

Online Supplemental Appendix

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eAppendix. Counterfactual Calculation

This supplemental material has been provided by the authors to give readers additional information about their work.

eAppendix

Counterfactual Calculation

We assume that the individual market data we report in the Table in the main text are representative of the full ACA-compliant individual market in 2016. This assumption implies that per member per month (PMPM) ACA-compliant individual market spending in 2016 was \$449 (for patients both with and without ESRD).

To estimate PMPM spending in the counterfactual scenarios, we proceed in three steps:

- **Estimate baseline ESRD and non-ESRD enrollment in 2016:** There were an estimated 177,136,137 member months of enrollment in ACA-compliant individual market plans nationwide in 2016 (eTable 1). Assuming our individual market data are representative of the ACA-compliant market nationwide, it follows that there were 182,010 ESRD member months of enrollment and 176,954,127 non-ESRD member months of enrollment in the full ACA-compliant individual market in 2016.
- **Estimate counterfactual ESRD enrollment with facility steering:** The United States Renal Data System indicates that there were 196,537 point prevalent dialysis patients under age 65 with Medicare as their primary coverage on December 31, 2016.¹ Assuming that the number of point prevalent patients was constant all year, this translates to 2,358,444 person-months of enrollment in 2016. If 10%, 20%, or 40% of these person-months had instead been in the ACA-compliant individual market, then the total number of ESRD member months in the market would have been, respectively: 417,854; 653,699; or 1,125,388.
- **Estimate counterfactual marketwide PMPM claims spending:** Finally, we assume that PMPM spending by the additional ESRD enrollees would have matched our estimate of spending by actual ESRD enrollees from the Table in the main text (for all enrollment months, not just months when a dialysis service was received). We then combine the estimates from the last two bullets with the PMPM spending estimates from the Table in the main text to calculate counterfactual PMPM spending of \$468, \$486, and \$523 in the three scenarios or, respectively, 4.1%, 8.2%, and 16.4% higher than the baseline estimate of \$449.

This calculation does not account for changes in individual market enrollment decisions resulting from increases in premiums spurred by the increase in claims spending. If enrollees who disenroll due to higher premiums are healthier than those who remain, that could amplify the increase in claims spending estimated here. However, evidence suggests that the follow-on effects of higher premiums on individual market risk mix are generally modest, in large part because most enrollees are shielded from premium changes by federal premium subsidies.²

¹ United States Renal Data System. 2018 Annual Data Report, Tables D.22 and D.23. 2018. <https://www.usrds.org/annual-data-report/previous-adrs/>

² See, for example, Appendix C in Fiedler M. The ACA's Individual Mandate In Retrospect: What Did It Do, And Where Do We Go From Here? *Health Affairs*. 2020; 39(3): 429-435.