

HEALTH MANAGEMENT ASSOCIATES

To: Dialysis Patient Citizens
From: Health Management Associates
Date: October 5, 2021
Re: Estimated Federal Impact of H.R. 1676, the Jack Reynolds Memory Medigap Expansion Act

Summary

Dialysis Patient Citizens requested Health Management Associates to evaluate the potential impact to the federal budget from H.R. 1676, titled the “Jack Reynolds Memory Medigap Expansion Act”. The proposed legislation would modify the Social Security Act to require insurers to make Medigap plans available to individuals under the age of 65 who are eligible for Medicare due to End Stage Renal Disease (ESRD). The proposed legislation would also extend the Medicare Secondary Payer (MSP) period for individuals with ESRD who have employer-based coverage by 12 months.

Currently there are 20 states plus the District of Columbia that do not require Medigap insurers to sell products to Medicare enrollees under the age of 65 with ESRD. This legislation would increase Medigap options and enrollment in these 20 states, while having a more modest impact in the remaining 30 states. The current MSP period for individuals with ESRD who have employer-based coverage is 30 months. This legislation would add up to 12 additional months, requiring employers to continue covering employees as long as they remain employed.

We estimate the proposed legislation would reduce federal spending by \$1.1 billion over the next 10 years. The modifications to Medigap rules would increase federal spending by \$50 million, largely from an anticipated increase in Part D drug costs for certain enrollees. The extension of the MSP would lower federal spending on Medicare by \$1.5 billion, but also lower tax revenues by \$340 million.

Table 1: Estimated Federal Impact of H.R. 1676

<i>\$ in millions</i>	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	FY22 – FY31
Modify Medigap	*	*	*	*	*	10	10	10	10	10	\$50
Extend MSP, Medicare effect	-90	-120	-130	-140	-150	-160	-170	-180	-190	-200	-\$1,520
Extend MSP, revenues effect	20	30	30	30	30	40	40	40	40	40	\$340
Net federal impact	-\$60	-\$90	-\$90	-\$110	-\$110	-\$120	-\$130	-\$140	-\$140	-\$150	-\$1,140

Note: "*" indicates less than \$10 million

Background

Medigap and ESRD

Individuals with Medicare coverage are responsible for a portion of their costs through a combination of deductibles and co-insurance. One of the ways individuals with traditional Medicare coverage help pay for these costs is through Medicare supplemental insurance products, often called “Medigap” plans. In 2020, approximately 13.9 million Medicare enrollees also had a Medigap plan, representing 36% of all individuals with traditional Medicare.¹ Most Medigap enrollees choose coverage that pays for the majority of their out-of-pocket (OOP) costs.²

Section 1882 of the Social Security Act (SSA) outlines the requirements for Medigap products. Section 1882(s)(2)(A) requires any issuer of a Medigap plan to make the plan available to individuals over the age of 65 provided the person applies for coverage within 6 months of becoming eligible for Medicare Part B services. The SSA does not require issuers to make plans available to individuals under the age of 65, including people who qualify for Medicare due to disability or ESRD. It does allow for individuals under 65 to enroll in a Medigap plan once they reach age 65.

Absent federal policy, many states’ insurance departments have issued requirements for Medigap insurers to offer policies to Medicare enrollees under the age of 65, although the type and range of policy options varies widely. As of September 2021, 29 states require at least some Medigap options for individuals under the age of 65 with ESRD, with some states also limiting the allowable premium differences between individuals with ESRD and other enrollees. The remaining 21 states and the District of Columbia do not require Medigap plans to be available to individuals under the age of 65 with ESRD.³ Table 1 provides an overview of Medigap options for these individuals.

Table 2: Medigap Options for Individuals with ESRD Under Age 65

Medigap Level	Medigap for individuals with ESRD under age 65	States	# of non-dual Medicare enrollees with ESRD under age 65 (2019)
A	State requires all or most Medigap plans and limits premiums	CT, HI, KS, ME, MN, NY, OR, PA	13,100
B	State requires some plans and limits premiums	ID, MD, MO, NJ, OK, SD	11,100
C	State requires some plans, but does not limit premiums	AR, CO, DE, FL, GA, IL, IN, LA, MI, MS, MT, NH, TN, TX, WI	46,600
D	State does not require any plans, some plans are available but are generally unaffordable	AL, AK, AZ, DC, IA, KY, NC, ND, NE, NM, NV, OH, RI, SC, UT, WA, WV, WY	22,500
F	State excludes coverage, some plans are available but are generally unaffordable	CA, MA, VA, VT	11,400

¹ National Association of Insurance Commissioners. “2020 Medicare Supplement Loss Ratios”

² Americas Health Insurance Plans. “The State of Medicare Supplement Coverage: Trends in Enrollment and Demographics”. May 2021.

