METHODOLOGY FOR REGIONAL LEADERSHIP COUNCIL BRIEFINGS

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Contents

Methodology for Affordable Connectivity Program Is Increasing Broadband Access in Congressional Districts

The number of households enrolled in the Affordability Connectivity Program (ACP) and the amount of financial assistance they received as of February 2024 are based on information released by the White House.[1] Household enrollment in each district was rounded to the nearest thousand households, and assistance amounts were rounded to the nearest $10,000.

Eligibility for the ACP was estimated using the Census Bureau American Community Survey's (ACS) estimates for households with incomes up to 200% of the federal poverty level (FPL) by congressional district. Beneficiaries can also qualify for the ACP through their existing enrollment in many other programs, such as SNAP or Medicaid; however, most of these programs have income eligibility thresholds below 200% FPL, meaning that these households would be included in the ACS-based estimates. In a few cases, households above 200% FPL may be able to access the program through participation in other programs, such as Pell Grants. These households are not included in these eligibility estimates, and the number of eligible households was rounded to the nearest thousand households.

Information about availability of plans costing less than $30 per month is based on the Federal Communications Commission's Fixed Broadband Deployment Data, which reports available internet service providers in each Census block.[2] Census blocks were matched to congressional districts and to the list of providers that have committed to offering high-speed Internet plans for $30 per month or less to estimate the percentage of the district with access to these low-cost plans.[3]

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[1] The White House, Fact Sheet: *As Affordable Connectivity Program Hits Milestone of Providing Affordable High- Speed Internet to 23 Million Households Nationwide, Biden-Harris Administration Calls on Congress to Extend Its Funding* (February 6, 2024) (https://www.whitehouse.gov/briefing-room/statements-releases/2024/02/06/fact-sheet-as-affordable-connectivity-program-hits-milestone-of-providing-affordable-high-speed-internet-to-23-million-households-nationwide-biden-harris-administration-calls-on-congr).

[2] Federal Communications Commission, *Fixed Broadband Deployment Data: December 2020* (August 1, 2023) (https://opendata.fcc.gov/Wireline/Fixed-Broadband-Deployment-Data-December-2020/hicn-aujz).

[3] White House, *Fact Sheet: President Biden and Vice President Harris Reduce High-Speed Internet Costs for Millions of Americans* (May 9, 2022) (https://www.whitehouse.gov/briefing-room/statements-releases/2022/05/09/fact-sheet-president-biden-and-vice-president-harris-reduce-high-speed-internet-costs-for-millions-of-americans/). Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (October 2022) (https://mcdc.missouri.edu/applications/geocorr2022.html).

Methodology for Estimating the Benefits of Enhanced ACA Subsidies in Congressional Districts

This section describes the methodology used for estimating the effect of the American Rescue Plan (ARP) and Inflation Reduction Act (IRA) on premiums for health insurance plans available through the marketplaces established by the Affordable Care Act (ACA). This analysis estimates the premium effects, by congressional district, of reverting from the current premium contribution limits for individuals who are eligible to purchase marketplace coverage to the higher contribution limits in place before the enactment of the ARP.[4] Before enactment of the IRA, these higher contribution limits were set to be reinstated in 2023 but the lower contribution limits will now be in place through 2025. As a result, no individual with marketplace coverage will pay more than 8.5% of their household's annual income for health insurance over the next two years, and the majority of marketplace enrollees will pay significantly less.

The methodology draws on information and data from the Department of Health and Human Services (HHS), the Census Bureau's American Community Survey (ACS), the Kaiser Family Foundation's "Health Insurance Marketplace Calculator," the Robert Wood Johnson Foundation's HIX Compare dataset, and the Missouri Census Data Center, as well as information published by state agencies in Minnesota and New York.

Enrollment and Average Premiums

This methodology estimates the number of marketplace enrollees and these enrollees' average premiums by congressional district. Two different methods for estimating enrollment and average premiums were used – one for districts in the states that use the federal marketplace (Healthcare.gov) and another for the remaining states that operate their own marketplaces.

Thirty-two states use the federal marketplace.[5] For these states, the number individuals who selected marketplace coverage and who qualified for financial assistance during the 2024 open enrollment period is based on district-level estimates from HHS.[6] Additional data published by HHS provides the average tax credit per person at the ZIP code level along with county-level information on average unsubsidized premiums, average subsidized premiums, the number of new enrollees, the average subsidized premium for enrollees receiving a premium tax credit, and the number of enrollees different income levels.[7] This county and ZIP code level data is used to develop district-level estimates of average out-of-pocket premiums for these states.[8]

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[4] The ACA established new premium tax credits (PTC) that reduce the cost of marketplace coverage for individuals and households with incomes between 100% and 400% of the federal poverty levels (FPL) and who have no other source of comprehensive and affordable health insurance. The ARP expanded PTC eligibility to individuals and households with incomes greater than 400% FPL and lowered the required premium contributions for those with incomes below 400% FPL. Individuals and households with incomes between 100%-250% FPL are also eligible for additional subsidies that limit their out-of-pocket medical expenses.

[5] Of these states, twenty-nine fully rely on the federal marketplace to perform all of the functions of their state's insurance marketplace. The three remaining states – Arkansas, Georgia, and Oregon – use a hybrid "State-based Marketplace-Federal Platform" exchange. Under this arrangement, each of these states administers most of the functions of its insurance marketplace but uses the federal marketplace to make eligibility determinations and enroll eligible individuals. See Kaiser Family Foundation, *State Health Insurance Marketplace Types* (2024) (https://www.kff.org/affordable-care-act/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D).

[6] Data from the Department of Health and Human Services provided to Congress.

[7] Department of Health and Human Services, *2024 Marketplace Open Enrollment Period Public Use Files* (March 22, 2024) (https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files).

[8] ZIP code-level information is mapped to a congressional district using a crosswalk from the Missouri Census Data Center. In cases where a ZIP code overlaps with two or more districts, the reported value of the ZIP code is divided proportionally by the population of

For the remaining states and the District of Columbia that operate their own marketplaces, enrollment and premium information for 2024 is available only at the state level.[9] For congressional districts in these states, the state-level premium information is divided in this analysis among districts proportionately based on the income levels of the individuals in the district with private insurance in 2021, as reported in the ACS.[10] Counts of enrollees are divided among congressional districts based on the number of people with income under 400% of the federal poverty levels (FPL) who have private insurance in the district, as determined from the 2017-2021 ACS microdata.[11]

For districts in New York and Minnesota, the number of Basic Health Plan enrollees is estimated using enrollment information published by each state.[12] In both states, county enrollment data for 2024 is mapped to a congressional district using the Missouri Census Data Center crosswalk.13[13] In cases where a county overlaps with two or more districts, the reported value of the county is divided proportionally by the population of the county residing in each congressional district.

Marketplace and Basic Health Plan enrollment estimates in all districts were rounded to the nearest 1,000 persons. The change in marketplace enrollment between 2020 and 2024 is rounded to nearest hundred

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the ZIP code residing in each congressional district. To maintain confidentiality, the enrollment and tax credit information for some ZIP codes is suppressed in HHS's data. All suppressed ZIP codes are mapped to the county-level open enrollment file in order to account for the values that were not observed in the ZIP code file. The unaccounted for portion of each county is similarly mapped to congressional districts to provide the total number of enrollees and enrollees receiving financial assistance, as well as the average tax credit received by enrollees receiving financial assistance. For counties spanning multiple congressional districts, the county-level data is proportionally distributed to congressional districts by the number of people in the districts with private health insurance under 400% FPL, based on the microdata from the 5-Year American Community Survey and a geography crosswalk. Missouri Census Data Center, Geocorr 2022: Geographic Correspondence Engine (October 2022) (https://mcdc.missouri.edu/applications/geocorr2022.html). The remaining county level data – which includes information on the average unsubsidized premium, average subsidized premium, number of new enrollees, average subsidized premium for enrollees receiving a tax credit, and number of enrollees at different income levels – is proportionally allocated from the county-level to congressional districts in a similar manner.

