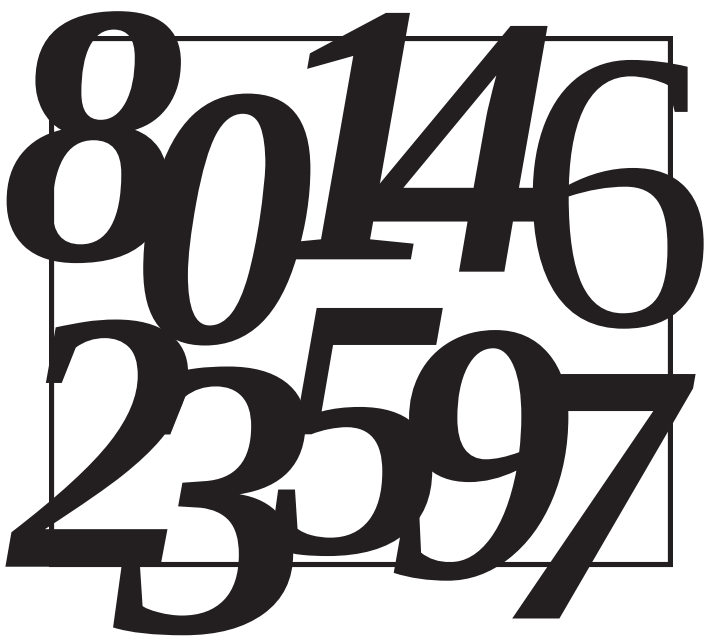
2007 CMS Statistics



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Preface

This reference booklet provides significant summary information about health expenditures and Centers for Medicare & Medicaid Services (CMS) programs. The information presented was the most current available at the time of publication. Significant time lags may occur between the end of a data year and aggregation of data for that year.

The data are organized as follows:

Glossary of Acronyms for Data Source Attribution

CMM	Center for Medicare Management
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
HCFA	Health Care Financing Administration
OACT	Office of the Actuary
OFM	Office of Financial Management
ORDI	Office of Research, Development, and Information
SSA	Social Security Administration

Highlights

Growth in CMS programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.1 million in 1966 to a projected 43.9 million in 2007, a 130 percent increase.
- On average, the number of Medicaid monthly enrollees in 2007 is estimated to be about 48.1 million, the largest group being children (23.5 million or 48.9 percent).
- In 2004, about 20.0 percent of the population was at some point enrolled in the Medicaid program.
- Medicare enrollees with end-stage renal disease increased from 66.7 thousand in 1980 to 432.8 thousand in 2006, an increase of 549 percent.
- Medicare State buy-ins have grown from about 2.8 million beneficiaries in 1975 to 7.1 million beneficiaries in 2006, an increase of about 154 percent.

- About 7.3 million persons on average were dually eligible for both Medicare and Medicaid in FY 2004.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,770 in December 1975 to 6,177 in December 2006. Total inpatient hospital beds have dropped from 46.5 beds per 1,000 enrolled in 1975 to 21.8 in 2006, a decrease of 53 percent.
- The total number of Medicare certified beds in short-stay hospitals showed a steady increase from less than 800,000 at the beginning of the program and peaked at 1,025,000 in 1984-86. Since that time, the number has dropped to about 803,000. (NOTE: This includes a reclassification of some short-stay hospitals as critical access hospitals. There were about 29,000 critical access hospital beds in 2006.)
- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, generally increased thereafter to over 15,000 in the late 1990's, and remains currently at this level.
- The number of participating home health agencies has fluctuated considerably over the years, almost doubling in number from 1990 to almost 11,000 in 1997, when the Balanced Budget Act was passed. The number decreased sharply but has since stabilized, reaching 8,618 in 2006.

Expenditures

- National health expenditures (NHE) were $1,987.7 billion in 2005, comprising 16.0 percent of the gross domestic product (GDP). Comparably, NHE amounted to $1,858.9 billion, or 15.9 percent of the GDP in 2004.

- In 2006, total net Federal outlays for CMS programs were $517.3 billion, 19.5 percent of the Federal budget.

- Medicare skilled nursing facility benefit payments increased slightly from $17.6 billion in 2005 to about $21.0 billion in 2007.

- Medicare home health agency benefit payments increased slightly between 2006 and 2007 from $12.6 billion to $14.2 billion.

- National health expenditures per person were $205 in 1965 and grew steadily to reach $6,697 by 2005.

Utilization of Medicare and Medicaid services

- Between 1990 and 2005, the number of short-stay hospital discharges increased from 10.5 million to 13.0 million, an increase of 24 percent.

- The short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.7 days in 2005, a decrease of 37 percent. Likewise, the average length of stay for excluded units decreased significantly from 19.5 days in 1990 to 11.5 days in 2005, a decrease of 41 percent.

- About 33.0 million persons received a reimbursed

service under Medicare fee-for-service during 2005. Comparably, almost 56 million persons used Medicaid services or had a premium paid on their behalf in 2004.

- The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 923 per 1,000 enrolled in 2004.

- 7.7 million persons received reimbursable fee-for-service inpatient hospital services under Medicare in 2005.

- 32.7 million persons received reimbursable fee-for-service physician services under Medicare during 2005. 23.9 million persons received reimbursable physician services under Medicaid during 2004.

- 24.4 million persons received reimbursable fee-for-service outpatient hospital services under Medicare during 2005. During 2004, 15.9 million persons received Medicaid reimbursable outpatient hospital services.

- Nearly 1.8 million persons received care in SNFs covered by Medicare during 2005. 1.7 million persons received care in nursing facilities, which include SNFs and all other nursing facilities other than mentally retarded, covered by Medicaid during 2004.

- Nearly 28.0 million persons received prescribed drugs under Medicaid during 2004

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Populations

Information about persons covered by Medicare, Medicaid, or SCHIP

For Medicare, statistics are based on persons enrolled for coverage. Historically, for Medicaid, recipient (beneficiary) counts were used as a surrogate of persons eligible for coverage, as well as for persons utilizing services. Current data systems now allow the reporting of total eligibles for Medicaid and for SCHIP. Statistics are available by major program categories, by demographic and geographic variables, and as proportions of the U.S. population. Utilization data organized by persons served may be found in the Utilization section.

Table 1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
July		In millions	
1966	19.1	19.1	--
1970	20.4	20.4	--
1975	24.9	22.7	2.2
1980	28.4	25.5	3.0
1985	31.1	28.1	2.9
1990	34.3	31.0	3.3
1995	37.6	33.2	4.4
Average monthly			
1999	39.2	33.9	5.2
2000	39.7	34.3	5.4
2001	40.1	34.5	5.6
2002	40.5	34.7	5.8
2003	41.2	35.0	6.2
2004	41.9	35.4	6.5
2005	42.6	35.8	6.8
2006	43.2	36.3	7.0
2007	43.9	36.8	7.1

NOTES: Represents those enrolled in HI (Part A) and/or SMI (Part B and Part D) of Medicare. Data for 1966-1995 are as of July. Data for 1999-2007 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on FY 2008 President's Budget.

SOURCE: CMS, Office of the Actuary.