³ Data compiled by Dialysis Patient Citizens and Health Management Associates, also available at <https://www.dialysispatients.org/policy-issues/promote-financial-security/medigap-coverage/>.

Starting in 2021, all Medicare enrollees with ESRD are able to select a Medicare Advantage (MA) plan as an alternative to traditional Medicare coverage.⁴ As a result, MA enrollment of individuals with ESRD increased by 31%, including a 70% increase by individuals under the age of 65. However, a significant portion of the enrollment gains for the under-65 group was by individuals eligible for both Medicare and Medicaid (so-called “dual eligible”).⁵ Recent projections in the Medicare Trustees report suggest that most MA enrollment by the under-65 ESRD population will continue to come from the dual eligible population.⁶

Medicare Secondary Payer and ESRD

In 1972, Congress passed legislation to make all individuals with ESRD regardless of age eligible for Medicare coverage provided they have worked at least 40 calendar quarters. For individuals under age 65, Medicare coverage generally begins within 3 months of the diagnosis of ESRD. One exception is for individuals with an employer group health plan. Section 1862(b)(1)(C)(ii) of the SSA requires an employer group plan to remain the primary payer of medical care for up to 30 months after the diagnosis of ESRD.⁷ During these 30 months, Medicare is considered the secondary payer, and covers the cost of any required services that are not covered by the employer group health plan.

Jack Reynolds Memory Medigap Expansion Act

The proposed legislation would make two changes to the SSA. First, it would modify section 1882(s) to require Medigap plans to offer coverage to individuals under the age of 65 who are eligible for Medicare due to ESRD. This provision would become effective on January 1, 2022 and provide current Medicare beneficiaries with ESRD the opportunity to enroll in a Medigap plan during the first 6 months of 2022. The provision would have the most significant impact on ESRD enrollees under the age of 65 residing in one of the 20 states or the District of Columbia who may not have access to a Medigap plan today.

Second, the proposed legislation would modify section 1862(b)(1)(C) to extend the Medicare secondary period to 42 months instead of the current 30 months. This provision would impact both the Medicare program as fewer individuals with ESRD would be enrolled each year, as well as employers who would be required to provide health insurance to employees with ESRD for an additional 12 months.

Data Sources

We used the following data sources to develop our estimates

- Medicare 100% fee-for-service claims data from 2017-2019
- National Association of Insurance Commissioners. “2020 Medicare Supplement Loss Ratios”. 2021.
- Americas Health Insurance Plans. “The State of Medicare Supplement Coverage: Trends in Enrollment and Demographics”. May 2021.

⁴ Prior to 2021, Medicare individuals with ESRD had limited options to join MA plans

⁵ HMA analysis of 2020 and 2021 Medicare Advantage enrollment

⁶ Boards of Trustees. “2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds”. Aug 2021.

⁷ If the individual loses their group health plan coverage due to job termination, Medicare can become the primary payer earlier than 30 months.

- Congressional Research Service. “Medicare Advantage Coverage of End Stage Renal Disease and Network Requirement Changes.” January 2021.
- Congressional Research Service. “Medigap: A Primer”. September 2012.
- Assistant Secretary for Planning and Evaluation. “Variation and Trends in Medigap Premiums”. December 2011.
- Boards of Trustees. “2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds”. Aug 2021.
- Weiss, Stephen. “Should Medigap Policies be Provided for Medicare Recipients Under 65 Years of Age in Virginia?” Joint Commission on Health Care. August 2017.
- Congressional Budget Office. “Preliminary Estimate of H.R. 6, the SUPPORT for Patients and Communities Act.” June 2018.

