Table I.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			
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	43.4	36.3	7.1
2007	44.1	36.9	7.2
2008	44.8	37.5	7.3

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 2000-2008 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on FY 2009 President's Budget.

SOURCE: CMS, Office of the Actuary.

Table I.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	44.6	44.3	41.3	31.8	40.9	3.4	0.3
Aged persons	37.4	37.0	34.8	--	34.5	2.5	0.3
Disabled persons	7.3	7.3	6.4	--	6.4	0.9	([1])

[1]Less than 500.

NOTES: Projected average monthly enrollment during fiscal year 2008. Aged/disabled split of Part D enrollment not available. Based on FY 2009 President's Budget.

SOURCE: CMS, Office of the Actuary.

Table I.3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	44,263	19,621	24,642
Aged	36,966	15,756	21,210
65-74 years	19,077	8,878	10,198
75-84 years	12,764	5,267	7,497
85 years and over	5,125	1,610	3,515
Disabled	7,297	3,866	3,432
Under 45 years	1,815	986	829
45-54 years	2,280	1,208	1,071
55-64 years	3,202	1,671	1,531
White	36,907	16,367	20,539
Black	4,447	1,898	2,549
All Other	2,838	1,328	1,509
Native American	186	83	102
Asian/Pacific	804	348	456
Hispanic	1,082	507	575
Other	766	391	376
Unknown Race	72	27	45

NOTES: Data as of July 1, 2007. Numbers may not add to totals because of rounding.

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

Table I.4
Medicare Part D enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	25,301	10,165	15,135
Aged			
65-74 years	10,286	4,336	5,950
75-84 years	7,095	2,560	4,535
85 years and over	2,881	750	2,131
Disabled			
Under 45 years	1,426	768	658
45-54 years	1,594	829	766
55-64 years	2,018	924	1,095

NOTE: Data as of March 2008, as recorded in MIIR. Totals may not add due to rounding.

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

Table I.5
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
2004 [1]	359.4	359.3	341.2
2005 [1]	371.2	371.1	351.9
2006 [1]	385.4	385.2	365.0
2007 [1]	395.8	395.7	374.9

[1]Denominator File; estimated person years.

NOTES: Data prior to 2000 are as of July 1; estimated person years 2000-2007.

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

Table I.6
Medicare enrollment/end stage renal disease demographics

	Number of enrollees (in thousands)
All persons	443.7
Age	
Under 35 years	27.1
35-44 years	41.7
45-64 years	175.0
65 years and over	199.8
Sex	
Male	248.5
Female	195.2
Race	
White	241.0
Other	200.5
Unknown	2.2

NOTES: Denominator Enrollment File. Represents persons with ESRD ever enrolled during calendar year 2007.

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

Table I.7
Medicare advantage, cost, PACE, demo, & prescription drug

	Number of Contracts	MA only	Drug Plan	Total
		(Enrollees in thousands)		
Total prepaid[1]	726	1,644	8,198	9,841
Local CCPs	509	411	6,555	6,966
PFFS	77	941	1,199	2,141
Demos	17	1	4	4
1876 Cost	25	105	166	271
1833 Cost (HCPP)	13	75	--	75
PACE	48	--	14	14
Other plans[2]	37	112	260	371
Total PDPs[1]	102	--	17,378	17,378
Total	828	1,644	25,575	27,219

[1]Totals include beneficiaries enrolled in employer/union only group 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, and RPPOs.

NOTE: Data as of April 2008.

SOURCE: CMS, Center for Drug and Health Plan Choice.

Table I.8
Medicare enrollment/CMS region

	Resident population[1]	Medicare enrollees[2]	Enrollees as percent of population
		In thousands	
All regions	301,621	43,259	14.3
Boston	14,264	2,261	15.9
New York	27,984	4,098	14.6
Philadelphia	29,028	4,529	15.6
Atlanta	59,210	9,243	15.6
Chicago	51,536	7,611	14.8
Dallas	36,620	4,694	12.8
Kansas City	13,417	2,126	15.8
Denver	10,423	1,277	12.2
San Francisco	46,741	5,717	12.2
Seattle	12,399	1,704	13.7

[1]Estimated July 1, 2007 resident population.

[2]Medicare enrollment file data are as of July 1, 2007. Excludes beneficiaries living in territories, possessions, foreign countries or with residence unknown.

NOTES: Resident population is a provisional estimate based on 50 States and the District of Columbia. Numbers may not add to totals because of rounding.

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

Table I.9
Medicare enrollment by health delivery system

	Total Enrollees	Fee-for-Service Enrollees	Managed Care Enrollees
		In thousands	
All regions[1]	44,263	35,490	8,773
Boston	2,261	1,954	308
New York	4,734	3,570	1,164
Philadelphia	4,529	3,581	948
Atlanta	9,243	7,676	1,568
Chicago	7,611	6,416	1,195
Dallas	4,694	3,999	695
Kansas City	2,126	1,854	272
Denver	1,277	1,010	267
San Francisco	5,732	3,821	1,911
Seattle	1,704	1,263	441

[1]Includes foreign residents and residence unknown.

NOTES: Data as of July 1, 2007. Totals may not add due to rounding.

