare spending due to their significant medical needs and the high costs associated with dialysis treatment. Historically, Medicare beneficiaries with ESRD were unable to enroll in Medicare Advantage (MA) unless they developed ESRD after enrolling in an MA plan. The 21st Century Cures Act changed this situation; as of January 1, 2021, all individuals with ESRD may enroll in MA. By 2023, MA penetration among ESRD beneficiaries reached parity with the non-ESRD population (see **Figure 1**).[1]

Figure 1. MA Penetration of Total vs. ESRD Beneficiaries



MA benchmarks highlight the unique cost profile of these patients. While typical MA county benchmarks range from $1,000–$1,500 per member per month, ESRD benchmarks are 5–10 times higher and vary only by state (see **Figure 2** for projected 2026 rates), reflecting the predictability and magnitude of ESRD medical costs. Plans are reimbursed based on risk-adjusted ESRD benchmarks regardless of which MA plan the member chooses. Many MA plans, however, lack appropriate networks—dialysis centers, transplant programs, and nephrology specialists—and benefits to address the needs of this population. Consequently, the well-being and financial risk of ESRD beneficiaries are often overlooked.

Figure 2. Comparison of MA Benchmark (Right Axis) and ESRD Benchmark (Left Axis)



ESRD Chronic Condition Special Needs Plans (C-SNPs)

Chronic Condition Special Needs Plans (C-SNPs) are MA plans designed specifically for individuals with severe lifelong conditions. While C-SNPs for diabetes, cardiovascular disease, and a few other diseases are widespread, ESRD C-SNPs remain rare. In 2017–2023, only two to five organizations offered ESRD C-SNPs in limited counties across 6 to 12 states. Although availability increased slightly in 2024 and 2025, enrollment remains low: fewer than 5,000 members nationwide in 2025, representing just 0.8 percent of all ESRD beneficiaries (see **Table 1** and **Figures 3** and **4**).

Table 1. Number of ESRD C-SNP Contracts, 2020–2026

State	2020	2021	2022	2023	2024	2025	2026
Arizona	1	1	1	2	2	2	2
California	3	3	4	5	6	6	5
Colorado			1	1	1	1	
Connecticut	1	1	1	1	1	1	1
Florida				1	2	2	1
Georgia			1	1	1	2	1
Illinois						1	1
Indiana					1	2	2
Kentucky			1	1	1	2	2
Michigan				1	2	3	2
Mississippi						1	2
New Jersey	1	1	1	1	1	1	1
Nevada	1				1	1	2
Ohio						1	1
Tennessee						1	1
Texas	1	1	1	1	1	2	2
Virginia			1	2	2	1	1
Washington			1	1	1	1	
Total	**8**	**7**	**13**	**18**	**23**	**31**	**27**

Figure 3. ESRD C-SNP Enrollment, 2017–2025

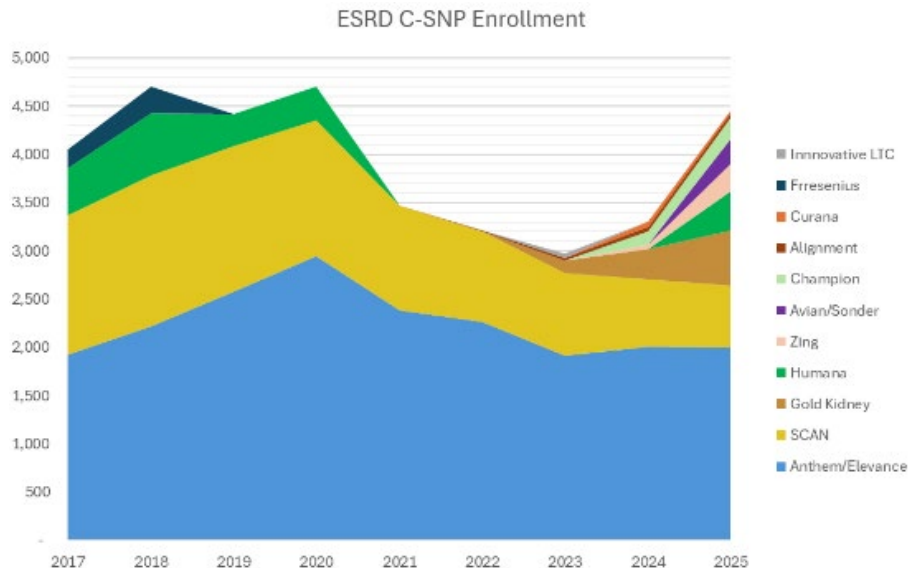
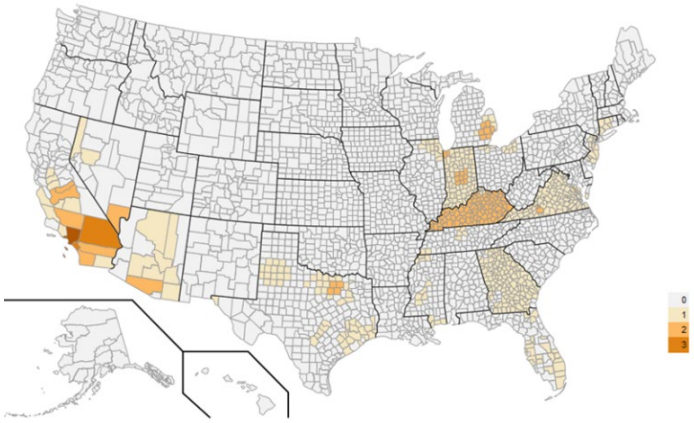