Methodology

Impact of Modifications to Medigap

We first extracted Medicare fee-for-service (FFS) data on all individuals with ESRD between 2017 and 2019. We calculated total spending as well as spending by setting and separated the enrollees by age (over versus under 65) and dual eligibility status. We calculated average spending per enrollee per month across all 50 states as well as the District of Columbia. Finally, we grouped individuals based on the general availability of Medigap plans to individuals under the age of 65 with ESRD.

Table 3: Average Per Member Per Month (PMPM) Medicare Spending for Individuals with ESRD, 2019

Medigap Level	Dual-Eligible Over 65		Non-dual Over 65		Dual-eligible Under 65		Non dual Under 65	
	Enrollees	Avg PMPM	Enrollees	Avg PMPM	Enrollees	Avg PMPM	Enrollees	Avg PMPM
A	12,400	\$10,630	20,200	\$9,333	17,700	\$9,762	13,100	\$8,608
B	6,100	\$10,157	15,700	\$9,426	9,800	\$9,678	11,100	\$8,520
C	29,600	\$9,492	54,400	\$8,656	55,100	\$8,907	46,600	\$7,653
D	13,700	\$8,723	31,100	\$8,319	27,200	\$8,574	22,500	\$7,497
F	17,400	\$10,200	18,100	\$9,570	21,500	\$9,834	11,400	\$8,205
Total	79,200	\$9,742	139,500	\$8,881	131,300	\$9,157	104,700	\$7,876

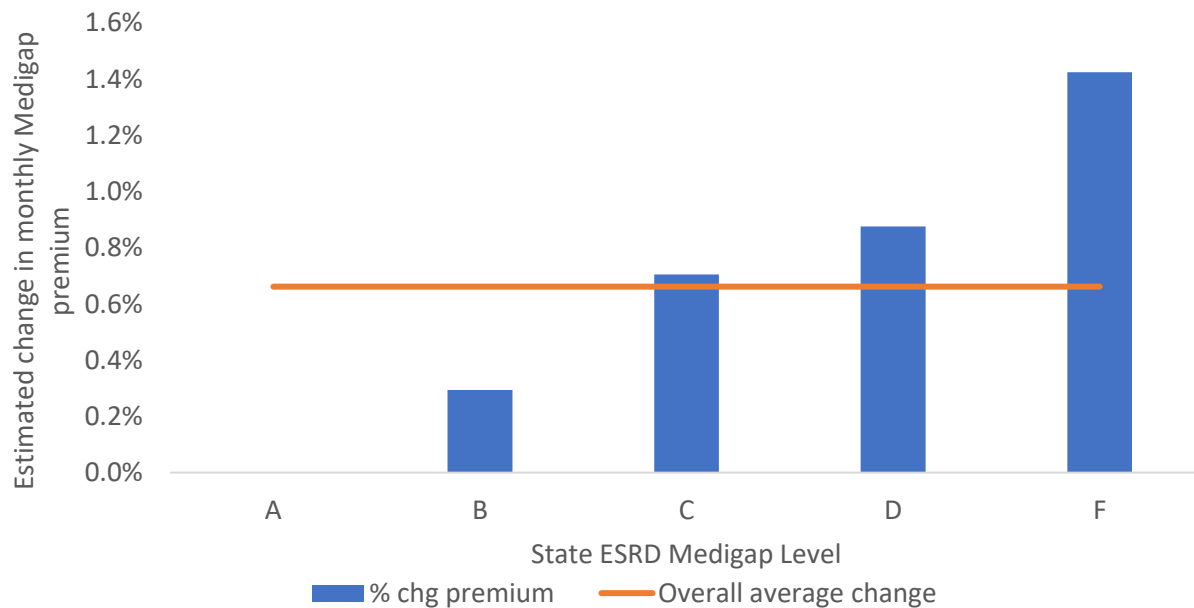
Source: HMA Analysis of 100% Medicare FFS Claims Data

The primary effect of modifying Medigap eligibility for individuals with ESRD would likely be on overall Medigap premiums, as the plans would be required to cover the approximate \$1300 per month OOP costs for individuals with ESRD. Since Medigap premiums are financed entirely by payments from enrollees, any change in these premiums would only impact federal spending to the extent that it would cause fewer non-ESRD individuals to enroll in a Medigap plan or lead to changes in overall Medicare spending.