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

Table I.10
Medicare Part D enrollment by CMS region

	Total Medicare Enrollees	Total Part D Enrollees	% of Total Enrollees
	In thousands		
All regions[1]	44,480	25,325	56.9
Boston	2,283	1,248	54.7
New York	4,779	2,650	55.5
Philadelphia	4,588	2,477	54.0
Atlanta	9,378	5,404	57.6
Chicago	7,700	4,017	52.2
Dallas	4,767	2,701	56.7
Kansas City	2,144	1,317	61.4
Denver	1,297	750	57.8
San Francisco	5,810	3,808	65.5
Seattle	1,732	951	54.9

[1]Includes beneficiaries with pending State designation.

NOTE: Data as of March 2008, as recorded in MIIR.

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

Table I.11
Medicare Part D enrollment by plan type

	Total Part D Enrollees	Total PDP Enrollees	Total MA-PD Enrollees
		In thousands	
All regions[1]	25,325	17,209	8,117
Boston	1,248	943	305
New York	2,650	1,558	1,092
Philadelphia	2,477	1,665	811
Atlanta	5,404	3,885	1,520
Chicago	4,017	2,977	1,040
Dallas	2,701	2,031	671
Kansas City	1,317	1,076	241
Denver	750	508	242
San Francisco	3,808	1,938	1,870
Seattle	951	627	324

[1]Includes beneficiaries with pending State designation.

NOTES: Data as of March 2008, as recorded in MIIR. Totals may not add due to rounding.

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

Table I.12
Medicare Part D and RDS enrollment

	Total Part D and RDS Enrollees	Total Part D Enrollees	Total RDS
		In thousands	
All regions[1]	31,782	25,325	6,457
Boston	1,626	1,248	378
New York	3,464	2,650	814
Philadelphia	3,116	2,477	639
Atlanta	6,656	5,404	1,252
Chicago	5,638	4,017	1,621
Dallas	3,321	2,701	620
Kansas City	1,535	1,317	218
Denver	889	750	139
San Francisco	4,380	3,808	572
Seattle	1,149	951	198

[1]Includes beneficiaries with pending State designation.

NOTES: Data as of March 2008, as recorded in MIIR. Totals may not add due to rounding.

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

Table I.13
Social Security Area Projected Population[1]

	2010	2020	2040	2060	2080	2100
			In millions			
Total	317	345	392	430	472	513
Under 20	86	90	99	107	115	123
20-64	191	201	216	236	256	274
65 years and over	40	54	77	87	101	116

[1] As of July 1.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2008 Trustees Report.

Table I.14
Period life expectancy at age 65,
Historical and Projected Intermediate Alternative

	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]	16.9	19.3
2020 [1]	17.6	19.8
2030 [1]	18.2	20.3
2040 [1]	18.8	20.9
2050 [1]	19.3	21.4
2060 [1]	19.8	21.9
2070 [1]	20.3	22.4
2080 [1]	20.8	22.8
2090 [1]	21.3	23.3
2100 [1]	21.7	23.7

[1]Preliminary.

SOURCE: Social Security Administration, Office of the Chief Actuary, based on the 2008 Trustees Report.

Table I.15
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
2005	77.8	78.3	73.2
		At Age 65	
1950	13.9	---	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
2005	18.7	18.8	17.2

SOURCE: Public Health Service, Health United States, 2007.

Table I.16
Medicaid and SCHIP enrollment

	Fiscal year					
	1990	1995	2000	2005	2007	2008
	Average monthly enrollment in millions					
Total	22.9	34.2	34.5	46.5	49.1	50.0
Age 65 years and over	3.1	3.7	3.7	4.6	5.0	5.1
Blind/Disabled	3.8	5.8	6.7	8.1	8.5	8.6
Children	10.7	16.5	16.2	22.3	23.5	24.0
Adults	4.9	6.7	6.9	10.6	11.1	11.3
Other Title XIX[1]	0.5	0.6	NA	NA	NA	NA
Territories	NA	0.8	0.9	1.0	1.0	1.0
SCHIP	NA	NA	2.0	4.4	4.8	5.2
	Unduplicated annual enrollment in millions					
Total	NA	43.3	44.3	58.4	61.7	62.8
Age 65 years and over	NA	4.4	4.3	5.3	5.9	5.9
Blind/Disabled	NA	6.5	7.5	8.9	9.4	9.5
Children	NA	21.3	21.1	28.1	29.5	30.2
Adults	NA	9.4	10.5	15.1	15.9	16.2
Other Title XIX[1]	NA	0.9	NA	NA	NA	NA
Territories	NA	0.8	0.9	1.0	1.0	1.0
SCHIP	NA	NA	3.4	6.8	7.7	8.4

[1]In 1997, the Other Title XIX category was dropped and the enrollees therein were subsumed in the remaining categories.

NOTES: 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-related recipients who are not disabled. Medicaid enrollment excludes Medicaid expansion SCHIP programs. SCHIP numbers include adults covered under waivers. Medicaid figures for FY 2006-2008 and SCHIP figures for FY 2008 are estimates from the President's FY 2009 budget. Enrollment for Territories for FY 2000 and later is estimated. Numbers may not add to totals because of rounding.

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

Table I.17
Medicaid eligibles/demographics

	Fiscal year 2005 Medicaid eligibles	Percent distribution
	In millions	
Total eligibles	58.7	100.0
Age	58.7	100.0
Under 21	31.9	54.3
21-64 years	20.8	35.4
65 years and over	6.0	10.2
Unknown	0.1	0.2
Sex	58.7	100.0
Male	23.8	40.6
Female	34.8	59.3
Unknown	0.1	0.2
Race	58.7	100.0
White, not Hispanic	24.9	42.4
Black, not Hispanic	13.6	23.2
Am. Indian/Alaskan Native	0.8	1.4
Asian	1.7	2.9
Hawaiian/Pacific Islander	0.6	1.0
Hispanic	13.9	23.7
Other	0.1	0.2
Unknown	3.2	5.5

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 has been made.