[9] Department of Health and Human Services, *2024 Marketplace Open Enrollment Period Public Use Files* (March 22, 2024) (https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files).

[10] Two steps are involved in estimating district-level marketplace enrollment and average premiums for the states using their own state-based marketplaces. First, the 2017-2021 five-year ACS is used to make preliminary determinations of the number of individuals in each district who purchased individual insurance, their income and family size, and the premiums they would have paid for coverage with and without the enhanced subsidies. In making these preliminary determinations, premiums for each individual are calculated using premium information from the HIX Compare dataset, which provides the 2024 pre-subsidy premium of benchmark silver plans for a single 27-year-old who does not use tobacco in each county. Each individual purchasing individual health insurance in 2021 is assumed to pay this rate, adjusted for the person's age using each state's premium rating age curve. See HIX Compare, *Individual Market: Current Version* (https://hixcompare.org/individual-markets.html). The data from the ACS used to make these preliminary estimates does not identify individuals who are ineligible for subsidized marketplace coverage based on their immigration status or having access to affordable insurance offered by their employer. In the second step, these preliminary district-level estimates are scaled so that the estimates would be consistent with the 2024 state-level data published by HHS.

[11] The ACS only asks respondents if they have enrolled in "private insurance" purchased in the nongroup market, which encompasses respondents who purchase coverage through the marketplaces established by the ACA and those who purchase nongroup coverage outside of the marketplaces. In order to focus on the respondents who are most likely to have marketplace insurance, this part of the analysis only includes only respondents who reported having private insurance and incomes below 400% FPL.

[12] The Basic Health Program was established by the ACA, and it provides states with the option of creating a separate health benefits program for individuals with incomes up to 200% FPL that is distinct from the coverage options available through a state's marketplace or Medicaid program. See Department of Health and Human Services, *Basic Health Program* (https://www.medicaid.gov/basic-health-program/index.html). See also *NY State of Health, Recipients Enrolled in QHP or EP as of March 1, 2024 by Issuer* (https://info.nystateofhealth.ny.gov/sites/default/files/EP and QHP Total Enrollees March 2024 Combined.pdf); Minnesota Department of Human Services, *Managed Care Enrollment Figures*, (March 2024) (https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_141529).

[13] Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (October 2022) (https://mcdc.missouri.edu/applications/geocorr2022.html).

enrollees. The percentage increase in enrollment between 2020 and 2024 is based on the unrounded increase in enrollment.

Change in Marketplace Premiums

The district-level savings from the enhanced subsidies is the difference between the average premium paid by enrollees in 2024 and a counterfactual estimate of what average premiums would have been without the enhanced subsidies.

First, the methodology assumes no changes in marketplace enrollees' incomes and household composition and that they would choose to enroll in the same type of marketplace plan without the enhanced subsidies.[14]

The first step of the analysis is to estimate the total amount of savings from the enhanced subsidies in each state. For districts in states that rely on Healthcare.gov, HHS publishes the average statewide premium savings from the enhanced subsidies for individuals who qualified for the subsidies.[15] HHS's average premium savings per subsidy-eligible enrollee is multiplied by the total number of subsidy-eligible enrollees in each state.

For states with their own marketplaces, a different method is used to calculate statewide premium savings. This calculation relies on additional information about the enhanced premium savings for marketplace enrollees in all states published by HHS in 2021, which is the most recent year where HHS published savings estimates for all states.[16] To estimate how these savings have changed between 2021 and 2024, the statewide savings amounts for Healthcare.gov states in 2021 is compared to the 2024 statewide savings estimates described in the previous paragraph. To estimate the 2024 statewide savings from the enhanced subsidies in states with state-based marketplaces, the 2021 savings estimates for these states is multiplied by the ratio of 2024 savings and 2021 savings in Healthcare.gov states. This latter ratio accounts for increased enrollment between 2021 and 2024, increases in the average amount of enhanced subsidies, and the savings for new marketplace enrollees.

The second step of the analysis is to estimate the amount of savings for marketplace enrollees in each district. This is done by allocating the total dollar value of the statewide calculated above according to the income levels of marketplace enrollees in each district. This allocation is necessary because the value of the enhanced premium subsidies varies depending on an enrollees' income. This allocation relies on the Urban Institute's estimates of the relative value of the enhanced subsidies in 2022 for marketplace enrollees at different income levels.[17] For example, using the Urban Institute's approximations, if a

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[14] Marketplace plans are standardized into one of four "metal levels" by the proportion of total health care costs that will be paid by the insurer for all its enrollees within a given level. Bronze plans are designed to cover roughly 60% of total medical costs, silver plans cover roughly 70%, gold plans cover roughly 80%, and platinum plans cover roughly 90%. Plans that cover a higher share of total medical costs have proportionally higher premiums.

[15] Department of Health and Human Services, *Health Insurance Marketplaces 2024 Open Enrollment Report*, Table 9, pages 23-24 (March 22, 2024) (https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf).

[16] Department of Human Services, *2021 Final Marketplace Special Enrollment Period Report* (September 4, 2021) (https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf).

[17] The Urban Institute's analysis divided enrollees nationally into four income categories: less than 150% FPL, 150%-400% FPL, greater than 400% FPL and who were eligible for premium tax credits, and those who did not qualify for premium tax credits. This analysis shows that marketplace enrollees in these respective categories would, on average, save $457, $1,045, $2,003, and $712 from the enhanced subsidies. These estimates are multiplied by the number of 2024 enrollees in a district belonging to each of the four income groups to approximate the savings for each district. Each district's relative approximate savings is used to allocate the statewide savings estimated for each state. Urban Institute, What If the American Rescue Plan Act Premium Tax Credits Expire?, Table 4, page 8 (April 2022) (https://www.urban.org/sites/default/files/2022-04/What If the American Rescue Plan Act Premium Tax Credits Expire.pdf).

district's estimated savings would be 20% of the state's total estimated savings, that district is assigned 20% of the total statewide savings calculated in the first step of the analysis.

To estimate the average per-enrollee savings from the enhanced subsides in a district, the premium savings allocated to a district is divided by the number of enrollees in the district.

In states operating their own marketplaces, additional calculations were required because county-level income and enrollment data for 2024 marketplace enrollees are not available. The analysis estimated the incomes of marketplace enrollees in each district in these states using microdata from the 2017-2021 ACS about the income of individuals purchasing private insurance and geographic crosswalks from the Missouri Census Data Center. [18]

District-level premiums and premium increases are rounded to the nearest $10 and may not add up due to this rounding. Additionally, the average percentage premium savings from the enhanced subsidies is calculated using the unrounded premium amounts.

Household Examples

The premiums paid by the representative household are determined using two Kaiser Family Foundation "Health Insurance Marketplace Calculators": (1) the calculator that provides estimates of premiums in 2024 and (2) the calculator that provides estimates of what premiums would have been in 2022 without the enhanced subsidies in the ARP.[19] In both calculators, the household's expected financial contribution towards the purchase of a benchmark silver plan is determined by the household's income and their plan's premium, which depends on the household's size, its geographic location, the age of the household's members, and whether any household members use tobacco.[20] The ACA and ARP established different premium contribution limits that cap a household's maximum premium at a specified percentage of its annual income, and both sets of contribution limits are sliding scales based on a household's income. The household's contribution under current law and contribution without the enhanced subsidies were calculated according to the applicable statutory maximum premium contributions.

Because the calculator that estimates premiums without the enhanced subsidies uses 2022 data, the premium savings in 2024 for the two-adult household with an income of $85,000 was adjusted to account for changes in the benchmark premiums between 2022 and 2024. The adjustment is the change in the average pre-tax credit benchmark premium from 2022 to 2024 for each district. This adjustment is necessary because in this example the household's income exceeds 400% FPL. Without the enhanced subsidies, such a household would be responsible for paying the entire benchmark premium.

