

# Medicare Advantage

## What Is Changing For Beneficiaries with End-Stage Renal Disease (ESRD) in 2021?

### What Is Medicare Advantage?

24 million seniors and people with disabilities choose Medicare Advantage (MA) because it delivers better services, better value, and better access to care. MA delivers affordable coverage by limiting out-of-pocket costs and offering additional benefits that the government-run traditional Medicare doesn't cover – such as integrated vision, hearing, dental, and wellness programs. MA has strong bipartisan support, because it is a prime example of the private sector and government working together to deliver lower costs, more choices, and better outcomes for the American people.

### What Are the Rules on MA for Individuals with ESRD?

ESRD, or kidney failure, affects more than 500,000 Medicare beneficiaries. These individuals are not currently eligible to enroll in the MA program but may be covered by an MA plan if they developed ESRD after enrollment or were grandfathered through employer-sponsored coverage. Currently 130,000 people with ESRD, or 25% of this population on Medicare, have coverage through an MA plan.

MA enrollment by individuals with ESRD is expected to accelerate beginning in 2021, when a provision of the 21st Century Cures Act (Cures Act) lifts the current enrollment restrictions. CMS estimates that an additional 83,000 people with ESRD will enroll in MA by 2026, which represents an increase of 63%.

### What Did CMS Propose to Do?

In early February, CMS issued several pieces of proposed regulatory guidance impacted by this change in the rules around MA enrollment for beneficiaries with ESRD: the [annual MA Advance Notice](#), which lays out the proposed policies governing plan payment for 2021; separate MA bidding instructions for 2021; and a [Proposed Rule](#) that would make policy and technical changes to the MA and Part D programs for 2021-2022.

### Kidney Acquisition Costs

The Cures Act requires that traditional Medicare cover the cost of kidney acquisition for transplant. As a result, CMS proposes to exclude these costs from the MA benchmark rates beginning in 2021. On average this change would reduce MA county rates by \$4 per-member per-month (PMPM) with the largest reduction at \$20 PMPM; for state ESRD rates, this change would reduce rates by \$36 PMPM on average with the largest reduction at \$75 PMPM. Areas

#### MA AND ESRD BY THE NUMBERS

**500,000**

The number of Medicare beneficiaries with ESRD; 130,000 are in MA

**1% vs. 7%**

1% of all Medicare beneficiaries have ESRD, but this population accounts for 7% of Medicare spending

**83,000**

CMS estimate of increased MA enrollment by beneficiaries with ESRD thru 2026

**112%**

The average MA plan medical loss ratio for beneficiaries with ESRD

**11 out of 15**

The number of highest MA enrollment counties where MA payments for ESRD are below traditional Medicare costs

**2**

The number of providers that own more than 70% of dialysis facilities

significantly impacted by this change include counties across Puerto Rico as well as Madison, WI; San Francisco, CA; New Orleans, LA; St. Louis, MO; San Antonio, TX, and Winston-Salem, NC. [An analysis](#) by the actuarial firm Wakely Consulting Group (Wakely) found inconsistencies between the CMS estimates in the Advance Notice and the Proposed Rule and was unable to validate the CMS analysis of kidney transplant rates using the agency's own claims data.

## Out-of-Pocket Spending

Unlike traditional Medicare, MA plans must cap their enrollees' annual out-of-pocket spending. In addition, MA plans are subject to limits on cost-sharing for certain individual services. As people with ESRD have been restricted from enrolling in MA plans, CMS previously excluded historical spending by these individuals in the methodology used to set beneficiary out-of-pocket spending limits.

To account for the new enrollment rules, CMS has proposed for 2021 to partially increase the maximum annual limit plans set for total beneficiary out-of-pocket spending as well as cost-sharing for certain inpatient hospital services. Beginning in 2022 and future years, CMS would continue to phase-in spending patterns by individuals with ESRD into these calculations until their costs are fully reflected in the annual out-of-pocket and service-level cost-sharing limits.

While this proposal will address some of the higher program costs from increased MA enrollment of patients with ESRD, the result could be to shift costs to beneficiaries without addressing the underlying inadequacy in MA payment rates for serving this population. Wakely found the current maximum out-of-pocket spending cap creates an average [underpayment of 9%](#) for beneficiaries with ESRD - the CMS proposal to increase this cap would only reduce that underpayment by 1 percentage point to 8%.

## Provider Networks

In a separate proposed rule on MA and Part D policy changes for 2021-2022 issued by CMS, the agency further proposed to increase plans' ability to reduce dialysis costs by allowing more flexibility to manage dialysis provider networks. These proposals included plan attestation to providing medically necessary dialysis services (such as for home health), allowing network adequacy exceptions in cases where home dialysis is widely available, and customizing network adequacy standards for dialysis facilities.

Increasing plan flexibility to design dialysis facility networks, including policies that support the expansion of home dialysis, will drive down costs for beneficiaries and taxpayers by increasing competition in this highly consolidated market.

## What CMS Did Not Do

Despite this significant programmatic change, CMS proposed no updates to the methodology for determining payments to MA plans for serving this population. Beneficiaries with ESRD represent less than 1% of the total Medicare population but 7% of spending. Wakely estimates that under current rules, the average MA plan has a [medical loss ratio of 112%](#) for their members with ESRD. Consistent with [analyses by Avalere](#), [Wakely also found](#) that in 11 of the 15 largest counties by MA enrollment, traditional Medicare costs exceed the MA payment rate.

A large influx of beneficiaries with ESRD into the MA program could put upward pressure on premiums or lead to reductions in supplemental benefits without major policy changes. According to Wakely, if every Medicare beneficiary with ESRD were to enroll in an MA plan, [premiums would need to increase](#) by \$18 PMPM on average (more than 75%) or benefits would need to decrease by the same magnitude.

## What Happens Next?

Stakeholders have until March 6 to comment on the Advance Notice, and until March 9 to comment on the bidding instructions prior to CMS issuing a Final Notice on April 6. Comments on the MA and Part D proposed rule for 2021 are also due on April 6. MA bids for 2021 are due to CMS on June 1.

## What Should CMS Do?

To ensure MA funding levels are stable and continue to support high-quality care and comprehensive benefits, in the 2021 CMS should:

- Ensure adequate funding for beneficiaries with ESRD.
- Allow plans more flexibility to manage dialysis provider networks.
- Ensure updated rules on benefit design adequately reflect expected program costs.
- Validate the rates of kidney acquisition cost excluded from MA payment rates and provide greater transparency into how they were calculated.