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

Table I.18
Medicaid eligibles/CMS region

	Resident population[1]	Medicaid enrollment[2]	Enrollment as percent of population
	In thousands		
All regions	295,896	59,046	20.0
Boston	14,217	2,572	18.0
New York	27,920	6,087	21.8
Philadelphia	28,727	4,464	15.5
Atlanta	57,378	11,573	20.2
Chicago	51,199	9,136	17.8
Dallas	35,564	7,122	20.0
Kansas City	13,240	2,234	16.9
Denver	10,038	1,227	12.3
San Francisco	45,619	12,528	27.5
Seattle	11,996	2,102	17.5

[1]Estimated July 1, 2005 population.

[2]Persons ever enrolled in Medicaid during fiscal year 2005.

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 I.19
Medicaid beneficiaries/State buy-ins for Medicare

	1975 [1]	1980 [1]	2000 [2]	2007 [2]
Type of Beneficiary		In thousands		
All buy-ins	2,846	2,954	5,549	7,307
Aged	2,483	2,449	3,632	4,422
Disabled	363	504	1,917	2,885
		Percent of SMI enrollees		
All buy-ins	12.0	10.9	14.9	17.8
Aged	11.4	10.0	11.1	12.7
Disabled	18.7	18.9	40.2	46.0

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

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

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

Table II.1
Inpatient hospitals/trends

	1990	2000	2006	2007
Total hospitals	6,522	5,985	6,177	6,163
Beds in thousands	1,105	991	939	934
Beds per 1,000 enrollees[1]	32.8	25.3	21.8	21.3
Short-stay	5,549	4,900	3,702	3,675
Beds in thousands	970	873	803	797
Beds per 1,000 enrollees[1]	28.8	22.3	18.7	18.1
Critical access hospitals	NA	NA	1,284	1,288
Beds in thousands	---	---	29	30
Beds per 1,000 enrollees[1]	---	---	0.7	0.7
Other non-short-stay	973	1,085	1,191	1,200
Beds in thousands	135	118	107	108
Beds per 1,000 enrollees[1]	4.0	3.0	2.5	2.4

[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 II.2
Medicare assigned claims/CMS region

	Net assignment rates		
	2005	2006	2007
All regions	98.8	99.0	99.1
Boston	([1])	([1])	([1])
New York	98.8	98.8	99.0
Philadelphia	99.2	99.4	99.7
Atlanta	98.6	99.1	99.3
Chicago	98.6	98.7	98.9
Dallas	98.6	99.1	99.2
Kansas City	98.6	98.8	99.0
Denver	98.1	98.3	99.0
San Francisco	99.3	99.3	99.4
Seattle	95.2	97.2	96.2

[1] No carriers in the Boston region.

NOTE: Calendar year data.

SOURCE: CMS, Office of Financial Management.

Table II.3
Medicare hospital and SNF/NF/ICF facility counts

Total participating hospitals	6,163
Short-term hospitals	3,669
Psychiatric units	1,265
Rehabilitation units	972
Swing bed units	556
Psychiatric	488
Long-term	394
Rehabilitation	221
Childrens	78
Religious non-medical	19
Critical access	1,294
Non-participating Hospitals	757
Emergency	407
Federal	350
All SNFs/SNF-NFs/NFs only	15,796
All SNFs/SNF-NFs	15,038
Title 18 Only SNF	824
Hospital-based	349
Free-standing	475
Title 18/19 SNF/NF	14,214
Hospital-based	758
Free-standing	13,456
Title 19 only NFs	758
Hospital-based	139
Free-standing	619
All ICF-MR facilities	6,429

NOTES: The table is designed to give a "snapshot" as of April 2008 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 II.4
Long-term facilities/CMS region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions[3]	15,054	780	6,443
Boston	995	15	152
New York	1,026	2	590
Philadelphia	1,374	47	419
Atlanta	2,618	68	649
Chicago	3,302	176	1,516
Dallas	1,929	140	1,567
Kansas City	1,364	179	191
Denver	578	49	89
San Francisco	1,422	77	1,190
Seattle	446	27	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 2007.

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

Table II.5
Other Medicare providers and suppliers/trends

	1975	1980	2006	2007
Home health agencies	2,242	2,924	8,618	9,024
Independent and Clinical Lab Improvement Act Facilities	NA	NA	199,817	206,065
End stage renal disease facilities	NA	999	4,892	5,095
Outpatient physical therapy and/or speech pathology	117	419	3,009	2,915
Portable X-ray	132	216	549	550
Rural health clinics	NA	391	3,723	3,781
Comprehensive outpatient rehabilitation facilities	NA	NA	589	539
Ambulatory surgical centers	NA	NA	4,707	4,964
Hospices	NA	NA	3,071	3,255

NOTES: Facility data for selected years 1975 and 1980 are as of July 1. Facility data for 2006 and 2007 are as of December 31.