Table 2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI		HI and SMI	HI only	SMI only
			Part B	Part D			
			In millions				
All persons	43.8	43.4	40.6	30.4	40.2	3.1	0.4
Aged persons	36.7	36.3	34.4	--	34.0	2.3	0.4
Disabled persons	7.1	7.1	6.3	--	6.3	0.8	([1])

[1]Number less than 500.

NOTE: Projected average monthly enrollment during fiscal year 2007. Aged/disabled split of Part D not available. Based on FY 2008 President's Budget.

SOURCE: CMS, Office of the Actuary.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	43,339	19,140	24,198
Aged	36,317	15,395	20,922
65-74 years	18,596	8,631	9,965
75-84 years	12,769	5,230	7,539
85 years and over	4,951	1,534	3,417
Disabled	7,022	3,745	3,277
Under 45 years	1,798	985	813
45-54 years	2,192	1,171	1,021
55-64 years	3,032	1,590	1,442
White	36,235	16,007	20,228
Black	4,320	1,841	2,479
All Other	2,708	1,265	1,443
Native American	180	81	99
Asian/Pacific	760	329	431
Hispanic	1,046	490	556
Other	722	365	357
Unknown Race	76	28	48

NOTES: Data as of July 1, 2006. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Research, Development, and Information.

Table 4
Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
		In thousands	
Year			
1980	66.7	66.3	64.9
1990	172.0	170.6	163.7
1995	257.0	255.0	245.1
2000[1]	291.8	291.3	273.1
2003[1]	350.1	347.3	332.3
2004[1]	359.4	359.3	341.2
2005[1]	371.2	371.1	351.9
2006[1]	432.8	385.2	365.0

[1]Denominator File; estimated person years.

NOTES: Data prior to 2000 are as of July 1; estimated person years 2000-2006.
SOURCE: CMS, Office of Research, Development, and Information.

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees (in thousands)
All persons	432.8
Age	
Under 35 years	27.7
35-44 years	41.3
45-64 years	169.1
65 years and over	194.7
Sex	
Male	241.1
Female	191.7
Race	
White	236.4
Other	194.4
Unknown	2.1

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2006.

SOURCE: CMS, Office of Research, Development, and Information.

Table 6
Medicare advantage, cost, PACE, demo & prescription drug

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	604	1,376	7,132	8,509
Local CCPs	410	419	5,706	6,125
PFFS	47	571	914	1,484
Demos	38	2	212	214
1876 Cost	27	147	160	307
1833 Cost (HCPP)	13	78	--	78
PACE	37	--	13	13
Other plans[2]	32	159	128	287
Total PDPs[1]	101	--	16,926	16,926
Total	705	1,376	24,058	25,435

[1]Totals include beneficiaries enrolled in employer/union only groups plans (contracts with "800 series" plan IDs). Where a beneficiary is enrolled in both an 1876 cost or PFFS plan and a PDP plan, both enrollments are reflected in these counts. [2]Includes MSA, EPFFS, Pilot, RPPOs.

NOTE: Data as of April 7, 2007.

SOURCE: CMS, Center for Beneficiary Choices.

Table 7
Medicare enrollment/CMS region

	Resident population[1]	Medicare enrollees[2]	Enrollees as percent of population
	In thousands		
All regions	296,410	42,356	14.3
Boston	14,240	2,224	15.6
New York	27,973	4,047	14.5
Philadelphia	28,809	4,449	15.4
Atlanta	57,416	9,025	15.7
Chicago	51,289	7,478	14.6
Dallas	35,639	4,565	12.8
Kansas City	13,270	2,095	15.8
Denver	9,993	1,241	12.4
San Francisco	45,761	5,582	12.2
Seattle	12,022	1,654	13.8

[1]Estimated July 1, 2005 resident population.
[2]Medicare denominator enrollment file data are as of July 1, 2006.

NOTES: Resident population is a provisional estimate. The 2005 resident population data for Outlying Areas, Puerto Rico, and the Virgin Islands are not available. Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of Research, Development, and Information; U.S. Bureau of the Census, Population Division, Population Estimates Branch.

Table 8
Social security population/projected[1]

	2010	2020	2040	2060	2080	2100
	In millions					
Total	314.7	339.3	376.9	402.1	428.2	453.6
Under 20	84.9	87.5	92.3	96.8	101.2	105.7
20-64	190.1	198.2	207.4	218.8	230.1	240.7
65 years and over	39.8	53.5	77.2	86.5	96.9	107.2

[1]As of July 1.

SOURCE: SSA, Office of the Actuary.

Table 9
Period life expectancy at age 65/trends

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1990	15.1	19.1
2000	15.9	19.0
2010[1]	16.6	19.1
2020[1]	17.3	19.7
2030[1]	17.9	20.2
2040[1]	18.4	20.8
2050[1]	19.0	21.3
2060[1]	19.5	21.9
2070[1]	20.0	22.3
2080[1]	20.5	22.8
2090[1]	21.0	23.2
2100[1]	21.4	23.7

[1]Preliminary.

SOURCE: Social Security Administration, Office of the Actuary.

Table 10
Life expectancy at birth and at age 65 by race/trends

Calendar Year	All Races	White	Black
		At Birth	
1950	68.2	69.1	60.8
1980	73.7	74.4	68.1
1990	75.4	76.1	69.1
1995	75.8	76.5	69.6
2000	77.0	77.6	71.9
2004	77.8	78.3	73.1
		At Age 65	
1950	13.9	NA	13.9
1980	16.4	16.5	15.1
1990	17.2	17.3	15.4
1995	17.4	17.6	15.6
2000	18.0	18.0	16.2
2004	18.7	18.7	17.1

SOURCE: Public Health Service, Health United States, 2006.

Table 11
Medicaid and SCHIP enrollment

	Fiscal year					
	1990	1995	2000	2005	2006	2007
	Average monthly enrollment in millions					
Total	22.9	33.4	33.6	45.4	46.9	48.1
Age 65 years and over	3.1	3.7	3.7	4.6	4.9	5.0
Blind/Disabled	3.8	5.8	6.7	8.0	8.3	8.5
Children	10.7	16.5	16.2	22.2	22.9	23.5
Adults	4.9	6.7	6.9	10.5	10.8	11.1
Other Title XIX	0.5	0.6	NA	NA	NA	NA
SCHIP	NA	NA	2.1	4.3	4.4	4.2
	Unduplicated annual enrollment in millions					
Total	NA	42.5	43.3	57.4	59.4	60.9
Age 65 years and over	NA	4.4	4.3	5.6	5.6	6.0
Blind/Disabled	NA	6.5	7.5	8.9	9.3	9.5
Children	NA	21.3	20.9	27.7	28.5	29.2
Adults	NA	9.4	10.6	15.3	15.8	16.2
Other Title XIX	NA	0.9	NA	NA	NA	NA
SCHIP	NA	NA	3.3	6.8	6.9	6.7

NOTES: Some totals for 1990 and later years may not equal the sum of categories because of rounding. Aged and Blind/Disabled eligibility groups include Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB). Children and Adult groups include both AFDC/TANF and poverty level recipients who are not disabled. Medicaid enrollment excludes Medicaid expansion SCHIP programs. SCHIP numbers include adults covered under waivers. Projections for fiscal years 2005-2007 were prepared by the Office of the Actuary for the President's 2008 Budget.