We explored the potential impact on premiums by assuming that individuals with ESRD in states other than Level A would increase enrollment in Medigap, with higher increases in states at levels D and F. We also assumed that the enrollment would follow the overall current distribution of Medigap selection, with some enrollees choosing lower-premium Medigap plans with higher OOP while others would choose higher premium Medigap plans with lower OOP.

Overall, our analysis found that the estimated change in Medigap premiums from this proposal would be approximately +0.7%, and with higher increases in level D and F states. The primary reason for the higher increase in premiums in certain states is tied to the expected number of new Medigap enrollees: we expect a significantly higher increase in Medigap enrollment in level F states where there are currently zero options compared to level B or C states where some options are currently available.

Figure 1: Estimated Change in Monthly Medigap Premiums



Source: HMA Analysis of 100% Medicare FFS Claims Data

Based on these expected increases in premiums, we do not believe that Medigap enrollment by individuals without ESRD would change, and therefore do not anticipate any change in Medicare spending on the non-ESRD population.

There are two other effects that changing eligibility rules for Medigap plans to require coverage of individuals under age 65 with ESRD could cause: increased utilization of services by individuals who gain coverage of Medigap, and fewer individuals dually-eligible for Medicare and Medicaid. We explored both of these effects as described below, but overall found little evidence in the current Medicare data to support either change, other than the potential for an increase in Part D drug utilization.

Increased Utilization of Services

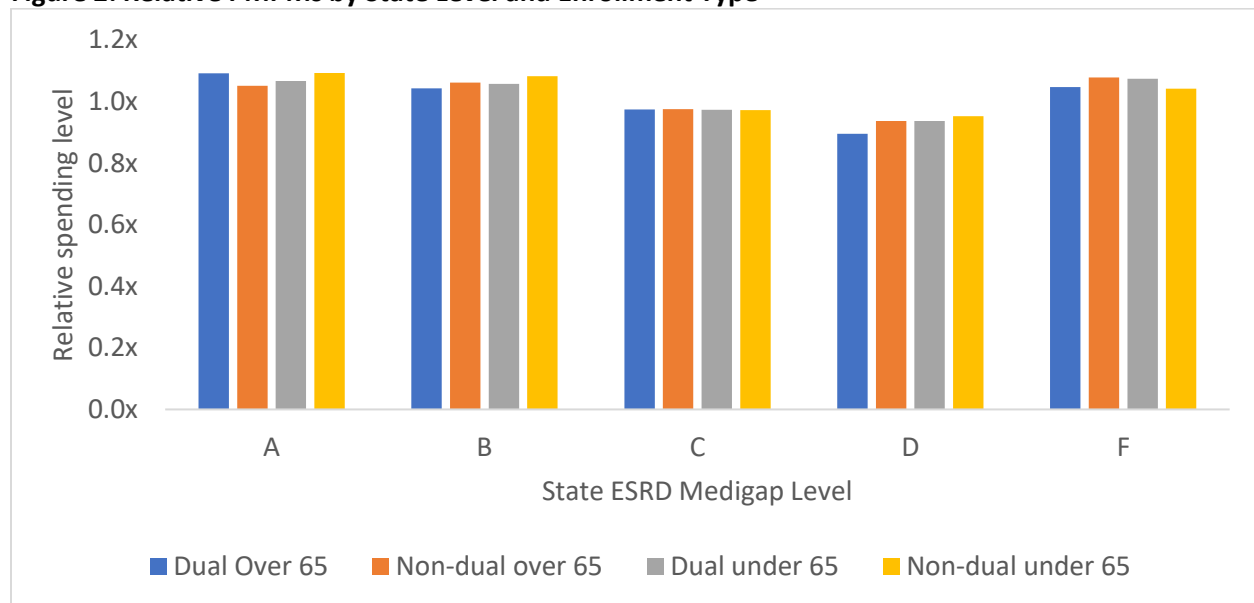
The healthcare economic literature has generally established a link between an individual's OOP costs and overall utilization, finding that people with lower OOP requirements tend to use more services.⁸ As such, we explored whether individuals in states with less Medigap options would be likely to increase utilization once plans became available to them. One potentially confounding element tied to this evaluation was determining whether the current differences in average per member per month (PMPM)

⁸ It is unclear if individuals with lower OOP requirements choose to use more services, or whether individuals who require more services are more likely to purchase more comprehensive insurance.

costs were the result of differences in demand or differences in geography, as Medicare providers receive adjusted rates based on their practice location.