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

Table II.6
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	3,675	15,054	9,024
		Percent of total	
Non-profit	60.1	26.8	23.0
Proprietary	20.2	67.9	67.4
Government	19.6	5.2	9.6

NOTES: Data as of December 31, 2007. 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 II.7
Periodic interim payment (PIP) facilities/trends

	1980	1990	2000	2006	2007
Hospitals					
Number of PIP	2,276	1,352	869	639	565
Percent of total participating	33.8	20.6	14.4	10.3	9.1
Skilled nursing facilities					
Number of PIP	203	774	1,236	837	462
Percent of total participating	3.9	7.3	8.3	5.6	3.1
Home health agencies					
Number of PIP	481	1,211	1,038	90	85
Percent of total participating	16.0	21.0	14.4	1.0	0.9

NOTES: Data from 1990 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 II.8
Part B practitioners active in patient care/selected years

	July 2007	
	Number	Percent
All Part B Practitioners	1,087,845	100.0
Physician Specialties	667,340	61.3
Primary Care	246,314	22.6
Medical Specialties	108,694	10.0
Surgical Specialties	108,031	9.9
Emergency Medicine	36,644	3.4
Anesthesiology	38,358	3.5
Radiology	37,595	3.5
Pathology	13,984	1.3
Obstetrics/Gynecology	38,515	3.5
Psychiatry	38,921	3.6
Other and Unknown	284	0.0
Limited Licensed Practitioners	126,006	11.6
Non-physician Practitioners	294,499	27.1

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 II.9
Part B practitioners/CMS region

	Active practitioners	Practitioners per 100,000 population
All regions	1,245,003 [1]	413
Boston	96,484	676
New York	147,395	527
Philadelphia	133,101	459
Atlanta	221,727	374
Chicago	211,442	410
Dallas	118,319	323
Kansas City	62,890	469
Denver	46,248	444
San Francisco	151,680	325
Seattle	55,717	449

[1]Includes non-Federal physicians, limited licensed and non-physician practitioners. Practitioners with multi-State practices are duplicated in the enumeration for each State in which they operate.

NOTES: Physicians as of July 2007. Civilian population as of July 1, 2007. Resident population for outlying areas and the Virgin Islands are not available.

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

Table II.10
Inpatient hospitals/CMS region

	Short-stay and CAH hospitals	Beds per 1,000 enrollees	Non Short-stay hospitals	Beds per 1,000 enrollees
All regions	4,963	19.0	1,200	2.5
Boston	193	14.5	70	4.7
New York	335	21.0	74	2.6
Philadelphia	374	16.5	134	3.0
Atlanta	931	19.2	213	2.1
Chicago	875	20.3	182	2.0
Dallas	772	21.2	309	3.9
Kansas City	465	22.9	56	2.0
Denver	309	19.9	40	2.7
San Francisco	497	16.9	100	1.5
Seattle	212	13.8	22	1.5

NOTES: Critical Access Hospitals have been grouped with short stay. Facility data as of December 31, 2007. Rates based on number of hospital insurance enrollees as of July 1, 2007, residing in U.S. and its territories.

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

Table III.1
CMS and total Federal outlays

	Fiscal year 2006	Fiscal year 2007
	$ in billions	
Gross domestic product (current dollars)	$13,015.5	$13,667.5
Total Federal outlays[1]	2,655.4	2,730.2
Percent of gross domestic product	20.4%	20.0%
Dept. of Health and Human Services[1]	614.3	672.0
Percent of Federal Budget	23.1%	24.6%
CMS Budget (Federal Outlays)		
Medicare benefit payments	375.2	434.6
SMI transfer to Medicaid[2]	0.3	0.4
Medicaid benefit payments	171.5	181.1
Medicaid State and local admin.	9.1	9.5
Medicaid offsets[3]	-0.3	-0.4
State Children's Health Ins. Prog.	5.5	6.0
CMS program management	3.3	2.9
Other Medicare admin. expenses[4]	1.9	1.9
State Eligibility Determinations, for Part D	0.0	0.0
Quality improvement organizations[5]	0.4	0.4
Health Care Fraud and Abuse Control	1.1	1.0
State Grants and Demonstrations[6]	1.3	1.3
User Fees and Reimbursables	0.2	0.2
Total CMS outlays (unadjusted)	569.4	638.9
Offsetting receipts[7]	-52.1	-65.6
Total net CMS outlays	517.3	573.3
Percent of Federal budget	19.5%	21.0%

[1]Net of offsetting receipts.

[2]SMI transfers to Medicaid for Medicare Part B premium assistance ($264.2 million in FY 2006 and $358.7 million in FY 2007).

[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 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 previously small programs rose to the $1 billion range in FY 2006, primarily reflecting Katrina hurricane relief outlays.

[7]Almost entirely Medicare premiums. Also includes offsetting collections for user fee and reimbursable activities, as well as refunds to the trust funds.

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

SOURCE: CMS, Office of Financial Management.

Table III.2
Program expenditures/trends

Fiscal year	Total	Medicare[1]	Medicaid[2]	SCHIP[3]
		$ in billions		
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
2007	782.7	440.8	333.2	8.7

[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 beneficiaries, nor do they include the 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 2001.

SOURCE: CMS, Office of Financial Management.