In 1997, the Other Title XIX category was dropped and the enrollees therein were subsumed in the remaining categories. Medicaid data after 2000 exclude enrollees in outlying territories and possessions. Some totals for territories not included in Medicaid numbers.

SOURCES: CMS, Office of the Actuary, and the Center for Medicaid and State Operations.

Table 12
Medicaid eligibles/demographics

	Fiscal year 2004 Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	58.2	100.0
Age	58.2	100.0
Under 21	31.4	54.0
21-64 years	20.7	35.6
65 years and over	6.0	10.3
Unknown	0.1	0.2
Sex	58.2	100.0
Male	23.6	40.5
Female	34.5	59.3
Unknown	0.1	0.2
Race	58.2	100.0
White, not Hispanic	25.4	43.6
Black, not Hispanic	13.4	23.0
Am. Indian/Alaskan Native	0.8	1.4
Asian	1.5	2.6
Hawaiian/Pacific Islander	0.5	0.9
Hispanic	12.8	22.0
Other	([1])	--
Unknown	3.6	6.2

[1]Less than 100,000.

NOTES: The percent distribution is based on unrounded numbers. Totals do not necessarily equal the sum of rounded components. Eligible is defined as any one eligible and enrolled in the Medicaid program at some point during the fiscal year, regardless of duration of enrollment, receipt of a paid medical service, or whether or not a capitated premium for managed care or private health insurance coverage had been made.

SOURCES: CMS, Center for Medicaid and State Operations, and the Office of Research, Development, and Information.

Table 13
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	293,638	58,161	19.8
Boston	14,242	2,485	17.4
New York	27,968	5,878	21.0
Philadelphia	28,622	4,257	14.9
Atlanta	56,464	11,886	21.1
Chicago	51,084	8,721	17.1
Dallas	35,185	6,886	19.6
Kansas City	13,192	2,210	16.8
Denver	9,858	1,210	12.3
San Francisco	45,178	12,494	27.7
Seattle	11,847	2,134	18.0

[1]Estimated July 1, 2004 population. [2]Persons ever enrolled in Medicaid during fiscal year 2004.

NOTES: Numbers may not add to totals because of rounding. Resident population is a provisional estimate. Excludes data for Puerto Rico, Virgin Islands and Outlying Areas.

SOURCES: CMS, Office of Research, Development, and Information; U.S. Department of Commerce, Bureau of the Census.

Table 14
Medicaid beneficiaries/State buy-ins for Medicare

	1975[1]	1980[1]	2005[2]	2006[2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	6,845	7,115
Aged	2,483	2,449	4,226	4,353
Disabled	363	504	2,619	2,763
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	17.3	17.6
Aged	11.4	10.0	12.5	12.7
Disabled	18.7	18.9	45.1	45.6

[1]Beneficiaries for whom the State paid the SMI premium during the year.
[2]Beneficiaries in person years.

NOTES: Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Research, Development, and Information.

Providers/Suppliers

Information about institutions, agencies, or professionals who provide health care services and individuals or organizations who furnish health care equipment or supplies

These data are distributed by major provider/supplier categories, by geographic region, and by type of program participation. Utilization data organized by type of provider/supplier may be found in the Utilization section.

Table 15
Inpatient hospitals/trends

	1990	1995	2005	2006
Total hospitals	6,522	6,376	6,180	6,177
Beds in thousands	1,105	1,056	947	939
Beds per 1,000 enrollees[1]	32.8	28.4	22.5	21.8
Short-stay	5,549	5,252	3,790	3,702
Beds in thousands	970	926	812	803
Beds per 1,000 enrollees[1]	28.8	24.9	19.3	18.7
Critical access hospitals	NA	NA	1,217	1,284
Beds in thousands	---	---	28	29
Beds per 1,000 enrollees[1]	---	---	0.7	0.7
Other non-short-stay	973	1,124	1,173	1,191
Beds in thousands	135	130	107	107
Beds per 1,000 enrollees[1]	1.0	1.2	2.5	2.5

[1] Based on number of total HI enrollees as of July 1.

NOTES: Facility data are as of December 31 and represent essentially those facilities eligible to participate the start of the next calendar year. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: CMS, Office of Research, Development, and Information

Table 16
Medicare assigned claims/CMS region

	Net assignment rates		
	2004	2005	2006
All regions	98.7	98.8	99.0
Boston	99.9	([1])	([1])
New York	98.8	98.8	98.8
Philadelphia	99.0	99.2	99.4
Atlanta	98.3	98.6	99.1
Chicago	98.3	98.6	98.7
Dallas	98.7	98.8	99.1
Kansas City	98.3	98.6	98.8
Denver	97.8	98.1	98.3
San Francisco	99.3	99.3	99.3
Seattle	95.2	96.7	97.2

[1]No carriers in the Boston region.

NOTE: Calendar year data.

SOURCE: CMS, Office of Financial Management.

Table 17
Medicare hospital and SNF/NF/ICF facility counts

Total participating hospitals	6,176
Short-term hospitals	3,708
Psychiatric units	1,284
Rehabilitation units	998
Swing bed units	573
Psychiatric	480
Long-term	391
Rehabilitation	217
Childrens	81
Religious non-medical	16
Critical access	1,283
Non-participating Hospitals	768
Emergency	418
Federal	350
All SNFs/SNF-NFs/NFs only	15,890
All skilled nursing facilities	15,042
SNFs	836
Hospital-based	389
Free-standing	447
SNF/NFs combination	14,206
Hospital-based	804
Free-standing	13,402
Title 19 only NFs	848
Hospital-based	143
Free-standing	705
All ICF-MR facilities	6,456

NOTES: The table is designed to give a "snapshot" as of the end of April 2007 of institutional providers participating in the program by type of provider (short term, long term, rehab., etc.). Numbers may differ from other reports and program memoranda.

SOURCES: CMS, CMM, CMSO, and ORDI.

Table 18
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions[3]	15,028	877	6,454
Boston	1,003	18	154
New York	1,014	2	603
Philadelphia	1,366	56	433
Atlanta	2,620	73	658
Chicago	3,287	207	1,517
Dallas	1,919	160	1,563
Kansas City	1,352	197	189
Denver	582	51	89
San Francisco	1,428	83	1,168
Seattle	447	30	80

[1]Skilled nursing facilities.
[2]Institutions for mentally retarded.
[3]All regions' totals include U.S. Possessions and Territories.

NOTE: Data as of December 2006.

SOURCE: CMS, Office of Research, Development, and Information.

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	2005	2006
Home health agencies	2,242	2,924	8,090	8,618
Independent and Clinical Lab Improvement Act Facilities	NA	NA	196,296	199,817
End stage renal disease facilities	NA	999	4,755	4,892
Outpatient physical therapy and/or speech patholgy	117	419	2,962	3,009
Portable X-ray	132	216	553	549
Rural health clinics	NA	391	3,661	3,723
Comprehensive outpatient rehabilitation facilities	NA	NA	634	589
Ambulatory surgical centers	NA	NA	4,445	4,707
Hospices	NA	NA	2,872	3,071

NOTES: Facility data for selected years 1975 and 1980 are as of July 1. Facility data for 2005 and 2006 are as of December 31.

