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—Inflation Reduction Act Research Series—

Projected Impacts for Rural Medicare Enrollees

The Inflation Reduction Act (IRA) is helping people with Medicare, including over 8 million Part D enrollees who reside in rural areas. Our review shows that in 2020, about 281,000 rural enrollees would have benefitted from the IRA's $35 insulin cap and in 2021 about 481,000 rural enrollees would not have had any out-of-pocket costs for recommended Part D covered adult vaccines. Under the IRA's Part D redesign, about 289,000 rural enrollees who do not receive financial assistance are projected to save $1,000 or more in 2025. Additional benefits are expected for this population from other IRA drug-related provisions.

Arielle Bosworth, Bisma A. Sayed, Yevgeniy Feyman, Rachael Zuckerman, Nancy De Lew and Thomas Buchmueller

KEY POINTS

- Rural Medicare enrollees have disproportionately higher rates of certain health conditions relative to their urban peers, including higher rates of heart disease, stroke, cancer, and chronic lower respiratory disease.[1] They also report greater health care cost related problems and difficulty affording prescription drugs.[2, 3] About 15 percent of Part D enrollees live in rural areas.
- The IRA expanded the low-income subsidy (LIS)[*] program in 2024 by folding partial LIS into full LIS. About 23 percent of partial LIS enrollees live in rural areas, which is higher than the share of Part D enrollees who live in rural areas (15 percent). This provision is estimated to result in a reduction of about $300 in average annual out-of-pocket costs for all eligible enrollees.[4] Rural enrollees are expected to especially benefit from this provision because a larger share experience poverty compared to their urban peers.[5]
- The IRA caps the monthly out-of-pocket costs for each covered insulin product to $35, which will result in greater affordability of insulin for rural enrollees.[†] This provision went into effect in January 2023 for covered insulin products under Part D and July 2023 for covered insulin products under Part B and Medicare Advantage. About 281,000 rural Medicare enrollees would have benefited from the insulin cap if it had been in effect in 2020.

[*] For eligible enrollees whose income and resources are limited, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 established Extra Help for prescription drugs. Subsidies are paid by the Federal government to drug plans and provide assistance with premiums, deductibles, and co-payments.

[†] The $35 cap for a month's supply of each covered insulin product went into effect for Part D enrollees on January 1, 2023 and for Part B covered insulin on July 1, 2023.

- The IRA vaccine provision made recommended Part D covered adult vaccines available without enrollee cost-sharing starting on January 1, 2023. Among the 3.4 million enrollees who received a vaccine under Medicare Part D in 2021, about 481,000 were from rural areas.[6] These enrollees would have had no out-of-pocket costs under the IRA vaccine provision if it had been in effect in 2021.
- Starting in 2025, enrollee out-of-pocket spending in Part D will be capped at $2,000 per year. This cap, which will be indexed to inflation, is expected to help enrollees who take high-priced drugs, including rural enrollees who have higher rates of certain health conditions that require costly medications (e.g., cancer).
- Among rural non-LIS enrollees projected to have out-of-pocket savings under the IRA's Part D redesign provisions, a sizeable number (about 289,000 or 5 percent of rural non-LIS enrollees) will have savings of $1,000 or more in out-of-pocket costs. Among these enrollees, rural non-LIS enrollees are estimated to save an average of $2,450 on out-of-pocket prescription drug costs in 2025.[7]
- Of the 10 drugs covered under Part D selected for participation in the Medicare Drug Price Negotiation Program for initial price applicability year 2026, the share of enrollees using these drugs that reside in rural areas is highest for NovoLog/Fiasp (about 20 percent), a proportion that is 5 percentage points greater than rural enrollee representation in the Part D population (15 percent).

BACKGROUND

The Inflation Reduction Act (IRA) is improving affordability of prescription drugs for Medicare enrollees through a variety of drug related provisions, including:[*]

- capping out-of-pocket spending for prescription drugs covered under Part D,
- reducing costs of covered insulins and recommended adult vaccines,
- expanding eligibility for financial assistance,
- changing the Part D benefit structure, and
- authorizing the Secretary of Health and Human Services to negotiate prices directly with participating manufacturers for selected drugs that have high total spending and are high expenditure, single source drugs without generic or biosimilar competition.

This fact sheet outlines the potential impacts of the IRA's key drug-related provisions for rural Medicare enrollees.