Table III.3
Benefit outlays by program

	1967	1968	2006	2007
Annually		Amounts in billions		
CMS program outlays	$5.1	$8.4	$684	$776
Federal outlays	NA	6.7	552	631
Medicare[1]	3.2	5.1	375	434
HI	2.5	3.7	184	205
SMI	0.7	1.4	159	181
Transitional Assistance[2]	NA	NA	0	0
Prescription (Part D)	NA	NA	32	49
Medicaid[3]	1.9	3.3	300	333
Federal share	NA	1.6	171	191
SCHIP[4]	NA	NA	9	9
Federal share	NA	NA	5	6

[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 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 2007 benefit outlays for payment adjustments totalled $9.8 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 III.4
Program benefit payments/CMS region

	Fiscal Year 2006 Net Expenditures Reported[1]	
	Medicaid	
	Total payments computable for Federal funding	Federal share
	In millions	
All regions	$299,022	$170,552
Boston	19,233	10,036
New York	53,510	26,833
Philadelphia	29,233	16,191
Atlanta	49,198	31,696
Chicago	45,558	25,647
Dallas	30,542	19,924
Kansas City	12,478	7,730
Denver	6,538	3,949
San Francisco	42,337	22,602
Seattle	10,396	5,945

[1]Data from Form CMS-64--Net Expenditures Reported by the States. Medical assistance payments only; excludes administrative expenses. Excludes Medicaid expansions under the State Children's Health Insurance Program (SCHIP).

SOURCE: CMS, Center for Medicaid and State Operations.

Table III.5
Medicare benefit outlays

	Fiscal year		
	2006	2007	2008
	In billions		
HI benefit payments	$185.0	$207.5	$221.2
Aged	157.3	175.7	186.9
Disabled	27.7	31.8	34.2
SMI benefit payments	154.5	169.2	183.7
Aged	128.6	141.7	151.6
Disabled	25.9	27.5	32.2
Part D	33.8	51.2	48.0

NOTES: Based on FY 2009 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 III.6
Medicare/type of benefit

	Fiscal year 2008 benefit payments[1] in millions	Percent distribution
Total HI[2]	$221,172	100.0
Inpatient hospital	132,900	60.1
Skilled nursing facility	22,645	10.2
Home health agency[3]	6,348	2.9
Hospice	10,454	4.7
Managed care	48,826	22.1
Total SMI[2]	183,736	100.0
Physician/other suppliers	60,636	33.0
DME	8,584	4.7
Other carrier	17,108	9.3
Outpatient hospital	21,597	11.8
Home health agency[3]	10,028	5.5
Other intermediary	13,015	7.1
Laboratory	6,954	3.8
Managed care	45,814	24.9
Total Part D	47,973	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 estimated based on outlays reported to date by the Treasury.

NOTES: Based on FY 2009 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, Office of the Actuary.

Table III.7
National health care/trends

	Calendar year			
	1965	1980	2000	2006
National total in billions	$41.0	$253.9	$1,353.3	$2,105.5
Percent of GDP	5.7	9.1	13.8	16.0
Per capita amount	$205	$1,102	$4,790	$7,026
Source of funds		Percent of total		
Private	75.1	58.1	55.9	53.9
Public	24.9	41.9	44.1	46.1
Federal	11.4	28.2	30.9	33.5
State/local	13.5	13.7	13.2	12.6

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 III.8
Medicaid/type of service

	Fiscal year		
	2004	2005	2006
		In billions	
Total medical assistance payments[1]	$281.8	$300.7	$299.0
		Percent of total	
Inpatient services	15.6	15.5	15.3
General hospitals	13.9	14.0	14.3
Mental hospitals	1.7	1.6	1.1
Nursing facility services	16.5	15.4	16.0
Intermediate care facility (MR) services	4.3	4.2	4.3
Community-based long term care svs.[2]	11.9	12.1	13.4
Prescribed drugs[3]	10.8	10.2	5.6
Physician services	4.1	4.1	4.2
Dental services	1.1	1.1	1.1
Outpatient hospital services	4.3	4.1	3.9
Clinic services[4]	2.9	3.0	3.1
Laboratory and radiological services	0.4	0.4	0.4
Early and periodic screening	0.4	0.4	0.4
Targeted case management services	1.0	1.0	1.0
Capitation payments (non-Medicare)	16.2	16.8	18.6
Medicare premiums	2.3	2.7	3.1
Disproportionate share hosp. payments	6.1	5.7	5.7
Other services	4.4	5.0	5.6
Collections[5]	-2.3	-1.7	-1.8

[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 third party liability, probate, fraud and abuse, overpayments, and other collections.

SOURCES: CMS, CMSO, and OACT.

Table III.9
Medicare savings attributable to secondary payor provisions/type of provision

	Fiscal Year			
	2005	2006	2007	
	in millions			
Total	$5,670.5	$6,088.6	$6,505.0	
Workers Compensation	101.9	93.1	877.2	[1]
Working Aged	2,780.9	2,980.6	2,919.0	
ESRD	280.8	298.6	278.1	
Auto	244.6	243.7	233.2	
Disability	1,920.6	2,033.7	1,938.9	
Liability	325.0	410.3	232.2	
VA/Other	16.8	28.6	26.3	

[1]Beginning FY 2007, includes Workers Compensation set asides.

SOURCE: CMS, Office of Financial Management.

Table III.10
Medicaid/payments by eligibility status

	Fiscal year 2006 Medical assistance payments	Percent distribution
	In billions	
Total[1]	$299.0	100.0
Age 65 years and over	68.7	23.0
Blind/disabled	123.5	41.3
Dependent children under 21 years of age	52.2	17.5
Adults in families with dependent children	36.2	12.1
DSH and other unallocated	18.4	6.2

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

SOURCE: CMS, Office of the Actuary.