SOURCE: CMS, Office of Research, Development, and Information.

Table 20
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,702	15,028	8,618
		Percent of total	
Non-profit	59.7	27.4	24.6
Proprietary	20.6	67.6	65.2
Government	19.7	5.0	10.2

NOTES: Data as of December 31, 2006. Facilities certified for Medicare are deemed to meet Medicaid standards. Percent distribution may not add to 100 percent due to rounding.

SOURCE: CMS, Office of Research, Development, and Information.

Table 21
Periodic interim payment (PIP) facilities/trends

	1980	1985	2003	2005	2006
Hospitals					
Number of PIP	2,276	3,242	657	671	639
Percent of total participating	33.8	48.3	10.9	10.9	10.3
Skilled nursing facilities					
Number of PIP	203	224	1,001	847	837
Percent of total participating	3.9	3.4	6.7	5.6	5.6
Home health agencies					
Number of PIP	481	931	44	59	90
Percent of total participating	16.0	16.0	0.1	0.1	1.0

NOTES: Data from 1985 to date are as of September; 1980 data are as of December. These are facilities receiving periodic interim payments (PIP) under Medicare. Effective for claims received on or after July 1, 1987, the Omnibus Budget Reconciliation Act of 1986 eliminates PIP for many PPS hospitals when the servicing intermediary meets specified processing time standards.

SOURCE: CMS, Office of Financial Management.

Table 22
Part B practitioners active in patient care/selected years

	March 2007	
	Number	Percent
All Part B Practitioners	1,075,571	100.0
Physician Specialties	660,819	61.4
Primary Care	243,687	22.7
Medical Specialties	107,528	10.0
Surgical Specialties	107,283	10.0
Emergency Medicine	36,118	3.4
Anesthesiology	38,046	3.5
Radiology	37,225	3.5
Pathology	13,859	1.3
Obstetrics/Gynecology	38,258	3.6
Psychiatry	38,526	3.6
Other and Unknown	289	0.0
Limited Licensed Practitioners	124,640	11.6
Non-physician Practitioners	290,112	27.0

NOTES: Specialty code is self-reported and may not correspond to actual board certification. Totals do not necessarily equal the sum of rounded components. Reflect unduplicated counts.

SOURCE: CMS, Office of Research, Development, and Information.

Table 23
Part B practitioners/CMS region

	Active practitioners	Practitioners per 100,000 population
All regions	[1]1,226,327	414
Boston	95,316	669
New York	145,680	457
Philadelphia	130,492	453
Atlanta	218,627	381
Chicago	208,189	406
Dallas	116,451	327
Kansas City	61,934	467
Denver	45,527	456
San Francisco	149,235	326
Seattle	54,876	456

[1]Non-Federal physicians only. Includes limited licensed, non-physician practitioners. Unduplicated count (may include practitioners practicing in multiple sites or States). Unknown provider States distributed. NOTES: Physicians as of March 2007. Civilian population as of July 1, 2005. Resident population for outlying areas and the Virgin Islands are not available.

SOURCES: CMS, ORDI, and the Bureau of the Census.

Table 24
Inpatient hospitals/CMS region

	Short-stay and CAH hospitals	Beds per 1,000 enrollees	Non Short-stay facilities	Beds per 1,000 enrollees
All regions	4,986	19.4	1,191	2.5
Boston	193	14.8	70	4.7
New York	337	21.4	75	2.8
Philadelphia	376	17.0	129	3.0
Atlanta	941	19.6	205	2.0
Chicago	875	20.9	187	2.1
Dallas	774	22.1	310	4.0
Kansas City	470	23.5	54	2.0
Denver	309	20.4	38	2.7
San Francisco	500	17.6	101	1.5
Seattle	211	14.1	22	1.6

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2006. Rates based on number of hospital insurance enrollees as of July 1, 2006.

SOURCE: CMS, Office of Research, Development, and Information.

Expenditures

Information about spending for health care services by Medicare, Medicaid, and in the Nation as a whole

Health care spending at the aggregate levels is distributed by source of funds, types of service, geographic area, and broad beneficiary or eligibility categories. Direct out-of-pocket, other private, and non-CMS-related expenditures are also covered in this section. Expenditures on a per-unit-of-service level are covered in the Utilization section.

Table 25
CMS and total Federal outlays

	Fiscal year 2005	Fiscal year 2006
	$ in billions	
Gross domestic product (current dollars)	$12,290.4	$13,061.1
Total Federal outlays[1]	2,472.2	2,655.4
Percent of gross domestic product	20.1	20.3
Dept. of Health and Human Services[1]	581.5	614.3
Percent of Federal Budget	23.5	23.1
CMS Budget (Federal Outlays)		
Medicare benefit payments	333.2	375.2
SMI transfer to Medicaid[2]	0.2	0.3
Medicaid benefit payments	173.3	171.5
Medicaid State and local admin.	8.4	9.1
Medicaid offsets[3]	-0.2	-0.3
State Children's Health Ins. Prog.	5.1	5.5
CMS program management	3.1	3.3
Other Medicare admin. expenses[4]	1.8	1.9
State Eligibility Determinations, for Part D	0.1	0.0
Quality improvement organizations[5]	0.4	0.4
Health Care Fraud and Abuse Control	1.1	1.1
State Grants and Demonstrations[6]	0.1	1.3
User Fees and Reimbursables	0.1	0.2
Total CMS outlays (unadjusted)	526.6	569.4
Offsetting receipts[7]	-40.8	-52.1
Total net CMS outlays	485.9	517.3
Percent of Federal budget	19.7	19.5

[1]Net of offsetting receipts.
[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($242.3 million in FY 2005 and $264.2 million in FY 2006).
[3]SMI transfers for low-income premium assistance.
[4]Medicare administrative expenses of the Social Security Administration and other Federal agencies.
[5]Formerly peer review organizations (PROs).
[6]Includes grants and demonstrations for various free-standing programs, such as the Ticket to Work and Work Incentives Improvement Act (P.L. 106-170) and the qualified high risk pools under the Trade Act of 2002 (P.L. 107-210). Outlays for these programs amounted to $84 million in FY 2005. The significant FY 2006 increase primarily reflects Katrina hurricane relief outlays.
[7]Almost entirely Medicare premiums. Also includes offsetting collections for user fee and reimbursable activities. Refunds to the trust funds also included beginning in FY 2005.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Financial Management.