To address issues of geography, we compared average spending by state level across the different types of ESRD enrollees. Since dual eligible enrollees have limited-to-no OOP costs, we could compare their spending levels to non-dual individuals under age 65 and determine if the relative differences were similar across states. As shown in Figure 2, average spending by state level was fairly comparable across all types of individuals with ESRD, which suggests that the overall differences in PMPM spending is tied to geography rather than demand.

Figure 2: Relative PMPMs by State Level and Enrollment Type



Source: HMA Analysis of 100% Medicare FFS Claims Data

In addition, we explored the sources of spending differences across enrollees with ESRD. If demand were to be impacted due to Medigap coverage, we would expect to see bigger effects in Part B (including physician and dialysis) spending compared to Part A (generally inpatient hospital care). We determined whether the average spending for these services was significantly different across enrollee types.

We also explored whether there were differences in Part D drug utilization. While Medigap does not provide support for Part D OOP costs, it is feasible that individuals without Medigap are spending a sizeable portion of their income on the OOP associated with physicians and dialysis, and limiting utilization of Part D drugs. Prior research has found that Medicare enrollees with ESRD who are not eligible for the Part D low-income subsidy (LIS) decreased the use of certain medications upon reaching the coverage gap, although this study did not address the impact of supplemental medical insurance for these individuals.⁹

⁹ Park, H. et. al. "Adherence and Persistence to Prescribed Medication Therapy Among Medicare Part D Beneficiaries on Dialysis: Comparisons of Benefit Type and Benefit Phase". *Journal of Managed Care Pharmacy*. 2014; 20*8): 862-76.

We found that average monthly spending on most Part B services was similar between non-dual individuals with ESRD under and over the age of 65, while spending on Part A and Part D services varied more widely. This suggests that most of the higher spending associated with older individuals with ESRD is due to higher hospitalization rates, and not from younger individuals avoiding care due to OOP concerns. The differences in Part B services can likely be attributed to physician care associated with inpatient stays. Importantly, the costs associated with dialysis are actually higher for the younger cohort. Finally, we noted a difference in Part D utilization which was more pronounced in level D and F states. The difference in Part D drugs is likely due partly to acuity but also could be the result of lower ability by the under-65 group to afford the OOP associated with Part D.

Table 4: Average Medicare Spending Per Member Per Month on Select Categories, 2019

Spending category	Avg PMPM for individuals with ESRD		
	Non-dual Under 65	Non-dual Over 65	% difference
Inpatient hospital	\$2,337	\$2,863	22.5%
All Part A services	\$2,589	\$3,691	42.5%
Dialysis care	\$3,815	\$3,500	-8.3%
All Part B services	\$5,563	\$5,793	4.1%
Total FFS	\$8,152	\$9,483	16.3%
Part D	\$186	\$313	67.6%

Source: HMA Analysis of 100% Medicare FFS Claims Data

Based on the data, we did not apply a change to spending for any Part A or Part B services to the individuals we anticipate will enroll in Medigap due to the proposed legislation. We did apply a slight increase to Part D utilization, such that individuals in level D and F states would have Part D costs that are in-line with individuals in other states.