Table III.11
Medicare/DME/POS[1]

Category	Allowed Charges [2]	
	2006	2007 [3]
	In thousands	
Total	$10,595,986	$10,398,649
Medical/surgical supplies	144,558	151,922
Hospital beds	306,206	287,076
Oxygen and supplies	2,753,989	2,790,146
Wheelchairs	1,593,956	1,276,573
Prosthetic/orthotic devices	1,731,068	1,876,486
Drugs admin. through DME	956,975	900,179
Other DME	3,109,234	3,116,266

[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.
[3]Data for 2007 are preliminary through March 2008.

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 III.12
National health care/type of expenditure

	National Total in billions	Per capita amount	Percent Paid		
			Total	Medicare	Medicaid
Total	$2,105.5	$7,026	33.7	19.1	14.7
Health serv/suppl.	1,966.2	6,561	36.1	20.4	15.7
Personal health care	1,762.0	5,880	37.8	21.6	16.2
Hospital care	648.2	2,163	45.9	28.9	17.1
Prof. services	660.2	2,203	39.0	26.3	12.7
Phys./clinical	447.6	1,494	27.6	20.6	7.0
Nursing/home hlth.	177.6	593	63.4	22.9	40.5
Retail outlet sales	276.0	921	24.7	17.6	7.0
Admn. and pub. hlth.	204.1	681	21.3	9.9	11.3
Investment	139.4	465	--	--	--

NOTE: Data are as of calendar year 2006.

SOURCE: CMS, Office of the Actuary.

Table III.13
Personal health care/payment source

	Calendar Year			
	1980	1990	2000	2006
	In billions			
Total	$215.3	$607.5	$1,139.9	$1,762.0
	Percent			
Total	100.0	100.0	100.0	100.0
Private funds	60.0	61.1	57.3	54.7
Private health insurance	28.4	33.7	35.4	36.0
Out-of-pocket	27.2	22.4	16.9	14.6
Other private	4.3	5.0	5.0	4.1
Public funds	40.0	38.9	42.7	45.3
Federal	28.9	28.4	32.4	35.1
State and local	11.1	10.4	10.3	10.2

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

SOURCE: CMS, Office of the Actuary.

Table IV.1
Medicare/short-stay hospital utilization

	1985	1990	2005	2006
Discharges				
Total in millions	10.5	10.5	13.0	12.5
Rate per 1,000 enrollees[1]	347	320	361	355
Days of care				
Total in millions	92	94	75	71
Rate per 1,000 enrollees[1]	3,016	2,866	2,073	2,023
Average length of stay				
All short-stay	8.7	9.0	5.7	5.6
Excluded units	18.8	19.5	11.5	11.7
Total charges per day	$597	$1,060	$4,882	$5,344

[1]Beginning in 1990, the population base for the denominator 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 2006 are based on 100 percent Medicare stay record files. Data may differ from other sources or from the same source with a different update cycle.

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

Table IV.2
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	45 [1]	2,461	75 [1]
2004	1,752	49 [1]	2,835	78 [1]
2005	1,847	51 [1]	2,976	81 [1]
2006	1,838	52 [1]	3,026	84 [1]

[1]Managed care enrollees excluded in determining rate.

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

Table IV.3
Medicare average length of stay/trends

	Fiscal year				
	1990	1995	2000	2005	2006
All short-stay units and excluded units					
Short stay PPS units	9.0	7.1	6.0	5.7	5.3
Short stay hospital non-PPS units	8.9	7.1	6.0	5.7	5.3
Excluded units	19.5	14.8	12.3	11.6	11.7

NOTES: Fiscal year data. Average length of stay is shown in days. Data for 1990 through 2006 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 IV.4
Medicare persons served/trends

	Calendar Year					
	1975	1985	1995	2000	2005	2006
Aged persons served per 1,000 enrollees						
HI and/or SMI	528	722	826	916	923	932
HI	221	219	218	232	234	234
SMI	536	739	858	965	979	994
Disabled persons served per 1,000 enrollees						
HI and/or SMI	450	669	759	835	865	877
HI	219	228	212	196	205	205
SMI	471	715	837	943	977	998

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 IV.5
Medicare fee-for-service (FFS) persons served

	Calendar year				
	2002	2003	2004	2005	2006
	Numbers in millions				
HI					
Aged					
FFS Enrollees	29.1	29.7	30.0	30.0	29.3
Persons served	6.3	6.9	6.9	7.0	6.8
Rate per 1,000	232	231	231	234	234
Disabled					
FFS Enrollees	5.4	5.7	6.0	6.3	6.2
Persons served	1.1	1.2	1.2	1.3	1.3
Rate per 1,000	202	203	203	205	205
SMI					
Aged					
FFS Enrollees	27.8	28.3	28.4	28.4	27.5
Persons served	26.9	27.4	27.6	27.8	27.3
Rate per 1,000	968	970	972	979	994
Disabled					
FFS Enrollees	4.8	5.0	5.3	5.5	5.4
Persons served	4.6	4.9	5.1	5.4	5.4
Rate per 1,000	963	969	965	977	998

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 IV.6
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]	27,603	932	5,461	877
Boston	1,463	913	297	844
New York[2]	2,533	911	458	850
Philadelphia	2,860	941	521	882
Atlanta	6,006	963	1,400	920
Chicago	5,359	968	962	887
Dallas	3,096	940	648	899
Kansas City	1,504	964	279	918
Denver	837	970	134	887
San Francisco[3]	2,748	890	520	805
Seattle	981	937	186	849

[1]Includes utilization for residents of outlying territories, possessions, foreign countries, and unknown.