Table 26
Program expenditures/trends

	Total	Medicare[1]	Medicaid[2]	SCHIP[3]
		$ in billions		
Fiscal year				
1980	$60.8	$35.0	$25.8	--
1990	182.2	109.7	72.5	--
2000	428.7	219.0	208.0	$1.7
2005	664.0	339.4	317.2	7.4
2006	707.5	381.8	316.7	9.0

[1]Medicare amounts reflect gross outlays (i.e., not net of offsetting receipts). These amounts include outlays for benefits, administration, the Health Care Fraud and Abuse Control (HCFAC) activity, Quality Improvement Organizations (QIOs), the SMI transfer to Medicaid for Medicare Part B premium assistance for low income Medicare beneficiaries and, since FY 2004, the administrative and benefit costs of the new Transitional Assistance and Part D Drug benefits under the Medicare Modernization Act of 2003. [2]The Medicaid amounts include total computable outlays (Federal and State shares) for benefits and administration, the Federal and State shares of the cost of Medicaid survey/certification and State Medicaid fraud control units and outlays for the Vaccines for Children program. These amounts do not include the SMI transfer to Medicaid for Medicare Part B premium assistance for low-income Medicare beneficiaries, nor do they include Medicare Part D compensation to States for low-income eligibility determinations in the Part D Drug Program. [3]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays. Please note that SCHIP-related Medicaid began to be financed under Title XXI in FY 2001.

SOURCE: CMS, Office of Financial Management.

Table 27
Benefit outlays by program

	1967	1968	2005	2006
Annually		Amounts in billions		
CMS program outlays	$5.1	$8.4	$642	$684
Federal outlays	NA	6.7	512	552
Medicare[1]	3.2	5.1	333	375
HI	2.5	3.7	183	184
SMI	0.7	1.4	150	159
Transitional Assistance[2]	NA	NA	1	0
Presciption (Part D)	NA	NA	NA	32
Medicaid[3]	1.9	3.3	302	300
Federal share	NA	1.6	173	171
SCHIP[4]	NA	NA	7	9
Federal share	NA	NA	5	5

[1]The Medicare benefit amounts reflect gross outlays (i.e., not net of offsetting premiums). These amounts exclude outlays for the SMI transfer to Medicaid for premium assistance and the Quality Improvement Organizations (QIOs). [2]The transitional Prescription Drug Card program, begun in the the third quarter of FY 2004 under the Medicare Modernization Act of 2003 (P.L. 108-173), was terminated in FY 2006 as it was replaced by Medicare Part D. Its FY 2006 benefit outlays totalled $229 million. [3]The Medicaid amounts include total computable outlays (Federal and State shares) for benefits and outlays for the Vaccines for Children program. [4]The SCHIP amounts reflect both Federal and State shares of Title XXI outlays as reported by the States on line 4 of the CMS-21. Please note that SCHIP-related Medicaid expansions began to be financed under SCHIP (Title XXI) in FY 2001.

NOTES: Fiscal year data. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Financial Management.

Table 28
Program benefit payments/CMS region

	Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$300,724	$172,071
Boston	19,602	10,323
New York	51,292	25,703
Philadelphia	29,632	16,272
Atlanta	52,455	33,881
Chicago	46,526	26,109
Dallas	30,464	20,118
Kansas City	12,251	7,545
Denver	6,356	3,883
San Francisco	41,642	22,257
Seattle	10,504	5,980

[1]Fiscal year 2005 data from Form CMS-64 --Net Expenditures Reported by the States, unadjusted by CMS. Medical assistance only. Excludes Medicaid expansions under the State Children's Health Insurance Program (SCHIP).

SOURCES: CMS, CMSO.

Table 29
Medicare benefit outlays

	Fiscal year		
	2005	2006	2007
	In billions		
HI benefit payments	$181.0	$181.5	$202.5
Aged	155.1	154.4	171.8
Disabled	25.9	27.1	30.7
SMI benefit payments	148.4	158.0	173.9
Aged	123.7	131.3	144.4
Disabled	24.7	26.8	29.5
Part D	1.1	34.6	54.2

NOTES: Based on FY 2008 President's Budget. Aged/disabled split of Part D benefit outlays not available. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, Office of the Actuary.

Table 30
Medicare/type of benefit

	Fiscal year 2007 benefit payments[1] in millions	Percent distribution
Total HI[2]	$202,545	100.0
Inpatient hospital	125,510	62.0
Skilled nursing facility	20,965	10.4
Home health agency[3]	6,442	3.2
Hospice	9,694	4.8
Managed care	39,934	19.7
Total SMI[2]	173,895	100.0
Physician/other suppliers	59,503	34.2
DME	8,563	4.9
Other carrier	16,809	9.7
Outpatient hospital	23,626	13.6
Home health agency[3]	7,709	4.4
Other intermediary	14,141	8.1
Laboratory	7,135	4.1
Managed care	36,409	20.9
Total Part D	49,174	100.0

[1]Includes the effects of regulatory items and recent legislation but not proposed law. [2]Excludes QIO expenditures. [3]Distribution of home health benefits between the trust funds reflects the actual outlays as reported by the Treasury.

NOTES: Based on FY 2008 President's Budget. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, OACT and OFM

Table 31
National health care/trends

	Calendar year			
	1965	1980	2000	2005
National total in billions	$41.0	$253.9	$1,353.3	$1,987.7
Percent of GDP	5.7	9.1	13.8	16.0
Per capita amount	$205	$1,102	$4,790	$6,697
Source of funds		Percent of total		
Private	75.1	58.1	55.9	54.6
Public	24.9	41.9	44.1	45.4
Federal	11.4	28.2	30.9	32.4
State/local	13.5	13.7	13.2	13.0

NOTE: Numbers may not add to totals because of rounding.

SOURCES: CMS, Office of the Actuary; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

Table 32
Medicaid/type of service

	Fiscal year		
	2003	2004	2005
	In billions		
Total medical assistance payments[1]	$262.6	$281.8	$300.7
	Percent of total		
Inpatient services	14.1	14.8	14.5
General hospitals	12.7	13.7	13.6
Mental hospitals	1.3	1.1	0.9
Nursing facility services	17.0	16.1	15.7
Intermediate care facility (MR) services	4.4	4.1	4.0
Community-based long term care svs.[2]	10.6	10.8	11.2
Prescribed drugs[3]	10.3	10.8	10.3
Physician services	3.7	4.1	4.1
Dental services	1.2	1.1	1.2
Outpatient hospital services	3.8	4.1	4.1
Clinic services[4]	2.8	2.8	3.0
Laboratory and radiological services	0.3	0.4	0.4
Early and periodic screening	0.4	0.4	0.4
Targeted case management services	1.1	1.0	0.9
Capitation payments (non-Medicare)	17.2	16.4	16.8
Medicare premiums	2.1	2.3	2.6
Disproportionate share hosp. payments	4.9	5.5	5.2
Other services	5.8	4.5	4.8
Adjustments[5]	0.3	0.9	0.8

[1]Excludes payments under SCHIP. [2] Comprised of home health, home and community-based waivers, personal care and home and community-based services for functionally disabled elderly. [3] Net of prescription drug rebates. [4] Federally qualified health clinics, rural health clinics, and other clinics. [5] Includes increasing and decreasing payment adjustments from prior quarters, collections, and other unallocated expenditures.

SOURCES: CMS, CMSO, and OACT.

Table 33
Medicare savings attributable to secondary payor provisions/type of provision

	Workers Comp.	Working Aged	ESRD	Auto	Disability	Total
2004	113.3	2,296.8	232.7	265.2	1,640.4	4,829.0
2005	101.9	2,780.9	280.8	244.6	1,920.6	5,670.5
2006	93.1	2,980.6	298.6	243.7	2,033.7	6,088.6

NOTES: Fiscal year data. In millions of dollars. FYs 2004 through 2006 totals include liability amounts of $280.6, $325.0, and $410.3 million, respectively.