All members of each household were assumed to not use tobacco.

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[18] U.S. Census Bureau. (2022). 2017-2021 American Community Survey 5-year Public Use Microdata Samples; Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (October 2022) (https://mcdc.missouri.edu/applications/geocorr2022.html).

[19] Kaiser Family Foundation, *Health Insurance Marketplace Calculator* (accessed on March 25, 2024). (www.kff.org/interactive/subsidy-calculator); Kaiser Family Foundation, *What Would ACA Subsidies Have Been in 2022 if COVID-19 Relief Had Not Passed?* (accessed on March 25, 2024) (https://www.kff.org/interactive/subsidy-calculator-without-arpa).

[20] New York and Vermont do not allow insurers to adjust premiums for marketplace coverage by an enrollee's age, and New Jersey and Massachusetts have stricter limits on age adjustments than those established by the ACA. These states, along with California, Connecticut, the District of Columbia, Massachusetts, New Jersey, and Rhode Island, also do not allow insurers to adjust premiums for marketplace coverage if an enrollee uses tobacco. Additionally, Colorado, Arkansas, and Kentucky limit how much insurers can adjust premiums for tobacco use. Department of Health and Human Services, *Market Rating Reforms: State Specific Rating Variations* (December 10, 2021) (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating).

Methodology for Estimating How the Inflation Reduction Act is Reducing Prescription Drug Costs for Medicare Enrollees in Congressional Districts

The primary source of data for the congressional district-level estimates of the savings on drug costs that Medicare beneficiaries will experience in 2024 and 2025 under the Inflation Reduction Act (IRA) is a January 2024 report from the Department of Health and Human Services: *Medicare Part D Enrollee Out-Of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act*. This report provides national and state-level data on the savings for Medicare beneficiaries from four primary provisions of the IRA:

- Limiting beneficiaries' monthly insulin costs to $35,
- Eliminating cost-sharing for all adult vaccinations covered by Medicare Part D,
- Eliminating beneficiaries' coinsurance above Part D's "catastrophic" out-of-pocket spending threshold, and
- Expanding eligibility for Part D's "full" LIS benefit from 135% to 150% of the federal poverty levels (FPL).[21]

This national and state-level data is combined with other data from the Centers for Disease Control and Prevention (CDC), the Department of Health and Human Services (HHS), the Kaiser Family Foundation, and the Missouri Census Data Center to develop district-level estimates.

These estimates do not include the effects of the IRA's Prescription Drug Price Negotiation Program, Part B and Part D inflation rebates, or the new option for Part D beneficiaries to pay their out-of-pocket costs in monthly installments starting in 2025.[22] Additionally, these estimates do not account for changes in Part D enrollment or changes in access to medications between 2021 and 2025, nor do they account for other federal or state programs that may reduce Part D beneficiaries' out-of-pocket costs or insurers' responses to the IRA's changes to the Medicare Part D program.[23]

Number of Medicare Beneficiaries in the District

The HHS report provides state-level estimates of the number of Medicare Part D enrollees in each district

[21] Department of Health and Human Services, *Medicare Part D Enrollee Out-of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act,* pages 6-8 (July 7, 2023 (revised January 30, 2024)). The estimates also include additional Part D policy changes from the IRA that have smaller impacts. (https://aspe.hhs.gov/sites/default/files/documents/1b652899fb99dd7e6e0edebbcc917cc8/aspe-part-d-oop.pdf). For more information about the IRA's changes to Medicare's LIS, *see infra* note 27.

[22] *See* Department of Health and Human Services, *Medicare Drug Price Negotiation Program* (July 2, 2024) (https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation); Department of Health and Human Services, *Inflation Rebates in Medicare* (July 10, 2024) (https://www.cms.gov/inflation-reduction-act-and-medicare/inflation-rebates-medicare); Department of Health and Human Services, *CMS Issues Additional Guidance on Program to Allow People with Medicare to Pay Out-of-Pocket Prescription Drug Costs in Monthly Payments* (February 15, 2024) (https://www.hhs.gov/about/news/2024/02/15/cms-issues-additional-guidance-program-allow-people-medicare-pay-out-of-pocket-prescription-drug-costs-monthly-payments.html).

[23] Department of Health and Human Services, *Part D Senior Savings Model* (https://innovation.cms.gov/innovation-models/part-d-savings-model); National Conference of State Legislatures, *Diabetes State Mandates and Insulin Copayment Caps* (December 19, 2023) (https://www.ncsl.org/health/diabetes-state-mandates-and-insulin-copayment-caps - toc4).

who will pay less for their prescriptions because of the Inflation Reduction Act (IRA) in 2024 and 2025.[24] Under the methodology, the number of Medicare Part D enrollees with savings as a result of the IRA within each state is proportionally allocated to congressional districts based on each district's share of statewide Part D enrollment as of February 2024.[25]

Total and Average Savings in the District

The estimates of the total district savings and the average beneficiary savings are calculated in a three-step process. First, the HHS report provides average savings for beneficiaries with savings at the state level in 2024 and 2025.[26]

Second, average savings at the state level are estimated for beneficiaries receiving low-income subsidies (LIS beneficiaries) and for beneficiaries without low-income subsidies (non-LIS beneficiaries). The HHS report does not provide this data at the state level, but it does provide the national average savings for all LIS beneficiaries and for all non-LIS beneficiaries.[27] The HHS report also provides the proportion of LIS beneficiaries and non-LIS beneficiaries who receive savings.[28] This data is used to generate national estimates of the average savings for LIS beneficiaries with savings and the average savings for non-LIS beneficiaries with savings. Medicare enrollment data is then used to estimate the proportion of LIS beneficiaries and non-LIS beneficiaries in the state.[29]

To estimate the average savings for LIS beneficiaries and non-LIS beneficiaries in the state, the methodology assumes (1) that the proportion of LIS and non-LIS beneficiaries who have savings is the

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[24] Department of Health and Human Services, *Medicare Part D Enrollee Out-of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act,* Table 12 Projected Impact of Inflation Reduction Act Medicare Part D Redesign for Enrollees Expected to Have Out-Of-Pocket Savings, by State, 2024 and 2025, pages 25-26 (July 7, 2023 (revised January 30, 2024)) (https://aspe.hhs.gov/sites/default/files/documents/1b652899fb99dd7e6e0edebbcc917cc8/aspe-part-d-oop.pdf).

[25] Department of Health and Human Services, *Medicare Monthly Enrollment* (June 28, 2024) (https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment)..

[26] Department of Health and Human Services, *Medicare Part D Enrollee Out-of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act,* Table 12 Projected Impact of Inflation Reduction Act Medicare Part D Redesign for Enrollees Expected to Have Out-Of-Pocket Savings, by State, 2024 and 2025, pages 25-26 (July 7, 2023 (revised January 30, 2024)) (https://aspe.hhs.gov/sites/default/files/documents/1b652899fb99dd7e6e0edebbcc917cc8/aspe-part-d-oop.pdf).

[27] Department of Health and Human Services, *Medicare Part D Enrollee Out-of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act,* Table 7A Model Specification A: Projected Average Annual Out-Of-Pocket Impact Per Enrollee of 2024 Inflation Reduction Act Medicare Part D Redesign, by Low-Income Subsidy (LIS) Status & Table 7B Model Specification B: Projected Enrollee Average Annual Out-of-Pocket Impact of 2025 Inflation Reduction Act Medicare Part D Redesign, by Low-Income Subsidy (LIS) Status (2025 Dollars), pages 19-20 (July 7, 2023 (revised January 30, 2024)). https://aspe.hhs.gov/sites/default/files/documents/1b652899fb99dd7e6e0edebbcc917cc8/aspe-part-d-oop.pdf).