Medicare Enrollment

In 2022, about 53 million Medicare enrollees have Part D prescription drug coverage, of whom about 8.1 million reside in rural areas. Estimates of Medicare Part D enrollees residing in rural areas vary due to differences in definitions and classification schemes to identify rural locations. Recent data shows that the number of rural enrollees with Part D coverage represent about 15 percent of Part D enrollees if all enrollees residing in non-metropolitan areas are classified as rural.[†] These include enrollees residing in micropolitan

[*] For a complete list of IRA drug-related provisions, please see: Inflation Reduction Act and Medicare | CMS

[†] In this fact sheet, rural is defined as non-metropolitan areas. Enrollees residing in micropolitan areas and all other non-metropolitan areas are classified as rural.

statistical areas.[8*] ASPE analyses cited in this Fact Sheet on the projected impacts of the IRA reflect the over 8 million rural Medicare Part D enrollees who do not live in a metropolitan area.

Health Status and Access to Care Among Rural Americans

Individuals of all ages living in rural areas have disproportionately higher rates of adverse health-related outcomes relative to non-rural peers. For example:

- Across the U.S. population, age adjusted morbidity rates for heart disease, stroke, cancer, and chronic lower respiratory disease are higher for people residing in rural areas vs non-rural areas.[9] They also are more likely to engage in risky behaviors, such as smoking and substance abuse.[10]
- Rural Americans overall have an 8 percent higher rate of all-cancer mortality than their urban counterparts.[11]
- Compared with the urban population, rural populations overall have a 16 percent higher prevalence of type 2 diabetes and 20 percent higher type 2 diabetes related mortality.[12]
- Across the U.S. population, the gap in mortality rates between rural and urban Americans has grown substantially over time, with life expectancy declining for both men and women between 2010-2019 in rural counties. By contrast, urban life expectancy made modest increases over the same time period.[13]

Many of the health disparities between rural and urban individuals also hold true for urban and rural Medicare enrollees. Among the Medicare population, existing research finds:

- Medicare enrollees living in a rural area have a 40 percent higher preventable hospitalization rate and a 23 percent higher mortality rate compared to those living in urban areas.[14]
- In comparison to their urban counterparts, rural Medicare Part D enrollees have a higher mean number of prescriptions, higher total prescription spending, and pay a higher proportion of their total prescription spending out-of-pocket.[15] Rural Medicare beneficiaries also tend to have lower medication adherence than their urban counterparts.[16]

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Projected Impacts of IRA's Drug-Related Provisions

Below, we highlight some key drug-related provisions of the IRA and their potential impacts for rural enrollees.

Expansion of Financial Assistance through the Low-Income Subsidy (LIS) Program

The Medicare Part D LIS program, also referred to as Extra Help, assists enrollees who meet income and asset limits to pay for their Part D drug costs. Prior to the IRA, in order to be eligible for full LIS, an enrollee must have income below 135 percent of the Federal Poverty Level (FPL) or $19,683 per year in 2023 for an individual and have limited assets.[†] Prior to 2024, enrollees were eligible for partial assistance if their incomes are between 135 and 150 percent of FPL. As of January 1, 2024, the IRA expanded full LIS benefits to individuals with incomes between 135 and 150 percent of FPL. Through full LIS benefits, eligible people with Medicare

[*] Micropolitan statistical areas consist of the county or counties (or equivalent entities) associated with at least one urban area of at least 10,000 but less than 50,000 population, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties.

[†] For details on the LIS and partial LIS program, please see here: [Limited Income and Resources | CMS]

can benefit from no deductible, no premium, and low, fixed copayments for covered Part D medications. The partial benefits that were phased out by the IRA include a premium paid on a sliding scale and higher coinsurance for covered prescription drugs.

Table 1. CY 2024 Resource Limits for Determining LIS Eligibility

Marital Status 2023	Resource Limit 2023	Resource Limit with Burial Expenses 2024	Resource Limit 2024	Resource Limit with Burial Expenses
Single	$9,090	$10,590	$15,720	$17,220
Married	$13,630	$16,630	$31,360	$34,360

Source: CMS Calendar Year (CY) 2024 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS)