SOURCE: CMS, OFM.

Table 34
Medicaid/payments by eligibility status

	Fiscal year 2005 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$300.7	100.0
Age 65 years and over	69.8	23.2
Blind/disabled	125.7	41.8
Dependent children under 21 years of age	50.9	16.9
Adults in families with dependent children	35.2	11.7
DSH and other unallocated	19.2	6.4

[1]Excludes payments under State Children's Health Insurance Program (SCHIP).

SOURCE: CMS, Office of the Actuary.

Table 35
Medicare/DME/POS[1]

Category	Allowed Charges[2]	
	2004	2005
	In thousands	
Total	$10,095,221	$10,205,304
Medical/surgical supplies	137,162	176,943
Hospital beds	370,434	319,279
Oxygen and supplies	2,669,003	2,679,455
Wheelchairs	1,434,402	1,554,703
Prosthetic/orthotic devices	1,729,111	1,605,247
Drugs admin. through DME	1,308,947	799,140
Other DME	2,446,163	3,070,537

[1]Data are for calendar year. DME=durable medical equipment. POS=Prosthetic, orthotic and supplies.
[2]The allowed charge is the Medicare approved payment reported on a line item on the physician/supplier claim.

NOTE: Over time, the composition of BETOS categories has changed with the re-assignment of selected procedures, services and supplies.

SOURCE: CMS, Office of Research, Development, and Information.

Table 36
National health care/type of expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$1,987.7	$6,697	32.9	17.2	15.6
Health serv/suppl.	1,860.9	6,270	35.1	18.4	16.7
Personal health care	1,661.4	5,598	37.4	19.9	17.4
Hospital care	611.6	2,061	46.8	29.5	17.3
Prof. services	621.7	2,095	22.3	16.3	6.1
Phys./clinical	421.2	1,419	28.3	21.2	7.1
Nursing/home hlth.	169.3	570	53.5	21.9	31.6
Retail outlet sales	258.8	872	16.0	1.5	14.4
Admn. and pub. hlth.	199.5	672	16.2	5.3	10.9
Investment	126.8	427	--	--	--

NOTES: Data are as of calendar year 2005.

SOURCE: CMS, Office of the Actuary.

Table 37
Personal health care/payment source

	Calendar year			
	1980	1990	2000	2005
	In billions			
Total	$215.3	$607.5	$1,139.9	$1,661.4
	Percent			
Total	100.0	100.0	100.0	100.0
Private funds	60.0	61.1	57.3	55.0
Private health insurance	28.4	33.7	35.4	35.9
Out-of-pocket	27.2	22.4	16.9	15.0
Other private	4.3	5.0	5.0	4.1
Public funds	40.0	38.9	42.7	45.0
Federal	28.9	28.4	32.5	34.2
State and local	11.1	10.4	10.2	10.7

NOTE: Excludes administrative expenses, research, construction and other types of spending that are not directed at patient care.

SOURCE: CMS, Office of the Actuary.

Utilization

Information about the use of health care services

Utilization information is organized by persons receiving services and alternately by services rendered. Measures of health care usage include: persons served, units of service (e.g., discharges, days of care, etc.), and dimensions of the services rendered (e.g., average length of stay, charge per person or per unit of service). These utilization measures are aggregated by program coverage categories, provider characteristics, type of service, and demographic and geographic variables.

Table 38
Medicare/short-stay hospital utilization

	1985	1990	2004	2005
Discharges				
Total in millions	10.5	10.5	13.0	13.0
Rate per 1,000 enrollees[1]	347	320	364	361
Days of care				
Total in millions	92	94	75	75
Rate per 1,000 enrollees[1]	3,016	2,866	2,110	2,073
Average length of stay				
All short-stay	8.7	9.0	5.8	5.7
Excluded units[2]	18.8	19.5	11.5	11.5
Total charges per day	$597	$1,060	$4,458	$4,882

[1]Beginning in 1990, the population base for the deominator is the July 1 HI fee-for-service enrollment excluding HI fee-for-service enrollees residing in foreign countries.

NOTES: Data may reflect underreporting due to a variety of reasons including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; no-pay Medicare secondary payer bills; and for certain years, discharges where the beneficiary received services out of State. The data for 1990 through 2005 are based on 100 percent MEDPAR stay record files. Data may differ from other sources or from the same source with different update cycle.

SOURCE: CMS, Office of Information Services.

Table 39
Medicare long-term care/trends

	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
Calendar year				
1985	315	10	1,576	51
1990	638	19	1,978	58
1995	1,233	37	3,468	103
2000	1,468	[1]45	2,634	[1]84
2002	1,622	[1]47	2,672	[1]79
2004	1,752	[1]49	2,966	[1]85
2005	1,847	[1]51	3,122	[1]85

[1]Managed care enrollees excluded in determining rate.

SOURCE: CMS, Office of Research, Development, and Information.

Table 40
Medicare average length of stay/trends

	Fiscal year					
	1984	1990	1995	2000	2004	2005
All short-stay hospitals	9.1	9.0	7.1	6.0	5.8	5.7
PPS hospitals	8.0	8.9	7.1	6.0	5.8	5.7
Excluded units	18.0	19.5	14.8	12.3	11.5	11.6

NOTES: Fiscal year data. Average length of stay is shown in days. For all short-stay and PPS hospitals, 1984 data are based on a 20-percent sample of Medicare HI enrollees. Data for 1990 through 2005 are based on 100-percent MEDPAR. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: CMS, Office of Information Services, and the Office of Research, Development, and Information.

Table 41
Medicare persons served/trends

	Calendar year					
	1975	1985	1995	2000	2004	2005
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	916	919	923
HI	221	219	218	232	231	234
SMI	536	739	858	965	972	979
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	835	856	865
HI	219	228	212	196	203	205
SMI	471	715	837	943	965	977

NOTES: Prior to 2000, data were obtained from the Annual Person Summary Record and were not yet modified to exclude persons enrolled in managed care. Beginning in 2000, utilization counts are based on a five-percent sample of fee-for-service beneficiaries and the rates are adjusted to exclude managed care enrollees.

SOURCES: CMS, Office of Information Services, and the Office of Research, Development, and Information.

Table 42
Medicare fee-for-service (FFS) persons served

	Calendar year				
	2001	2002	2003	2004	2005
	Numbers in millions				
HI					
Aged					
FFS Enrollees	28.3	29.1	29.7	30.0	30.0
Persons served	6.7	6.3	6.9	6.9	7.0
Rate per 1,000	233	232	231	231	234
Disabled					
FFS Enrollees	5.2	5.4	5.7	6.0	6.3
Persons served	1.0	1.1	1.2	1.2	1.3
Rate per 1,000	199	202	203	203	205
SMI					
Aged					
FFS Enrollees	27.0	27.8	28.3	28.4	28.4
Persons served	26.1	26.9	27.4	27.6	27.8
Rate per 1,000	968	968	970	972	979
Disabled					
FFS Enrollees	4.5	4.8	5.0	5.3	5.5
Persons served	4.3	4.6	4.9	5.1	5.4
Rate per 1,000	952	963	969	965	977

NOTES: Enrollment represents persons enrolled in Medicare fee-for-service as of July. Persons served represents estimates of beneficiaries receiving reimbursed services under fee-for-service during the calendar year.