[28] Department of Health and Human Services, *Medicare Part D Enrollee Out-of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act*, Table 10A Specification A: Distribution of Projected Out-of-Pocket Savings for 2024 IRA Drug-Related Provisions, by LIS Status & Table 10B Specification B: Distribution of Projected Out-of-Pocket Savings for 2025 IRA Drug-Related Provisions, by LIS Status, page 23 (July 7, 2023 (revised January 30, 2024)) (https://aspe.hhs.gov/sites/default/files/documents/1b652899fb99dd7e6e0edebbcc917cc8/aspe-part-d-oop.pdf).

[29] Department of Health and Human Services, *Medicare Monthly Enrollment* (June 28, 2024) (https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment).

same for all states in the country and (2) that the proportion of their average savings to the average savings of non-LIS beneficiaries in the state is the same as the national proportion.

In the third step, total and average district-level savings are estimated by applying the estimates of the average savings of LIS beneficiaries in the state and the average savings of non-LIS beneficiaries in the state to the number of LIS beneficiaries and non-LIS beneficiaries in the district. The number of these beneficiaries in each district come from Medicare enrollment data.[30]

Insulin Savings

The number of Medicare beneficiaries with diabetes is estimated in two steps using information from HHS and the CDC. First, the estimated number of Medicare Part D enrollees in the district is multiplied by the nationwide proportion of Medicare beneficiaries who reported a diabetes diagnosis (18.7%) in the 2021 Medicare Current Beneficiary Survey.[31] Second, this initial estimate is adjusted by the prevalence of diabetes among all adults using county-level data from the CDC.[32] For instance, if the rate of diagnosed diabetes for all adults in the district is 10% higher than the national average, the initial estimate of Medicare beneficiaries with diabetes in the district is increased by 10%.

The number of Medicare beneficiaries using insulin in each district is calculated using statewide estimates from the Kaiser Family Foundation.[33] These statewide estimates are based on 2020 data and distributed to each congressional district within a state according to the district's share of statewide insulin prescriptions filled by Part D beneficiaries in 2022.[34]

The total amount of Part D spending on insulin within congressional districts is estimated using the 2022 price and utilization data published by HHS and the Kaiser Family Foundation.[35] This data contains

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Center for Medicare & Medicaid Services (https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data).

[31] Department of Health and Human Services, *Medicare Current Beneficiary Survey* (June 7, 2024) (https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey).

[32] Centers for Disease Control and Prevention, *Diagnosed Diabetes - Total, Adults Aged 20+ Years, Age-Adjusted Percentage, Natural Breaks, All Counties, 2021* (https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html).

[33] Kaiser Family Foundation, *Insulin Out-of-Pocket Costs in Medicare Part D*, Table 1: *Number of Medicare Part D Enrollees Using Insulin Products and Average Annual Out-of-Pocket Spending on Insulin in 2020, by State* (July 28, 2022) (https://www.kff.org/medicare/issue-brief/insulin-out-of-pocket-costs-in-medicare-part-d/).

[34]Department of Health and Human Services, *Medicare Part D Prescribers - by Provider and Drug Public Use Files* (June 4, 2024) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-provider-and-drug).

[35] Department of Health and Human Services, *Medicare Part D Prescribers - by Geography and Drug* (June 4, 2024) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-geography-and-drug). Because the HHS data is available at the provider level, a crosswalk is used to match the ZIP codes and cities areas to congressional districts. The crosswalk is provided by the Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (https://mcdc.missouri.edu/applications/geocorr2022.html). HHS partially suppresses data at the local level for privacy reasons. The methodology applies a correction factor at the state level to ensure that the total number of beneficiaries, prescriptions filled, and costs at the local level sum up to HHS's reported statewide totals. This assumes that the rate of data suppression in each state is consistent across all congressional districts within that state. The totals in the methodology are based on the most prescribed insulins to Medicare beneficiaries identified in an analysis from the Kaiser Family Foundation. *See* Kaiser Family Foundation, *Insulin Out-of-Pocket Costs in Medicare* (July 28, 2022) (https://www.kff.org/medicare/issue-brief/insulin-out-of-pocket-costs-in-medicare-part-d/).

information on the amounts paid by Part D plans and Medicare Advantage plans, as well as any government subsidies, third-party payers, manufacturer rebates and discounts, and out-of-pocket expenses incurred by enrollees. The total amount of spending was reduced by 63% to account for rebates paid by drug manufacturers and Part D insurers as well as discounts for beneficiaries for diabetes medications.[36]

The average savings for Medicare beneficiaries from the IRA's $35 per month cap on insulin out-of-pocket spending is calculated in a two-step process using state-level estimates published by HHS.[37] HHS's estimates provide the number of Part D beneficiaries in each state who would have benefited from the insulin cap had it been in place during 2020, as well as the average savings for LIS and non-LIS beneficiaries in each state.

First, to allocate HHS's state-level estimates to congressional districts, the Census Bureau's American Community Survey (ACS) is used to identify the location and incomes of Medicare beneficiaries.[38] For non-LIS beneficiaries, the number of beneficiaries benefiting from the insulin cap is allocated to districts based on the proportion of Medicare enrollees with annual incomes above 150% of the FPL in each state. For LIS beneficiaries, the number of LIS beneficiaries benefiting from the insulin cap is allocated based on the proportion of statewide Medicare enrollees with incomes at or below 150% FPL. The total number of Medicare beneficiaries benefiting from the insulin cap in each district is calculated by adding these subtotals.

Second, to determine the average savings for the district, HHS's state-wide estimates of total savings for each type of Part D beneficiary is allocated to the district in the same manner using information from the ACS. The allocated non-LIS and LIS savings are added together and divided by the total number of Medicare beneficiaries benefiting from the insulin cap in the district, as calculated in the first step. This final calculation provides the average out-of-pocket savings for Medicare beneficiaries using insulin in the district.

Insulin-Specific Examples

The estimated out-of-pocket savings for beneficiaries using Novolog Flexpen, Lantus Solostar, and

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[36] The 63% reduction is based on information published by the Medicare Payment Advisory Commission. *See* Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program* Chart 10-22: Top 15 Therapeutic Classes of Drugs Covered Under Part D, by Spending, 2022, page 167 (June 2024) (https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf). The 63% reduction is the sum of 50% and the amount of coverage-gap discounts for diabetic therapies as a percentage of total spending for diabetic therapy medications.

[37] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Insulin Affordability and the Inflation Reduction Act: Medicare Beneficiary Savings by State and Demographics, Table A-1: Estimated Medicare Part D Annual Out-of-Pocket Savings If Inflation Reduction Act $35/month Out-of-Pocket Insulin Cap Had Been in Effect in 2020, by LIS Status and State* (January 24, 2023) (https://aspe.hhs.gov/sites/default/files/documents/bd5568fa0e8a59c2225b2e0b93d5ae5b/aspe-insulin-affordibility-datapoint.pdf

[38] U.S. Census Bureau, *American Community Survey 2017-2021 5-Year Data Release* (December 8, 2022) (https://www.census.gov/newsroom/press-kits/2022/acs-5-year.html).

Humalog insulins is based on 2022 price and utilization data published by HHS.[39] The annual total cost of each insulin is estimated by dividing the total cost of each drug prescribed in the district by the total number of monthly prescriptions prescribed to beneficiaries in the district. The monthly cost of each drug is annualized by multiplying it by 12.17.[40]

The savings calculation for each drug is for a beneficiary who is enrolled in a standard Part D plan and is not eligible for the LIS. Under this type of plan, a beneficiary is responsible for all prescription drug costs up to a deductible of $545 and 25% of the cost above the deductible until they spend $3,300 on brand name prescriptions and reach Part D's "catastrophic" threshold.[41] The estimated out-of-pocket savings for each drug reflects the difference between the costs under standard Part D coverage without the IRA's $420 annual limit on insulin out-of-pocket spending and the reduced cost-sharing with IRA's new annual limit.