Projected Impact: In 2020, about 461,000 Medicare enrollees received partial LIS benefits; about 23 percent of whom lived in rural areas, which is higher than the rural share of Part D enrollees (15 percent).[17] Analysis suggests that expansion of LIS eligibility could reduce average annual out-of-pocket costs for these enrollees by $300 per enrollee.[18] This provision is expected to help individuals living in rural areas ages 65 and older and those who qualify for Medicare based on disability or illness. The poverty rate among the overall rural population is 15.4 percent, which is higher than the rate for metro dwelling individuals at 11.9 percent. This rural-urban poverty gap has increased over the last 10 years and extends across all age ranges and racial groups.[19]

Out-of-Pocket Spending Capped at $35 for a Month's Supply of each Insulin

Under the IRA, insulin is capped at $35 for a month's supply of each covered insulin product; this provision went into effect in January 2023 for covered insulin under Part D and July 2023 for covered insulin under Part B as well as Medicare Advantage. Prior to the IRA, there was no cap on out-of-pocket costs for insulin products under Medicare Part B or Part D.[*] Taking insulin as prescribed is critical to controlling diabetes, however, patients may ration their insulin if they cannot afford it.[20] Consequences of uncontrolled diabetes among rural patients include hospitalizations and serious health consequences. In rural areas of the South, Midwest, and West, there is a 29 percent higher odds of diabetes related hospital mortality when compared to urban areas.[21] Moreover, diabetes patients in rural areas have more difficulties acquiring diabetes monitoring supplies, like glucose meter strips, or accessing diabetes-related screenings.[22]

Projected Impact: The IRA capped monthly out-of-pocket costs for insulin to $35 for each covered insulin product. This reduction may improve access to insulin for rural enrollees and will reduce expenditures for enrollees who use insulin. Under Medicare Part B and Part D, 281,000 rural enrollees would have benefited from the insulin cap if it had been in effect in 2020. The reduction in out-of-pocket spending, in turn, may improve access and adherence to prescribed insulin regimens, which may avert hospitalizations and health care complications associated with uncontrolled diabetes.[†]

[*] The Part D Senior Savings Model required participating enhanced alternative Part D plans to offer insulin at reduced cost prior to the passage of the IRA. For more information on this Model, please see here: Part D Senior Savings Model | CMS Innovation Center

[†] There are many reasons why patients may not be able to follow prescribed insulin regimens and out-of-pocket costs are one factor. Please see the following for a more detailed discussion: aspe-insulin-affordibility-rtc.pdf (hhs.gov).

Elimination of Copays for Recommended Adult Part D Covered Vaccines

Under the IRA, beginning in 2023, enrollees do not have to pay out-of-pocket costs for adult vaccines covered under Part D that are recommended by the Advisory Committee on Immunization Practices (ACIP). Prior to the IRA, Part D covered vaccines, including shingles, tetanus and diphtheria, pertussis, hepatitis A, hepatitis B, and others, were subject to out-of-pocket costs. Vaccination rates among adults, including older adults, are generally low.

Projected Impact: The IRA provides access to recommended adult vaccines covered under Medicare Part D without any out-of-pocket costs. Among 3.4 million enrollees who received a vaccine under Medicare Part D in 2021, about 481,000 resided in rural areas.[23] These enrollees paid a total of about $39.4 million dollars in out-of-pocket costs for Part D covered vaccines, averaging about $79 per enrollee in rural micropolitan areas and $85 per enrollee in all other rural areas in 2021. These enrollees would not have had to pay out of pocket for recommended adult vaccines covered under Part D if the IRA vaccine provision had been in effect in 2021.[24] There are many factors that shape whether individuals are able to obtain recommended vaccinations, including out-of-pocket costs. Thus, this provision may increase accessibility of Part D covered vaccines for this population and will eliminate their out-of-pocket spending on Part D covered vaccines.

Changes in Part D Benefit Design

The IRA changes the Part D benefit design. Key changes include: 1) in 2024, eliminating cost sharing in the catastrophic coverage phase that required patients to pay 5 percent of their drug costs and 2) in 2025, establishing a $2,000 maximum out-of-pocket cap that is indexed to inflation annually thereafter and eliminating the coverage gap phase. It also limits annual increases in Part D premiums and allows enrollees to spread their out-of-pocket prescription costs over the year through the new Medicare Prescription Payment Plan. .[*]

Projected Impact: The Part D redesign, which includes provisions that eliminate the coverage gap phase and establish a maximum out-of-pocket cap of $2,000 in 2025 and indexed to inflation annually thereafter, is expected to help all enrollees, but especially those who have the highest out-of-pocket drug spending for diseases such as cancer, hypertension, diabetes, and others. Rural Medicare enrollees have higher rates of serious health conditions such as some types of cancer, heart disease, and diabetes and are expected to benefit from these provisions.