SOURCE: CMS, Office of Research, Development, and Information.

Table 43
Medicare persons served/CMS region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	28,071	923	5,436	865
Boston	1,465	914	285	843
New York[2]	2,581	913	451	845
Philadelphia	2,909	929	538	851
Atlanta	6,085	951	1,390	902
Chicago	5,475	956	935	878
Dallas	3,121	931	628	893
Kansas City	1,524	954	273	910
Denver	853	954	133	869
San Francisco[3]	2,764	884	525	805
Seattle	994	939	188	843

[1]Includes utilization for residents of outlying territories, possessions and foreign countries.
[2]Excludes residents of Puerto Rico and Virgin Islands.
[3]Excludes residents of American Samoa, Guam, and Northern Mariana Islands.

NOTES: Data as of calendar year 2005 for persons served under HI and/or SMI. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations. Numbers may not add to totals because of rounding.

SOURCE: CMS, Office of Research, Development, and Information.

Table 44
Medicare/end stage renal disease (ESRD)

	Calendar year		
	2002	2003	2004
Total enrollees[1]	336,545	350,085	358,193
Dialysis patients[2]	297,928	310,095	320,404
Outpatient	269,741	281,460	292,084
Home	28,187	28, 635	28,320
Transplants performed[3]	14,714	15,589	16,568
Living related donor	4,044	4,217	4,200
Cadaveric donor	9,026	9,402	10,062
Living unrelated donor	1,644	1,970	2,306
Average dialysis payment rate	$129	$129	$129
Hospital-based facilities	$131	$131	$131
Freestanding facilities	$127	$127	$127

[1]Medicare ESRD enrollees as of July 1.
[2]Includes Medicare and non-Medicare patients receiving dialysis as of December 31.
[3]Includes kidney transplants for Medicare and non-Medicare patients.

SOURCES: CMS, Office of Clinical Standards and Quality, and the Office of Research, Development, and Information.

Table 45
Medicaid/type of service

	Fiscal year 2004 Medicaid beneficiaries
	In thousands
Total eligibles	58,161
Number using service:	
Total beneficiaries, any service[1]	55,553
Inpatient services	
General hospitals	5,420
Mental hospitals	117
Nursing facility services[2]	1,718
Intermediate care facility (MR) services[3]	114
Physician services	23,949
Dental services	9,015
Other practitioner services	5,920
Outpatient hospital services	15,943
Clinic services	11,113
Laboratory and radiological services	16,033
Home health services	1,148
Prescribed drugs	27,970
Personal care support services	851
Sterilization services	174
PCCM capitation	8,548
HMO capitation	23,587
PHP capitation	16,995
Targeted case management	2,478
Other services, unspecified	10,343
Additional service categories	7,458
Unknown	82

[1]Excludes summary records with unknown basis of eligibility, most of which are lump-sum payments not attributable to any one person. [2]Nursing facilities include: SNFs and all categories of ICF, other than "MR". [3]"MR" indicates mentally retarded.

NOTES: Beneficiary counts include Medicaid eligibles enrolled in Medicaid Managed Care Organizations.

SOURCE: CMS, Center for Medicaid and State Operations.

Table 46
Medicaid/units of service

	Fiscal year 2004 units of service
	In thousands
Inpatient hospital	
Total discharges	8,126
Beneficiaries discharged	5,420
Total days of care	35,461
Nursing facility	
Total days of care	454,709
Intermediate care facility/mentally retarded	
Total days of care	45,938

NOTES: Data are derived from the MSIS 2004 State Summary Mart. Excludes territories.

SOURCE: CMS, Office of Research, Development, and Information.

Administrative/Operating

Information on activities and services related to oversight of the day-to-day operations of CMS programs

Included are data on Medicare contractors, contractor activities and performance, CMS and State agency administrative costs, quality control, and summaries of the operation of the Medicare trust funds.

Table 47
Medicare administrative expenses/trends

Fiscal Year	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
1967	$89	3.5
1970	149	3.1
1980	497	2.1
1990	774	1.2
1995	1,300	1.1
2000[1]	2,350	1.8
2004[1]	2,920	1.8
2005[1]	2,850	1.6
2006[1]	3,086	1.7
SMI Trust Fund[2]		
1967	[3]135	20.3
1970	217	11.0
1980	593	5.8
1990	1,524	3.7
1995	1,722	2.7
2000	1,780	2.0
2004	2,664	2.0
2005	2,348	1.6
2006	3,108	1.6

[1]Includes non-expenditure transfers for Health Care Fraud and Abuse Control. [2]Starting in FY 2004 includes the transactions of the Part D account. [3]Includes expenses paid in fiscal years 1966 and 1967.

SOURCE: CMS, Office of the Actuary.

Table 48
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	23	16
Other	2	3

NOTES: Data as of FY 2006. Numbers do not include MACs or DMACs.

SOURCE: CMS, Office of Financial Management.

Table 49
Medicare appeals

	Intermediary reconsiderations	Carrier reviews
Number processed	22,953	2,312,580
Percent with increased payments[1]	N/A	70.1

[1]Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 2006.

SOURCE: CMS, Office of Financial Management.

Table 50
Medicare physician/supplier claims assignment rates

	2000	2002	2003	2004	2005	2006
			in thousands			
Claims total	720.5	822.0	860.7	922.2	951.6	944.9
Claims assigned	705.7	808.6	847.8	909.9	940.7	935.1
Claims unassigned	15.3	13.3	12.9	12.3	10.9	9.8
Percent assigned	97.9	98.4	98.5	98.7	98.9	99.0

NOTE: Fiscal year data. Historical data revised from earlier year editions.

SOURCE: CMS, Office of Financial Management

Table 51
Medicare claims processing

	Intermediaries	Carriers
Claims processed in millions	185.0	971.0
Total PM costs in millions	$433.2	$1,261.4
Total MIP costs in millions	$531.8	$279.0
Claims processing costs in millions	$290.4	$889.6
Claims processing unit costs	$0.82	$0.50
Range		
High	$1.74	$1.09
Low	$0.52	$0.34

NOTES: Data for fiscal year 2006. PM= Program Management. MIP= Medicare Integrity Program. Beginning in FY 2002, provider enrollment has been removed from the claims processing costs and unit costs.

SOURCE: CMS, Office of Financial Management.

Table 52
Medicare claims received

	Claims received
Intermediary claims received in millions	185.7
	Percent of total
Inpatient hospital	8.2
Outpatient hospital	56.3
Home health agency	7.1
Skilled nursing facility	2.8
Other	25.7
Carrier claims received in millions	944.1
	Percent of total
Assigned	99.0
Unassigned	1.0

NOTE: Data for calendar year 2006.

SOURCE: CMS, Office of Financial Management.

Table 53
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	912.8	10.9
Percent reduced	87.4	82.3
Total covered charges		
Amount in millions	$246,608	$894
Percent reduced	52.6	17.5
Amount reduced per claim	$152.63	$18.46

NOTES: Data for calendar year 2006. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity, and global fee/rebundling reductions.