The methodology does not include any potential interactions between the Medicare Drug Price Negotiation Program and the $35-a-month limit on insulin costs. The methodology also does not include any effects related to HHS's Part D Senior Savings Model or state government programs to reduce the out-of-pocket price of insulins.[42]

Catastrophic Savings

The total number of Part D enrollees living in the district is estimated using enrollment data from February 2024.[43]

The estimated out-of-pocket savings for beneficiaries using Revlimid, Xtandi, and Enbrel is based on 2022

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[39] Department of Health and Human Services, *Medicare Part D Prescribers - by Geography and Drug* (June 4, 2024) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-geography-and-drug).

[40] The 12.17 factor is equal to 365 divided by 30.

[41] Kaiser Family Foundation, *An Overview of the Medicare Part D Prescription Drug Benefit* (October 17, 2023) (https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/); Department of Health and Human Services, *Costs for Medicare Drug Coverage* (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage); Kaiser Family Foundation, *Changes to Medicare Part D in 2024 and 2025 Under the Inflation Reduction Act and How Enrollees Will Benefit* (April 20,2023) (https://www.kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit). Starting in 2024, due to the Inflation Reduction Act, Part D enrollees no longer have cost sharing above Medicare Part D's "catastrophic" threshold. This threshold amount is based on an enrollee's "True Out-of-Pocket" costs, which include the enrollee's out-of-pocket spending, drug manufacturers' discount payments for brand name drugs, and Medicare's LIS payments. A non-LIS beneficiary in 2024 will reach the catastrophic limit once they spend $3,300 out of pocket on brand name medications. All three of these insulins are brand name drugs and would be discounted for beneficiaries with enough drug spending to qualify for manufacturers' discounts. These discounts are accounted for in these savings calculations.

[42] Department of Health and Human Services, *Part D Senior Savings Model* (https://innovation.cms.gov/innovation-models/part-d-savings-model); National Conference of State Legislatures, *Diabetes State Mandates and Insulin Copayment Caps* (December 19, 2023) (https://www.ncsl.org/health/diabetes-state-mandates-and-insulin-copayment-caps - toc4).

[43] Department of Health and Human Services, *Medicare Monthly Enrollment* (June 28, 2024) (https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment).

price and utilization data published by HHS.[44] The annual total cost of each drug is estimated by dividing the total cost of each drug prescribed in the district by the total number of monthly prescriptions prescribed to beneficiaries in the district. The monthly cost of each drug is annualized by multiplying it by 12.17.[45]

The savings calculation for each drug is for a beneficiary who is enrolled in a standard Part D plan and is not eligible for the LIS. Under this type of plan, a beneficiary is responsible for all prescription drug costs up to a deductible of $545 and 25% of the cost above the deductible until they spend $3,300 on brand name prescriptions and reach Part D's "catastrophic" threshold.[46] For 2024, the estimated out-of-pocket savings for each drug represents the difference between the amount a beneficiary would pay under standard Part D coverage with a 5% coinsurance above the catastrophic threshold and the amount they would pay with no coinsurance above the threshold.

The savings estimates for 2025 highlight the difference between the out-of-pocket costs under standard Part D coverage with a 5% coinsurance above the catastrophic threshold and the new cost-sharing cap of $2,000, with no additional costs beyond this limit.

The methodology does not include any potential interactions between the Medicare Drug Price Negotiation Program and these limits on enrollees' out-of-pocket spending.

All dollar amounts in this portion of the methodology are rounded to the nearest $100.

Vaccine Savings

The estimated out-of-pocket savings for Part D enrollees prescribed a joint tetanus, diphtheria, and pertussis (Tdap) vaccine and the shingles vaccine Shingrix are based on 2022 price and utilization data published by HHS.[47] The per capita cost for each vaccine is estimated by dividing the total cost of each vaccine administered in the district by the total number of vaccine doses prescribed to beneficiaries in the district. For the Tdap vaccine, the number of doses is assumed to match the number Medicare enrollees vaccinated in a year. For the Shingrix vaccine, since it requires two doses within six months, the number of Medicare enrollees receiving the vaccine is estimated by dividing the number of doses by two.[48]

The savings calculation for each vaccine is based on a beneficiary who is enrolled in a standard Part D plan and not eligible for the LIS. The savings for each vaccine is the difference between the cost of each vaccine without the IRA's vaccine cost-sharing limits and $0. The savings estimate for the Tdap vaccine is for a single dose, and the savings estimate for Shingrix includes the two required doses.

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[44] Department of Health and Human Services, *Medicare Part D Prescribers - by Geography and Drug* (June 4, 2024) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-geography-and-drug).

[45] The 12.17 factor is equal to 365 divided by 30.

[46] All three of these drugs are brand name drugs. These savings calculations account manufacturers' discounts for enrollees with sufficient drug spending and do not account for any other brand or generic drug spending. *See supra* note 19 for more information.

[47] Department of Health and Human Services, *Medicare Part D Prescribers - by Geography and Drug* (June 4, 2024) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-geography-and-drug).

[48] Centers for Disease Control and Prevention, *Administering Shingrix* (January 24, 2024) (https://www.cdc.gov/vaccines/vpd/shingles/hcp/shingrix/administering-vaccine.html).

Expanded Help for Low-Income Beneficiaries
The estimated savings for Part D enrollees who are newly eligible for Part D's "full" Low-Income Subsidy (LIS) in 2024 and who were prescribed Revlimid are based on 2022 price and utilization data published by HHS.[49] The annual total cost of Revlimid is estimated using the same method described in the "Catastrophic Savings" section above.

The out-of-pocket savings estimate is calculated for a single beneficiary with an annual income equal to 149% FPL and a qualifying amount of financial assets for the partial LIS benefit in 2023 and full LIS benefit 2024.[50] The enrollee's out-of-pocket costs for Revlimid in 2023 were estimated using the pre-IRA cost-sharing parameters for partial LIS beneficiaries published by HHS.[51] For the enrollees' estimated out-of-pocket costs in 2024, the post-IRA cost-sharing parameters for all LIS beneficiaries were used.[52] The percentage reduction in out-of-pocket spending was calculated by subtracting the 2024 estimate of out-of-pocket spending from the 2023 estimate and dividing this difference by the 2023 cost-sharing estimate.

Methodology for Estimating the Benefits of Lower Insulin Prices in Congressional Districts

This analysis relies on data from the Census Bureau, Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS), and the Kaiser Family Foundation (KFF).

Medicare
The estimated number of Medicare beneficiaries enrolled in Medicare Part D in each district is based on monthly Medicare enrollment data as of January 2023.[53] This data provides the number of Medicare Part D enrollees in each county. In cases where a county spans more than one congressional district, the county-level Part D enrollment totals are proportionally allocated to

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[49] Department of Health and Human Services, *Medicare Part D Prescribers - by Geography and Drug* (June 4, 2024) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-geography-and-drug). Before 2024, Medicare's Low-Income Subsidy (LIS) had two types of benefits. Medicare enrollees with incomes up to 135% FPL and limited financial assets were eligible for the "full" LIS benefit, which eliminated their Part D premiums and deductible, and allowed them to enroll in Part D coverage reduced copayments. Medicare enrollees with incomes between 135% FPL and 150% FPL and a qualifying amount of financial assets were eligible for a "partial" LIS benefit, which partially reduced their Part D premiums and deductible. These beneficiaries paid a 15% coinsurance above their deductible up to Part D's catastrophic spending limit and then paid low, fixed copayments above that threshold. *See* Department of Health and Human Services, *Medicare Enrollees and the Part D Drug Benefit: Improving Financial Protection Through the Low-Income Subsidy* (February 2024) (https://aspe.hhs.gov/sites/default/files/documents/1b1f69ae062bac6482241b17a6a7f17e/lis-issue-brief.pdf).
[50] Social Security Administration, *Program Operations Manual System, HI 03001.005 Medicare Part D Extra Help (Low-Income Subsidy or LIS)* (April 9, 2024) (https://secure.ssa.gov/poms.nsf/lnx/0603001005).
[51] Department of Health and Human Services, *Letter from Director Jerry Mulcahy to All Prescription Drug Plan Sponsors, Medicare Advantage Organizations, Cost Plans, Programs for All-Inclusive Care for the Elderly, and Demonstration Organizations* (February 9, 2023) (https://www.cms.gov/files/document/2023medicarepartdlowincomesubsidylisincomeandresourcestandardsg.pdf).
[52] Department of Health and Human Services, *Letter from Director Jennifer Shapiro to All Part D Plan Sponsors* (November 30, 2023) (https://www.cms.gov/files/document/lis-memo.pdf).
[53] Department of Health and Human Services, *January 2023 Medicare Monthly Enrollment Data* (https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data).