[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 2006 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 IV.7
Medicare/end stage renal disease (ESRD) incidence, trends by demographics

	Calendar year		
	2003	2004	2005
Total--all patients	89,410	90,784	91,373
Age			
0-19 years	818	862	776
20-64 years	38,877	39,801	39,964
65-74 years	23,815	23,908	23,683
75 years and over	25,900	26,213	26,950
Sex			
Male[1]	48,739	50,417	50,949
Female	40,671	40,367	40,424
Race			
White	59,547	60,945	61,448
African American	24,972	24,635	25,140
Other/Unknown	4,891	5,204	4,785

[1]Includes small number of unknowns.

SOURCE: United States Renal Data System.

Table IV.8
Medicare/end stage renal disease (ESRD) point prevalence, by treatment of modality, 2005

	Treatment Modality		
	Total	Dialysis	Functioning graft
Total--all patients	406,812	307,952	98,860
Age			
0-19 years	3,696	1,533	2,163
20-64 years	238,218	161,757	76,461
65-74 years	90,707	73,694	17,013
75 years and over	74,191	70,968	3,223
Sex			
Male[1]	227,782	168,548	59,234
Female	179,030	139,404	39,626
Race			
White	246,546	173,797	72,749
African American	134,204	113,950	20,254
Other/Unknown	26,062	20,205	5,857

[1]Includes small number of unknowns.

SOURCE: United States Renal Data System.

Table IV.9
Medicaid/type of service

	Fiscal year 2005 Medicaid beneficiaries
	In thousands
Total eligibles	58,739
Number using service:	
Total beneficiaries, any service[1]	57,349
Inpatient services	
General hospitals	5,462
Mental hospitals	119
Nursing facility services[2]	1,703
Intermediate care facility (MR) services[3]	109
Physician services	24,030
Dental services	9,261
Other practitioner services	5,836
Outpatient hospital services	16,153
Clinic services	11,810
Laboratory and radiological services	15,894
Home health services	1,192
Prescribed drugs	28,162
Personal care support services	932
Sterilization services	178
PCCM capitation	8,558
HMO capitation	23,897
PHP captitation	19,741
Targeted case management	2,709
Other services, unspecified	10,114
Additional service categories[4]	7,727
Unknown	73

[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 other facilities formerly classified as ICF, other than "MR".

[3]"MR" indicates mentally retarded.

[4]Additional services not shown separately sum to 7.7 million beneficiaries, not unduplicated.

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

SOURCE: CMS, Center for Medicaid and State Operations.

Table IV.10
Medicaid/units of service

	Fiscal year 2005 units of service
	In thousands
Inpatient hospital	
Total discharges	7,900
Beneficiaries discharged	5,462
Total days of care	41,345
Nursing facility	
Total days of care	421,652
Intermediate care facility/mentally retarded	
Total days of care	42,142

NOTES: Data are derived from the MSIS 2005 State Summary Mart. Excludes territories.

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

Table V.1
Medicare administrative expenses/trends

Fiscal Year	Administrative expenses: Amount in millions	Administrative expenses: 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
2005 [1]	2,850	1.6
2006 [1]	3,086	1.7
2007 [1]	2,636	1.3
SMI Trust Fund[2]		
1967	135 [3]	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
2005	2,348	1.6
2006	3,108	1.6
2007	3,398	1.5

[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 Actuary.

Table V.2
Medicare contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	22	16
Other	2	3

NOTES: Data for Fiscal Year 2007. Numbers do not include MACs or DMACs.

SOURCE: CMS, Office of Financial Management.

Table V.3
Medicare Redeterminations

	Intermediary Redeterminations (Part A Cases Involved)	Intermediary Redeterminations (Part B Cases Involved)	Carrier Redeterminations (Part B Cases Involved)
Number Processed	33,628	203,083	1,909,295
Percent Reversed (Includes Fully & Partially Reversed Cases)	27.4	54.9	56.5

NOTES: Data for fiscal year 2007. Data presented in cases.

SOURCE: CMS, Office of Financial Management.

Table V.4
Medicare physician/supplier claims assignment rates

	2000	2003	2004	2005	2006	2007
			In millions			
Claims total	720.5	860.7	922.2	951.6	944.9	944.3
Claims assigned	705.7	847.8	909.9	940.7	935.1	935.8
Claims unassigned	15.3	12.9	12.3	10.9	9.8	8.6
Percent assigned	97.9	98.5	98.7	98.9	99.0	99.1

NOTES: Fiscal year data. Historical data may be revised from earlier year editions.

SOURCE: CMS, Office of Financial Management.

Table V.5
Medicare claims processing

	Intermediaries	Carriers
Claims processed in millions	185.7	970.1 [1]
Total PM costs in millions	$487.7	$1,306.6
Total MIP costs in millions	$460.0	$247.5
Claims processing costs in millions	$335.0	$927.1 [2]
Claims processing unit costs	$0.75	$0.43
Range		
High	$2.08	$1.34
Low	$0.50	$0.30

[1]Excludes replicate claims.

[2]Beginning in FY 2002, provider enrollment has been removed from the claims processing costs and unit costs.