SOURCE: CMS, Office of Financial Management.

Table 54
Medicaid administration

	Fiscal year	
	2005	2006
	In millions	
Total payments computable for Federal funding[1]	$15,146	$16,032
Federal share[1]		
Family planning	33	28
Design, development or installation of MMIS[2]	244	223
Skilled professional medical personnel	447	415
Operation of an approved MMIS[2]	1,164	1,208
All other	6,339	6,772
Mechanized systems not approved under MMIS[2]	81	93
Total Federal Share	$8,308	$8,739
Net adjusted Federal share[3]	$8,256	$8,733

[1]Source: Form CMS-64. (Net Expenditures Reported--Administration).
[2]Medicaid Management Information System.
[3]Includes CMS adjustments.

Sources: CMS, Office of Research, Development, and Information.

Reference

Selected reference material including cost-sharing features of the Medicare program, program financing, and Medicaid Federal medical assistance percentages

Program financing, cost sharing and limitations

Medicare/source of income

Medicare Part A

Hospital Insurance trust fund:

1. Payroll taxes*
2. Income from taxation of social security benefits
3. Transfers from railroad retirement account
4. General revenue for uninsured persons and military wage credits
5. Premiums from voluntary enrollees
6. Interest on investments

*Contribution rate	2005	2006	2007
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90
Maximum taxable amount (CY 2007)		None[1]	
Voluntary HI monthly premium[2]		$410.00	

Part A (effective date)	Amount
Inpatient hospital deductible (1/1/07)	$992/benefit period
Regular coinsurance days (1/1/07)	$248/day for 61st thru 90th day
Lifetime reserve days (1/1/07)	$496/day (60 non-renewable days)
SNF coinsurance days (1/1/07)	$124/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/07)	$410/month; $226/mo. with at least 30 quarters of coverage
Limitations:	
Inpatient psychiatric hospitals	190 nonrenewable days

[1]The Omnibus Reconciliation Act of 1993 eliminated the Annual Maximum Taxable Earnings amounts for 1994 and later. For these years, the contribution rate is applied to all earnings in covered employment. [2]Premium paid for voluntary participation of individuals aged 65 and over not otherwise entitled to hospital insurance and certain disabled individuals who have exhausted other entitlement. A reduced premium of $226 is available to individuals aged 65 and over who are not otherwise entitled to hospital insurance but who have, or whose spouse has or had, at least 30 quarters of coverage under Title II of the Social Security Act.

SOURCE: CMS, Office of the Actuary.

Program financing, cost sharing and limitations

Medicare Part B

Supplementary Medical Insurance trust fund:
1. Premiums paid by or on behalf of enrollees.
2. General revenue
3. Interest on investments

Part B (effective date)	**Amount**
Deductible (1/1/07)	$131 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/07)	$93.50/month
Limitations:	
Outpatient treatment for illness	No limitations

[1]The Part B deductible and coinsurance applies to most services. Items and/or services not subject to either the deductible or coinsurance are clinical diagnostic lab tests subject to a fee schedule, home health services, items and services furnished in connection to obtaining a second or third opinion, and some preventive services. In addition, federally qualified health center services and some preventive services are not subject to the deductible but are subject to the coinsurance.

SOURCE: CMS, Office of the Actuary

Medicare Part B (continued)

Listed below are the 2007 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $80,000	Less than or equal to $160,000	$0.00	$93.50
Greater than $80,000 and less than or equal to $100,000	Greater than $160,000 and less than or equal to $200,000	$12.30	$105.80
Greater than $100,000 and less than or equal to $150,000	Greater than $200,000 and less than or equal to $300,000	$30.90	$124.40
Greater than $150,000 and less than or equal to $200,000	Greater than $300,000 and less than or equal to $400,000	$49.40	$142.90
Greater than $200,000	Greater than $400,000	$67.90	$161.40

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse, but file a separate return from their spouse and lived with their spouse at some time during the taxable year are listed below:

Married beneficiaries who lived with their spouse and filed a separate tax return	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $80,000	$0.00	$93.50
Greater than $80,000 and less than or equal to $120,000	$49.40	$142.90
Greater than $120,000	$67.90	$161.40

SOURCE: CMS, Office of the Actuary.

Program financing, cost sharing and limitations

Medicare Part D Standard Benefits

Deductible (1/1/2007)	$265 in charges/year
Initial coverage limit (1/1/2007)	$2,400 in charges/year
Out-of-pocket threshold (1/1/2007)	$3,850 in charges/year
Base beneficiary premium (1/1/2007)[1]	$27.35/month

Medicaid financing

1. Federal contributions (ranging from 50 to 76 percent for fiscal year 2007)
2. State contributions (ranging from 26 to 50 percent for fiscal year 2007)

[1]The base beneficiary premium was calculated based on a national average plan bid. The actual premiums that a beneficiary pay varies according to the plan in which the beneficiary is enrolled. For 2007, the average premium rate paid by beneficiaries is estimated to be about $22.

NOTES: The beneficiaries who qualify for the low-income subsidy under Part D pay a reduced or zero premium. In addition, low-income beneficiaries are subject to only minimal copayment amounts in most instances.

SOURCE: CMS, Office of the Actuary.

Geographical jurisdictions of CMS regional offices and Medicaid Federal medical assistance percentages (FMAP) fiscal year 2007

I.	Boston	FMAP	II.	New York	FMAP
	Connecticut	50.00		New Jersey	50.00
	Maine	63.27		New York	50.00
	Massachusetts	50.00		Puerto Rico	50.00
	New Hampshire	50.00		Virgin Islands	50.00
	Rhode Island	52.35		Canada	--
	Vermont	58.93			
			IV.	Atlanta	
III.	Philadelphia			Alabama	68.85
	Delaware	50.00		Florida	58.76
	Dist. of Columbia	70.00		Georgia	61.97
	Maryland	50.00		Kentucky	69.58
	Pennsylvania	54.39		Mississippi	75.89
	Virginia	50.00		North Carolina	64.52
	West Virginia	72.82		South Carolina	69.54
				Tennessee	63.65
V.	Chicago				
	Illinois	50.00	VI.	Dallas	
	Indiana	62.61		Arkansas	73.37
	Michigan	56.38		Louisiana	69.69
	Minnesota	50.00		New Mexico	71.93
	Ohio	59.66		Oklahoma	68.14
	Wisconsin	57.47		Texas	60.78
VII.	Kansas City		VIII.	Denver	
	Iowa	61.98		Colorado	50.00
	Kansas	60.25		Montana	69.11
	Missouri	61.60		North Dakota	64.72
	Nebraska	57.93		South Dakota	62.92
				Utah	70.14
IX.	San Francisco			Wyoming	52.91
	Arizona	66.47			
	California	50.00	X.	Seattle	
	Hawaii	57.55		Alaska	51.07
	Nevada	53.93		Idaho	70.36
	American Samoa	50.00		Oregon	61.07
	Guam	50.00		Washington	50.12
	N. Mariana Islds	50.00			

Source: CMS, Center for Medicare and State Operations.

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