congressional districts based on the percentage of the county's population living in each district using information from the Missouri Census Data Center.[54]

The amount of Part D spending on insulin within congressional districts is determined from the Medicare Payment Database for 2020.[55] This database contains information on the amounts paid by Part D plans or Medicare Advantage plans, as well as any government subsidies, third-party payers, and out-of-pocket expenses incurred by the beneficiary.

The number of Medicare beneficiaries with diabetes is estimated in two steps using information from HHS and the CDC. First, the estimated number of Medicare Part D enrollees in the district is multiplied by the nationwide proportion of Medicare beneficiaries who reported a diabetes diagnosis (19.1%) in the 2020 Medicare Current Beneficiary Survey.[56] Second, this initial estimate is adjusted by the prevalence of diabetes among all adults using county-level data from the CDC.[57] For instance, if the rate of diagnosed diabetes for all adults in the district is 10% higher than the national average, the initial estimate of Medicare beneficiaries with diabetes in the district is increased by 10%.

The number of Medicare beneficiaries using insulin in each district in 2020 is calculated using statewide estimates from the Kaiser Family Foundation.[58] These statewide estimates are distributed to each congressional district within a state according to the district's share of statewide insulin prescriptions filled by Part D beneficiaries in 2020.[59]

To estimate the number of Medicare beneficiaries who would benefit from the IRA's $35 cap on out-of-pocket insulin spending, HHS state-level estimates were used.[60] These estimates provide the number of Part D beneficiaries in each state who would have benefited from the insulin cap had it been in place during 2020, as well as their average savings. The analysis separated

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[54] Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (https://mcdc.missouri.edu/applications/geocorr2022.html).

[55] Department of Health and Human Services, Medicare Part D Prescribers - by Geography and Drug, (April 26, 2023) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-geography-and-drug). Because the HHS data is available at the provider level, a crosswalk is used to match the ZIP codes and cities areas to congressional districts. The crosswalk is provided by the Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (https://mcdc.missouri.edu/applications/geocorr2022.html). At the local level, HHS suppresses some data for privacy reasons. This analysis applies a correction factor at the state level such that the totals of beneficiaries, prescriptions filled, and costs at the local level sum up to HHS's reported statewide totals. This assumes that the rate that these data are suppressed in each state is the same in each congressional district within a state.

[56] Department of Health and Human Services, *2020 Medicare Current Beneficiary Survey COVID-19 Fall Supplement PUF* (February 6, 2023) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/MCBS-Public-Use-File).

[57] Centers for Disease Control and Prevention, *Diagnosed Diabetes - Total, Adults Aged 20+ Years, Age-Adjusted Percentage, Natural Breaks, All Counties, 2020* (https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html).

[58] Kaiser Family Foundation, *Insulin Out-of-Pocket Costs in Medicare Part D, Table 1: Number of Medicare Part D Enrollees Using Insulin Products and Average Annual Out-of-Pocket Spending on Insulin in 2020, by State* (July 28, 2022) (https://www.kff.org/medicare/issue-brief/insulin-out-of-pocket-costs-in-medicare-part-d/).

[59] Department of Health and Human Services, Medicare Part D Prescribers - by Provider and Drug Public Use Files (April 26, 2023) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-provider-and-drug).

[60] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Insulin Affordability and the Inflation Reduction Act: Medicare Beneficiary Savings by State and Demographics, Table A-1: Estimated Medicare Part D Annual Out-of-Pocket Savings If Inflation Reduction Act $35/month Out-of-Pocket Insulin Cap Had Been in Effect in 2020, by LIS Status and State* (January 24, 2023) (https://aspe.hhs.gov/sites/default/files/documents/bd5568fa0e8a59c2225b2e0b93d5ae5b/aspe-insulin-affordibility-datapoint.pdf).

beneficiaries into those who qualify for the program's Low-Income Subsidy (LIS) and those who do not.[61]

To allocate HHS's state-level estimates to congressional districts, information from the Census Bureau's American Community Survey was used to identify the location and incomes of Medicare beneficiaries.[62] For non-LIS beneficiaries, the number of beneficiaries benefiting from the insulin cap was allocated to districts according to the proportion of Medicare enrollees with annual incomes at or above 150% of the federal poverty level (FPL) in each state. For LIS beneficiaries, the estimate of LIS beneficiaries benefiting from the insulin cap was allocated based on the proportion of statewide Medicare enrollees with incomes below 150% FPL. The total number of Medicare beneficiaries benefiting from the insulin cap in each district was calculated by adding these subtotals.

To determine the average savings for the district, the aggregate amount of statewide savings for each type of Part D beneficiary was allocated to the district in the same manner using information from the ACS. The allocated non-LIS and LIS savings were added together and divided by the total number of Medicare beneficiaries benefiting from the insulin cap in the district, as calculated above. This calculation provided the average out-of-pocket savings for Medicare beneficiaries using insulin in the district.

Drug-Specific Examples

The estimated savings for beneficiaries using Novolog Flexpen, Lantus Solostar, and Humalog insulins is based on 2020 price and utilization data from the Medicare Payment Database.[63] The annual cost of each drug is estimated by dividing the total cost of each drug prescribed in the district by the total number of monthly prescriptions prescribed to beneficiaries in the district. The monthly cost of each drug is annualized by multiplying it by 12.17.[64]

The savings calculation for each drug is for a beneficiary who is enrolled in a standard Part D plan. Under this type of plan, a beneficiary is responsible for all prescription drug costs up to a deductible of $505 and 25% of the cost above the deductible.[65] The estimated savings for each drug is the difference between the amount estimated under the standard Part D plan and the new annual limit of $420 established by the IRA.

This analysis does not include any potential interactions between the Part D drug negotiation provision and the $35-a-month limit on insulin costs. If an insulin becomes subject to negotiation,

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[61] National Council on Aging, *Part D Low Income Subsidy/Extra Help Eligibility and Coverage Chart* (January 31, 2023) (https://www.ncoa.org/article/part-d-low-income-subsidy-extra-help-eligibility-and-coverage-chart).

[62] U.S. Census Bureau, *American Community Survey 2017-2021 5-Year Data Release* (December 8, 2022) (https://www.census.gov/newsroom/press-kits/2022/acs-5-year.html).

[63] Department of Health and Human Services, *Medicare Part D Prescribers - by Geography and Drug* (April 26, 2023) (https://data.cms.gov/provider-summary-by-type-of-service/medicare-part-d-prescribers/medicare-part-d-prescribers-by-geography-and-drug).

[64] The 12.17 factor used to annualize the cost of a prescription is equal to 365 divided by 30.