Figure 4. Map of Available ESRD C-SNP Contracts in 2026



ESRD C-SNPs face numerous barriers, including:

- Dialysis treatment and transplant-related costs can be unpredictable. Even with elevated ESRD benchmarks, risk adjustment often underestimates true costs.
- Network difficulties, especially contracting with dialysis providers, and needing agreements with transplant centers. DaVita and Fresenius operate approximately 75–80 percent of facilities nationwide, giving them substantial leverage to negotiate.

- Clinical complexity, as ESRD patients have multiple comorbidities requiring specialized clinical teams that MA plans often lack.
- Member instability, including high hospitalization and disenrollment rates, thereby complicating care management and cost prediction.
- Data limitations associated with clinical data captured in CROWNWeb/ESRD QIP systems (not claims) create gaps in real-time insights for MA plans.

These challenges explain why ESRD C-SNPs are difficult to operate and remain rare.

Unique Benefit Design Requirements for ESRD C-SNPs

An effective ESRD C-SNP must address the intensive, highly specialized needs of ESRD patients—needs that typical MA plans do not cover. Essential components include:

1. **Dialysis-Focused Benefits**
   - Guaranteed and reliable access to in-network dialysis centers
   - Home dialysis training and support
   - Zero or low dialysis member cost sharing
2. **Transplant-Related Services**
   - Fast-track transplant evaluation
   - Transplant center coordination
   - Post-transplant benefit coverage
3. **Comprehensive Care Coordination**
   - Dedicated renal care manager and integration of dialysis facility care plans
   - Interdisciplinary team (nephrologists, nurses, social workers)
   - 24/7 nurse line
   - Nephrologists often serve as PCPs
4. **Medication Affordability**
   - Low or $0 copays for key renal medications (phosphate binders, potassium regulators, etc.)
5. **Social Determinants of Health Supports**
   - ESRD patients often face significant socioeconomic barriers. Benefits can be offered through Special Supplemental Benefits for the Chronically Ill (SSBCI) flexibility to mitigate these barriers, such as:
     - Extra transportation (critical for thrice-weekly dialysis)

- Renal patient-appropriate food or grocery benefits
- Housing or utility support

6. Management of Comorbid Conditions

- Diabetes care
- Cardiovascular risk management
- Behavioral health support

Plans must combine robust supplemental benefits with high-touch care coordination to meet these intensive needs.

The Future: From ESRD C-SNP to CKD C-SNP in 2026

Starting in 2026, CMS is expanding C-SNP condition categories to include CKD, redefining ESRD C-SNPs as CKD C-SNPs. This change integrates the entire kidney disease spectrum—from early CKD to ESRD—into a single, coordinated model.

Early CKD intervention can significantly improve outcomes, including slowing or stopping the progression of kidney deterioration, reducing hospitalizations, preventing or delaying the onset of ESRD, improving quality of life, and lowering long-term medical costs.

Integrating CKD and ESRD into a unified C-SNP allows plans to manage the continuum of kidney disease, addressing gaps in care models, aligning with CMS's value-based care initiatives, and improving equity by reaching patients earlier—particularly those in underserved communities. In addition, the CKD populations are larger, more stable, and less financially volatile. Creating a more predictable base makes SNPs more viable than the previous ESRD-only models.

Conclusion

For decades, ESRD patients have been among Medicare's most vulnerable, yet least supported, populations. Traditional MA benefit structures and networks have been unable to meet their needs, and ESRD C-SNPs have remained rare because of financial, operational, and clinical complexities. With this evolution, ESRD patients may finally receive the focused attention they have long been denied.

The transition to CKD-ESRD C-SNPs in 2026 represents a pivotal opportunity to redesign kidney care in Medicare Advantage. By enabling earlier intervention, integrating transplant pathways, supporting home dialysis, and addressing socioeconomic barriers, MA plans can finally establish models of care that match the intensity of care that kidney patients deserve. If effective, CKD-ESRD C-SNPs can offer a promise of better outcomes, lower long-term costs, and a more equitable future for millions of Americans living with kidney disease.

ABOUT THE AUTHORS

Yucheng Feng
Senior Consulting Actuary
yucheng.feng@wakely.com

Mike Krentzman
Senior Consulting Actuary
michaelk@wakely.com

ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

ENDNOTES

[1] Medicare enrollment and projection are from Table II-6 of Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.