In 2025, the out-of-pocket cap and other Part D related provisions in the IRA are projected to save rural enrollees an average of 30 percent in out-of-pocket costs, which translates to annual savings of about $145 for rural each enrollee.[25] Among rural non-LIS enrollees projected to have out-of-pocket savings under the IRA, a sizeable number (about 289,000 or 5 percent of rural Medicare non-LIS enrollees) will have savings of $1,000 or more in out-of-pocket costs. Among this population with savings of $1,000 or more, rural non-LIS enrollees are estimated to save an average of about $2,450 on out-of-pocket prescription drug costs.[26]

Negotiation for Selected Drugs for Initial Price Applicability Year 2026

Under the IRA, the Secretary of the Department of Health and Human Services (HHS) is authorized to directly negotiate the prices of certain high expenditure, qualifying single source drugs without generic or biosimilar competition with participating manufacturers.[27] The 10 drugs selected for negotiation for initial price applicability year 2026 are presented in Table 2 below along with the common conditions they treat, the total

[*] Medicare Prescription Payment Plan Draft Part Two Guidance (cms.gov)

number of Medicare Part D enrollees taking the drug in calendar year 2022, and the percent of enrollees taking the drug who live in rural areas.

Projected Impact: The projected impact of the negotiation program for the selected drugs for initial price applicability year 2026 is not yet available. However, existing analysis shows that the share of enrollees that are rural and taking the 10 drugs selected for initial price applicability year 2026 is higher than the representation of rural enrollees in the Part D population (15.2 percent). The share of rural enrollees taking one of the drugs is highest for NovoLog/Fiasp (about 20 percent), which is 5 percentage points greater than their representation in the Part D population (15 percent).[28]

Table 2. Medicare Part D Enrollees' Calendar Year 2022 Use of Drugs Selected for Negotiation for Initial Price Applicability Year 2026

Drug Name	Commonly Treated Conditions	Total Number of Medicare Part D Enrollees Taking the Drug in CY 2022	Share of Enrollees Taking Each Drug That Reside in Rural[a] Areas in CY 2022
Eliquis	Prevention and treatment of blood clots	3,505,000	17.1%
Jardiance	Diabetes; Heart failure	1,321,000	15.8%
Xarelto	Prevention and treatment of blood clots; Reduction of risk for patients with coronary or peripheral artery disease	1,311,000	17.1%
Januvia	Diabetes	885,000	15.4%
Farxiga	Diabetes; Heart failure; Chronic Kidney Disease	639,000	17.2%
Entresto	Heart failure	521,000	16.8%
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis	47,000	17.3%
Imbruvica	Blood cancers	22,000	16.9%
Stelara	Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis	20,000	15.4%
NovoLog/Fiasp[b]	Diabetes	763,000	19.5%

Source: Available from: ASPE-IRA-Drug-Negotiation-Fact-Sheet-9-13-2023.pdf (hhs.gov)

Notes: Percentages are calculated for rural enrollees using the total number of enrollees taking the drug as the denominator. ASPE estimates may differ from drug use figures reported by CMS due to differences in the time period that is examined. The drug use estimates are for Part D enrollees using the drug and not limited to those using the drug for the conditions shown in this Table.

[a]Geographic area estimates are based on mapping of beneficiary county and zip code information in the Medicare Enrollment Database to Census Core-Based Statistical Areas (CBSAs). Enrollees are classified as rural if they reside in areas that can be mapped to a county and a zip code located in non-metropolitan areas. Micropolitan areas and all other non-metropolitan areas are classified as rural.

[b]The drug is also identified with the proprietary names: NovoLog; NovoLog FlexPen; NovoLog PenFill; Fiasp; Fiasp FlexTouch; Fiasp PenFill.

CONCLUSION

The IRA includes provisions to increase accessibility and affordability of prescription drugs for Medicare enrollees, reduce the rate of growth in Medicare drug spending, and improve the financial sustainability of the Medicare program. This fact sheet reviews the estimated impacts of key IRA provisions for rural Medicare enrollees. Findings are promising, suggesting that the IRA Medicare drug-related provisions are projected to disproportionately lower out-of-pocket drugs costs and improve the affordability of medications for rural Medicare enrollees.

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Office of the Assistant Secretary for Planning and Evaluation

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