[65] The average beneficiary is assumed not to have drug expenses above the "catastrophic" out-of-pocket threshold of $7,400. Part D beneficiaries enrolled in standard Part D coverage are responsible for 5% of any additional drug costs above this threshold. Kaiser Family Foundation, *Changes to Medicare Part D in 2024 and 2025 Under the Inflation Reduction Act and How Enrollees Will Benefit* (April 20, 2023) (https://www.kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit).

beneficiaries' monthly out-of-pocket costs would be limited to the lesser of (1) $35, (2) 25% of the drug's "maximum fair price" (while the negotiations are pending, or (3) 25% of the drug's new negotiated price.[66] This analysis also does not include any effects of the Part D Senior Savings Model created by HHS in 2021.[67]

Employer-Sponsored Insurance

The number of district residents enrolled in employer-sponsored insurance (ESI) and diagnosed with diabetes and using insulin is based on information from the CDC's National Health Interview Survey (NHIS), the Census Bureau's ACS, and two analyses published by the Health Care Cost Institute (HCCI).

The overall number of district residents with ESI is estimated using the ACS.[68] Because the prevalence of diabetes is higher among low-income households, the estimated number of ESI enrollees is grouped into three categories according to their incomes: 1) those with incomes below 150% FPL, 2) between 150- 400% FPL, and 3) above 400% FPL.[69] The number of ESI enrollees in each income category who have diabetes and who use insulin is estimated using the 2019-2021 NHIS. This is done by multiplying the estimated number of ESI enrollees in each income category by the national percentage of ESI enrollees with diabetes in the same income category, as reported in the NHIS.[70] The number of ESI enrollees using insulin in the district is estimated separately using the same method, but with the national average of ESI enrollees using insulin in each income category as reported in the NHIS.[71] The total number of ESI enrollees with diabetes and the total number of ESI enrollees using insulin in the district are the sum of the estimates in each income category.

Uninsured

The number of uninsured residents in the district who are diabetic and using insulin are estimated using the ACS and NHIS. The total number of uninsured district residents were grouped into the same income categories used for estimating the number of ESI enrollees described above.[72] The proportion who are diabetic is estimated by multiplying the estimated number of uninsured district residents in each income category by the national percentage of the uninsured in each income category who reported being diabetic in the 2019-2021 NHIS.[73] To estimate the number who use insulin, the same method is used except the national average of uninsured in each income category who reported using insulin on the NHIS was used. The total number of uninsured with

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[66] Kaiser Family Foundation, *Explaining the Prescription Drug Provisions in the Inflation Reduction Act* (January 24, 2023) (https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/#:~:text=The%20Inflation%20Reduction%20Act%20requires,inflation%20(CPI%2DU).

[67] Department of Health and Human Services, *Part D Senior Savings Model* (February 13, 2023) (https://innovation.cms.gov/innovation-models/part-d-savings-model).

[68] U.S. Census Bureau, *American Community Survey 2017-2021 5-Year Data Release* (December 8, 2022) (https://www.census.gov/newsroom/press-kits/2022/acs-5-year.html).

[69] Centers for Disease Control and Prevention, *Income-Related Inequalities in Diagnosed Diabetes Prevalence Among US Adults, 2001-2018* (April 13, 2020) (https://pubmed.ncbi.nlm.nih.gov/37053158/).

[70] Centers for Disease Control and Prevention, NHIS Data, *Questionnaires and Related Documentation* (April 6, 2023) (https://www.cdc.gov/nchs/nhis/data-questionnaires-documentation.htm).

[71] *Id.*

[72] U.S. Census Bureau, *American Community Survey 2017-2021 5-Year Data Release* (December 8, 2022) (https://www.census.gov/newsroom/press-kits/2022/acs-5-year.html).

[73] Centers for Disease Control and Prevention, NHIS Data, *Questionnaires and Related Documentation* (April 6, 2023) (https://www.cdc.gov/nchs/nhis/data-questionnaires-documentation.htm).

diabetes and insulin are equal to the sum estimated in each income category.

Total Number of District Residents Diagnosed with Diabetes and Using Insulin
In addition to the estimated number of Medicare beneficiaries, ESI enrollees, and uninsured residents diagnosed with diabetes and using insulin, the total number of district residents diagnosed with diabetes and using insulin also includes Medicaid beneficiaries and nongroup insurance enrollees. The number of Medicaid and nongroup enrollees diagnosed with diabetes and using insulin were estimated using information from the ACS and NHIS. As described above for ESI enrollees and the uninsured, the number of Medicaid and nongroup enrollees identified in the ACS are grouped into three income categories multiplied by the national rate of diabetes and insulin use for each type of insurance reported in the 2019-2021 NHIS.

Methodology for Assessing the Benefits of the Infrastructure Investment and Jobs Act and the Inflation Reduction Act in Congressional Districts

The information in this report is drawn from multiple sources, including the Department of Transportation, Environmental Protection Agency, Federal Aviation Administration, USASpending.gov, and the White House.

Unless otherwise noted, all years are references to the federal fiscal year (October 1 through September 30).

*Infrastructure Investment and Jobs Act (IIJA) and Inflation Reduction Act (IRA) Funding for Specific Projects***UPDATED***

Information about specific funded projects is taken from the White House's "Investing in America" website.[74] This data contains information about preliminary funding amounts from the Infrastructure Investment and Jobs Act (IIJA), also known as the Bipartisan Infrastructure Law, and Inflation Reduction Act (IRA) that have been announced as of April 11, 2024, and funding awarded as of February 29, 2024 for a selected number of programs. The funding totals included in this data are from a subset of programs funded by the IIJA and IRA and do not represent a comprehensive total of the laws' funding. The published data also includes projects funded by the Creating Helpful Incentives to Produce Semiconductors (CHIPS) and Science Act, but this funding was not included in this analysis.

For announced funding, amounts are as of April 11, 2024, for which there is approximate information about the specific location of a project (i.e., at least county or Tribe-level information). These amounts are preliminary and nonbinding. The final amount of funding that will be provided to any project is dependent on the actual performance of the entities receiving the funding and other contingencies.

[74] The White House, *Investing in America* (as of April 29, 2024) (https://www.whitehouse.gov/invest/?utm_source=invest.gov).

For awarded funding, amounts represent the total amount of funding that has been obligated as of February 29, 2024. These amounts only include funding awards of $100,000 or more and for which there is approximate information about the specific location of a project.

Additionally, the announced and awarded funding amounts are not necessarily the total amount of funding that will be spent on a project, which could be funded by multiple funding awards.

The location of projects in the White House's data is illustrative. In most cases, the location is the geographic center of the city or county in which the funded project is located. The precise location of projects, however, will depend on the specific nature of the project. Additionally, this data excludes all projects spanning multiple counties and states.

Projects were assigned to cities, counties overlapping congressional districts based on the city and/or county listed in the White House's data using information from the Missouri Census Data Center, as well as the metropolitan statistical areas associated with the cities and counties within a district.[75] **In cases where a city or county contains multiple congressional districts, additional information from the project's description and other publicly available information was used to assign a project to a specific district.**ASSUMPTION

Airports

The amount of 2022, 2023, and 2024 Airport Infrastructure Grant and 2022, 2023, and 2024 Airport Terminals Program funding airports received within each district is based on funding allocations released by the Federal Aviation Administration (FAA).[76] Airport locations were matched to districts using information provided by these allocations and information from the Missouri Census Data Center.[77] **Airports located outside a congressional district but in in cities, counties within a district, and/or metropolitan areas associated with those cities and counties overlapping the district were included if they are likely used by residents of the congressional district.**ASSUMPTION

Information about the number of passengers and amount of cargo moving through particular airports during calendar year 2022 is provided by the Federal Aviation Administration.[78]

Environment and Water

The amount of 2022, 2023, and 2024 Congestion Mitigation and Air Quality (CMAQ) Improvement is based on FHWA's 2022, 2023, and 2024 funding allocations.[79]

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[75] Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (October 2022) (https://mcdc.missouri.edu/applications/geocorr2022.html).