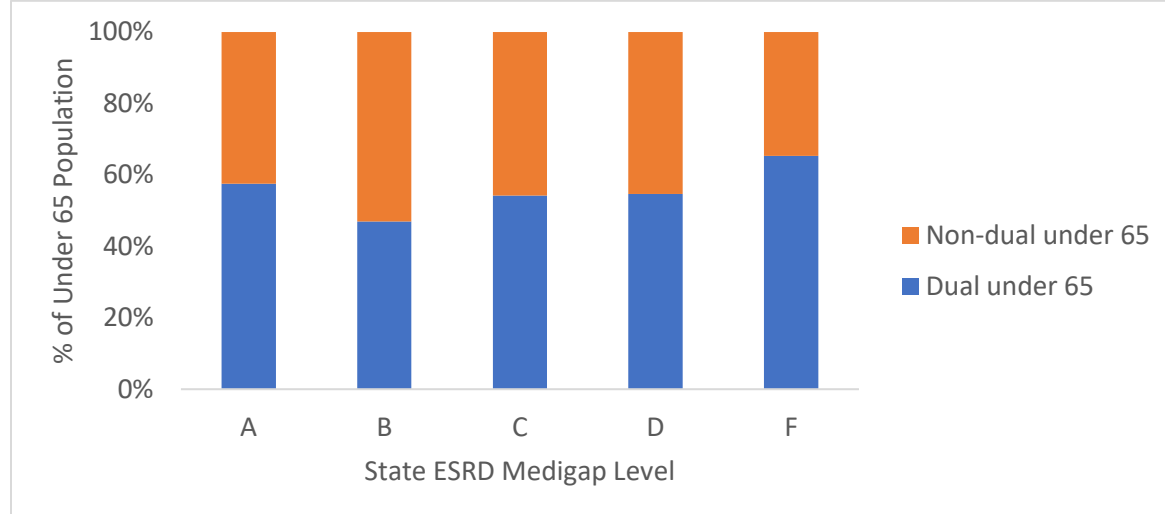
Medicaid Eligibility

The other aspect of Medigap reform that could have an impact on the federal budget would be Medicaid eligibility. In theory, individuals under the age of 65 with ESRD who do not have access to a Medigap plan would be more likely to 'spend down' their assets and reach dual eligibility at a faster pace than individuals who have access to a Medigap plan. We also recognized that other factors could also play a role in dual eligibility, including overall income and assets as well as individual state approaches to Medicaid eligibility.

To evaluate the potential for fewer dual-eligible individuals due to the change in Medigap requirements, we explored the rate of dual eligibility for the ESRD population across the various state levels. If Medigap availability slowed down Medicaid enrollment, we would expect to see lower rates of dual eligible individuals in states with more Medigap options than states with fewer/no Medigap options.

We found no evidence to support this hypothesis. In level A states, approximately 58% of individuals under age 65 with ESRD are dual eligible, while in level F states 65% of the same individuals are dual eligible. Meanwhile level D states, only 55% of these individuals are dual eligible. This suggests there are factors other than Medigap availability that are leading to dual eligibility for the under 65 population.

Figure 3: Dual Eligible Rates for Individuals Under Age 65 by State Level, 2019



Source: HMA Analysis of 100% Medicare FFS Claims Data

Impact of Medicare Secondary Payer Extension

The second element of the proposed legislation would extend the ESRD MSP period by an additional 12 months. This adjustment would have two effects. First, it would decrease the number of individuals with ESRD who have primary coverage from Medicare, thereby reducing total Medicare expenditures. Second, it would increase the number of individuals with ESRD who have employer-based health insurance, which would lead to higher employer costs for insurance and lower taxable income, ultimately reducing tax revenues collected by the government. The lower taxes would likely impact both overall income taxes as well as Social Security taxes, which would lower both on-budget and off-budget federal revenues.

Based on prior analyses from the Congressional Budget Office and current forecasts of the Medicare population with ESRD from the Medicare Trustees, we estimate the 12-month MSP extension would lower the number of individuals with ESRD covered by Medicare by approximately 2,000 each year. We used the same PMPM costs as described above to estimate the reduction in Medicare costs, accounting for the expected impact on beneficiary OOP as well as any effects on Medicare Part B premiums or Medicare Advantage payments.

Source of Uncertainty

The most significant source of uncertainty associated with our estimates is related to changes in utilization by individuals gaining Medigap options. Our analysis of the historical claims data did not find sufficient evidence to warrant a factor, which aligns with the overall understanding of the nature of dialysis care. However, it is still possible that individuals gaining Medigap would utilize more services, which would increase federal spending beyond what we have forecast.

In addition, while we did not find any evidence to demonstrate that Medigap enrollment reduces dual eligibility for individuals with ESRD, it is certainly feasible that the high OOP for individuals with ESRD is a driver of an individual’s asset depletion and ultimate Medicaid eligibility. To the extent the legislation did result in fewer Medicaid enrollees, both federal and state spending would be reduced as the costs were shifted to Medigap plans.