NOTES: Data for fiscal year 2007. PM = Program Management. MIP = Medicare Integrity Program. FY 2007 PM costs include an estimate of $103.9 M for MAC/DMAC and MIP costs include a MAC/DMAC estimate of $17.1 M. Since MACs do not report by traditional categories, unit costs do not include MACS/DMACs.

SOURCE: CMS, Office of Financial Management.

Table V.6
Medicare claims received

	Claims received
Intermediary claims received in millions	186.5
	Percent of total
Inpatient hospital	8.0
Outpatient hospital	57.8
Home health agency	7.5
Skilled nursing facility	3.0
Other	23.7
Carrier claims received in millions	951.0
	Percent of total
Assigned	99.1
Unassigned	0.9

NOTE: Data for calendar year 2007.

SOURCE: CMS, Office of Financial Management.

Table V.7
Medicare charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	819.0	7.3
Percent reduced	92.5	88.1
Total covered charges		
Amount in millions	$253,248	$790
Percent reduced	58.0	18.2
Amount reduced per claim	$179.54	$19.63

NOTES: Data for calendar year 2007. 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 V.8
Medicaid administration

	Fiscal Year	
	2006	2007
	In millions	
Total payments computable for Federal funding[1]	$16,032	$16,423
Federal share[1]		
Family Planning	28	29
Design, development or installation of MMIS[2]	223	292
Skilled professional medical personnel	415	421
Operation of an approved MMIS[2]	1,208	1,192
All other	6,772	6,953
Mechanized systems not approved under MMIS[2]	93	84
Total Federal Share	$8,739	$8,971
Net adjusted Federal share[3]	$8,733	$8,982

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

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

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	2006	2007	2008
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90
Maximum taxable amount (CY 2008)		None[1]	
Voluntary HI monthly premium[2]		$423.00	

Part A (effective date)	Amount
Inpatient hospital deductible (1/1/08)	$1,024/benefit period
Regular coinsurance days (1/1/08)	$256/day for 61st thru 90th day
Lifetime reserve days (1/1/08)	$512/day (60 non-renewable days)
SNF coinsurance days (1/1/08)	$128/day after 20th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/08)	$423/month; $233/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 $233 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 (1/1/08)	$135 in allowed charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Monthly standard premium (1/1/08)	$96.40/month
Limitations:	
Outpatient treatment for mental 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 2008 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 $82,000	Less than or equal to $164,000	$0.00	$96.40
Greater than $82,000 and less than or equal to $102,000	Greater than $164,000 and less than or equal to $204,000	$25.80	$122.20
Greater than $102,000 and less than or equal to $153,000	Greater than $204,000 and less than or equal to $306,000	$64.50	$160.90
Greater than $153,000 and less than or equal to $205,000	Greater than $306,000 and less than or equal to $410,000	$103.30	$199.70
Greater than $205,000	Greater than $410,000	$142.00	$238.40

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse 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 $82,000	$0.00	$96.40
Greater than $82,000 and less than or equal to $123,000	$103.30	$199.70
Greater than $123,000	$142.00	$238.40

SOURCE: CMS, Office of the Actuary

Program financing, cost sharing and limitations

Medicare Part D Standard Benefits	
Deductible (1/1/2008)	$275 in charges/year
Initial coverage limit (1/1/2008)	$2,510 in charges/year
Out-of-pocket threshold (1/1/2008)	$4,050 in charges/year
Base beneficiary premium (1/1/2008)[1]	$27.93/month

Medicaid financing

1. Federal contributions (ranging from 50 to 76 percent for fiscal year 2008)
2. State contributions (ranging from 24 to 50 percent for fiscal year 2008)

[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 2008, the average premium rate paid by beneficiaries is estimated to be about $25.

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 2008

I.	Boston	FMAP
	Connecticut	50.00
	Maine	63.31
	Massachusetts	50.00
	New Hampshire	50.00
	Rhode Island	52.51
	Vermont	59.03

III.	Philadelphia	
	Delaware	50.00
	Dist. of Columbia	70.00
	Maryland	50.00
	Pennsylvania	54.08
	Virginia	50.00
	West Virginia	74.25

V.	Chicago	
	Illinois	50.00
	Indiana	62.69
	Michigan	58.10
	Minnesota	50.00
	Ohio	60.79
	Wisconsin	57.62

VII.	Kansas City	
	Iowa	61.73
	Kansas	59.43
	Missouri	62.42
	Nebraska	58.02

IX.	San Francisco	
	Arizona	66.20
	California	50.00
	Hawaii	56.50
	Nevada	52.64
	American Samoa	50.00
	Guam	50.00
	N. Mariana Islds	50.00

II.	New York	FMAP
	New Jersey	50.00
	New York	50.00
	Puerto Rico	50.00
	Virgin Islands	50.00
	Canada	--

IV.	Atlanta	
	Alabama	67.62
	Florida	56.83
	Georgia	63.10
	Kentucky	69.78
	Mississippi	76.29
	North Carolina	64.05
	South Carolina	69.79
	Tennessee	63.71

VI.	Dallas	
	Arkansas	72.94
	Louisiana	72.47
	New Mexico	71.04
	Oklahoma	67.10
	Texas	60.56

VIII.	Denver	
	Colorado	50.00
	Montana	68.53
	North Dakota	63.75
	South Dakota	60.03
	Utah	71.63
	Wyoming	50.00

X.	Seattle	
	Alaska	52.48
	Idaho	69.87
	Oregon	60.86
	Washington	51.52

SOURCE: CMS, Center for Medicare and State Operations.