[76] Federal Aviation Administration, *Bipartisan Infrastructure Law Airport Infrastructure Grant Funding Amounts* (as of May 30, 2024) (https://www.faa.gov/general/bipartisan-infrastructure-law-airport-infrastructure-grant-funding-amounts) (does not include funding announced on May 31, 2024); Federal Aviation Administration, *Bipartisan Infrastructure Law Airport Terminal Program Grants File* (February 15, 2024)

[77] MCDC Data Applications, *Geocorr 2022: Geographic Correspondence Engine* (October 2022) (https://mcdc.missouri.edu/applications/geocorr2022.html).

[78] Federal Aviation Administration, *Passenger Boarding (Enplanement) and All-Cargo Data for U.S. Airports* (April 25, 2024) (https://www.faa.gov/airports/planning_capacity/passenger_allcargo_stats/passenger).

[79] Federal Highway Administration, *Notice 4510.858 - FY2022 Federal-Aid Highway Program Apportionments Under the Bipartisan*

UPDATEDThe funding amounts for the Carbon Reduction Program (CRP) are based on the FHWA's 2022, 2023, and 2024 funding allocations.[80] Each state is required to obligate 65% of its CRP funding to urbanized areas with populations between 5,000 to over 200,000 and non-urban areas with fewer than 5,000 residents in proportion to the population in those areas, and the remaining 35% of CRP funds can be used for projects in any area of the state.[81] Estimates of CRP funding received by local governments within a congressional district are based on FHWA's funding allocation tables and population information from the Missouri Census Data Center.[82]

The amount of 2022, 2023, and 2024 Clean Water Revolving Fund and Drinking Water Revolving Fund funding received by states is based on the Environmental Protection Agency's 2022, 2023, and 2024 funding allocations.[83]

Methodology for Estimating the Benefits of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act

The information in this report is based on information published by the Department of Veterans Affairs and the White House.

The information in this report is based on information published by the Department of Veterans Affairs and the White House. The total number of Veterans with a potential toxic exposure is

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Infrastructure Law (December 14, 2021) (https://www.fhwa.dot.gov/legsregs/directives/notices/n4510858/n4510858_t1.cfm); Federal Highway Administration, *Notice 4510.870 - FY 2023 Federal-Aid Highway Program Apportionments Under the Bipartisan Infrastructure Law* (October 3, 2022); (https://www.fhwa.dot.gov/legsregs/directives/notices/n4510870/n4510870_t1.cfm); Federal Highway Administration, *Notice 4510.880 Apportionment of Federal-Aid Highway Program Funds for Fiscal Year 2024*. (October 2, 2024) (https://www.fhwa.dot.gov/legsregs/directives/notices/n4510880.cfm). These totals do not include post-apportionment set-asides, penalties, or federal sequestration.

[80] Federal Highway Administration, *Fiscal Year (FY) 2022 Supplementary Tables – Apportionments Pursuant to the Infrastructure Investment and Jobs Act.* (May 31, 2022) (https://www.fhwa.dot.gov/legsregs/directives/notices/n4510868/); Federal Highway Administration, *Fiscal Year (FY) 2023 Supplementary Tables – Apportionments Pursuant to the Infrastructure Investment and Jobs Act.* (January 20, 2023) (https://www.fhwa.dot.gov/legsregs/directives/notices/n4510876/); Federal Highway Administration, *Fiscal Year (FY) 2024 Supplementary Tables – Apportionments Pursuant to the Infrastructure Investment and Jobs Act* (January 17, 2024) (https://www.fhwa.dot.gov/legsregs/directives/notices/n4510887/).

[81] Federal Highway Administration, *Memorandum: Carbon Reduction Program (CRP) Implementation Guidance,* pages 10-11 (April 21, 2022) (https://www.fhwa.dot.gov/environment/sustainability/energy/policy/crp_guidance.pdf).

[82] Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (October 2022) (https://mcdc.missouri.edu/applications/geocorr2022.html).

[83] Environmental Protection Agency, *Implementation of the Clean Water and Drinking Water State Revolving Funding Provisions of the Bipartisan Infrastructure Law, Attachment 1 - Appendix A*, pages 30-31 (March 8, 2022) (https://www.epa.gov/system/files/documents/2022-03/combined_srf-implementation-memo_final_03.2022.pdf); Environmental Protection Agency, *FY 2023 Clean Water State Revolving Fund Base Allotment Availability, Attachment A* (March 30, 2023) (https://www.epa.gov/system/files/documents/2023-03/fy2023-cwsrf-base-allotment.pdf); Environmental Protection Agency, *FY 2023 Allotments for the Drinking Water State Revolving Fund based on the Seventh Drinking Water Infrastructure Needs Survey and Assessment* (April 3, 2023) (https://www.epa.gov/system/files/documents/2023-04/Final_FY23%20DWSRF%20Allotment%20Memo%20and%20Attachments_April%202023.pdf); Environmental Protection Agency, *FY 2024 Distribution of State Revolving Funds Appropriation* (https://www.epa.gov/system/files/documents/2024-05/fy-2024-srf-bilbase-allotments-by-state_5.13.24.final_.pdf).

based on information published by the White House.[84]

The national level statistics about the number of processed and approved PACT Act-related claims, number of toxic exposure screenings, and number Veterans identified as having at least one toxic exposure are based on information published by the Department of Veterans Affairs.[85] These statistics are as of October 21, 2023.

The total amount of PACT Act-related benefits paid to date is also published by the Department of Veterans Affairs. This amount is as of October 7, 2023.[86]

The number of Veterans residing in the district and the count of PACT Act claims submitted by these Veterans are based on district-level information published by the Department of Veterans Affairs.[87] The number of Veterans living in the district is an estimate as of September 30, 2022. The count of PACT Act-related claims submitted by Veterans in the district represents the total number of submitted Veterans Benefit Administration claims with at least one PACT Act-related condition as of October 7, 2023.

The two illustrative examples of disability compensation benefits are based on payment rates for fiscal year 2023.[88] The first example is based on the monthly payment rate for a Veteran with no dependents and a 100% disability rating.[89] The second example is based on the monthly payment rate for a Veteran with one child, a spouse, and two parents.[90] Both amounts are multiplied by 12 and rounded to the nearest $10.

The final illustrative example is based on the monthly Dependency and Indemnity benefit for surviving spouses of Veterans who died on or after January 1, 1993.[91]

In addition to the sources cited in the footnotes, the methodologies in this document use information and approaches developed by Co-Equal.

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[84] White House, *FACT SHEET: President Biden Signs PACT Act and Delivers on His Promise to America's Veterans* (August 10, 2023). (https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/10/fact-sheet-president-biden-signs-the-pact-act-and-delivers-on-his-promise-to-americas-veterans/).

[85] Department of Veterans Affairs, *PACT Act Performance Dashboard, Issue 19* (October 27, 2023). (https://www.accesstocare.va.gov/pdf/VA_PACTActDashboard_Issue19_102723_Final_508.pdf).

[86] Department of Veterans Affairs, *PACT Act Performance Dashboard, Issue 18* (October 13, 2023). (https://www.accesstocare.va.gov/pdf/VA_PACTActDashboard_Issue18_101323_508.pdf).

[87] Department of Veterans Affairs, *PACT Act Performance Dashboard, Issue 18* (October 13, 2023), Supplemental Data for Download (October 13, 2023). (https://www.accesstocare.va.gov/PactAct).

[88] Department of Veterans Affairs, *2023 Veterans Disability Compensation Rates* (November 29, 2022).

[89] Ibid., *With a Dependent Spouse or Parent, But No Children, Basic Monthly Rates for 70% to 100% Disability Rating* (November 29, 2022). (https://www.va.gov/disability/compensation-rates/veteran-rates/).

[90] Ibid, *With Dependents, Including Children, Basic Monthly Rates for 70% to 100% Disability Rating* (November 29, 2022). (https://www.va.gov/disability/compensation-rates/veteran-rates/).

[91] Department of Veterans Affairs, *2023 VA DIC Rates for Spouses and Dependents* (January 3, 2023). (https://www.va.gov/disability/survivor-dic-rates/).