Table 2.B1—Federal benefit rates, by living arrangement, 1974–2006

Act	Effective date	Amount [a] (dollars)	
		Individual	Couple
		Own household [b]	
1972	January 1, 1974 [c]	130.00	195.00
1973	January 1, 1974	140.00	210.00
1973	July 1, 1974	146.00	219.00
1974 [d]	July 1, 1975	157.70	236.60
	July 1, 1976	167.80	251.80
	July 1, 1977	177.70	266.70
	July 1, 1978	189.40	284.10
	July 1, 1979	208.20	312.30
	July 1, 1980	238.00	357.00
	July 1, 1981	264.70	397.00
	July 1, 1982	284.30	426.40
1983	July 1, 1983 [e]	304.30	456.40
	January 1, 1984	314.00	472.00
	January 1, 1985	325.00	488.00
	January 1, 1986	336.00	504.00
	January 1, 1987	340.00	510.00
	January 1, 1988	354.00	532.00
	January 1, 1989	368.00	553.00
	January 1, 1990	386.00	579.00
	January 1, 1991	407.00	610.00
	January 1, 1992	422.00	633.00
	January 1, 1993	434.00	652.00
	January 1, 1994	446.00	669.00
	January 1, 1995	458.00	687.00
	January 1, 1996	470.00	705.00
	January 1, 1997	484.00	726.00
	January 1, 1998	494.00	741.00
	January 1, 1999	500.00	751.00
	January 1, 2000	[f] 513.00	769.00
	January 1, 2001	[f] 531.00	796.00
	January 1, 2002	545.00	817.00
	January 1, 2003	552.00	829.00
	January 1, 2004	564.00	846.00
	January 1, 2005	579.00	869.00
	January 1, 2006	603.00	904.00
		Receiving institutional care covered by Medicaid [g]	
1972	January 1, 1974	25.00	50.00
1987	July 1, 1988	30.00	60.00

SOURCES: Social Security Act of 1935 (the Act), as amended through December 31, 2005; regulations issued under the Act; and precedential case decisions (rulings). Specific laws, regulations, rulings, legislation, and a link to the *Federal Register* can be found at http://www.socialsecurity.gov/regulations/index.htm. Social Security Administration, Office of the Chief Actuary, "SSI Federal Payment Amounts," http://www.socialsecurity.gov/OACT/COLA/SSIamts.html.

NOTE: For those in another person's household receiving support and maintenance there, the federal benefit rate is reduced by one-third.

a. For those without countable income. These payments are reduced by the amount of countable income of the individual or couple.
b. Includes persons in private institutions whose care is not provided by Medicaid.
c. Superseded by the provision of 1973.
d. Mechanism established for providing cost-of-living adjustments.
e. General benefit increase.
f. Benefits originally paid in 2000 and through July 2001 were based on federal benefit rates of $512 and $530, respectively. Pursuant to Public Law 106-554, monthly payments beginning in August 2001 were effectively based on the higher $531 amount. Lump-sum compensation payments were made on the basis of an adjusted benefit rate for months prior to August 2001.
g. Must be receiving more than 50 percent of the cost of the care from Medicaid (Title XIX of the Social Security Act).

CONTACT: Alfreda Brooks (410) 965-9849.

Table 2.C1—Medicare cost sharing and premium amounts, 1966–2007

Effective date [a]	Hospital Insurance (Medicare Part A): All expenses in "benefit period" covered except—: Inpatient hospital deductible (IHD) covers first 60 days (dollars)	Inpatient hospital daily coinsurance: Days 61 through 90 (1/4 x IHD) (dollars)	Inpatient hospital daily coinsurance: Lifetime reserve days after 90 days (1/2 x IHD)	Skilled nursing facility daily coinsurance after 20 days (1/8 x IHD) (dollars)	Monthly premium [b] (dollars)	Supplementary Medical Insurance (Medicare Parts B and D): Part B: Annual deductible [c] (dollars)	Part B: Coinsurance [c] (percent)	Part B: Monthly premium (dollars): For enrollee [g,h] (aged and disabled)	Part B: Monthly premium: Government amounts for—: Aged	Part B: Monthly premium: Government amounts for—: Disabled [h]	Part D: Annual deductible [d,e] (dollars)	Part D: Initial coverage limit [d,e] (dollars)	Part D: Out-of-pocket threshold [d,e] (dollars)	Part D: Base beneficiary premium [d,f] (dollars)
1966	40	10	[i]	[i]	. . .	50	20	3.00	3.00	. . .	. . .	. . .	. . .	. . .
1967	40	10	[i]	5.00	. . .	50	20	3.00	3.00	. . .	. . .	. . .	. . .	. . .
1968	40	10	20	5.00	. . .	[j] 50	[j] 20	[k] 4.00	[k] 4.00	. . .	. . .	. . .	. . .	. . .
1969	44	11	22	5.50	. . .	50	20	4.00	4.00	. . .	. . .	. . .	. . .	. . .
1970	52	13	26	6.50	. . .	50	20	5.30	5.30	. . .	. . .	. . .	. . .	. . .
1971	60	15	30	7.50	. . .	50	20	5.60	5.60	. . .	. . .	. . .	. . .	. . .
1972	68	17	34	8.50	. . .	50	[l] 20	5.80	5.80	. . .	. . .	. . .	. . .	. . .
1973	72	18	36	9.00	33	60	20	[m] 6.30	6.30	22.70	. . .	. . .	. . .	. . .
1974	84	21	42	10.50	36	60	20	6.70	6.70	29.30	. . .	. . .	. . .	. . .
1975	92	23	46	11.50	40	60	20	6.70	8.30	30.30	. . .	. . .	. . .	. . .
1976	104	26	52	13.00	45	60	20	7.20	14.20	30.80	. . .	. . .	. . .	. . .
1977	124	31	62	15.50	54	60	20	7.70	16.90	42.30	. . .	. . .	. . .	. . .
1978	144	36	72	18.00	63	60	20	8.20	18.60	41.80	. . .	. . .	. . .	. . .
1979	160	40	80	20.00	69	60	20	8.70	18.10	41.30	. . .	. . .	. . .	. . .
1980	180	45	90	22.50	78	60	20	9.60	23.00	41.40	. . .	. . .	. . .	. . .
1981	204	51	102	25.50	89	[n,o] 60	[o] 20	11.00	34.20	62.20	. . .	. . .	. . .	. . .
1982	260	65	130	32.50	113	[p] 75	[p] 20	12.20	37.00	72.00	. . .	. . .	. . .	. . .
1983	304	76	152	38.00	113	75	20	12.20	41.80	80.00	. . .	. . .	. . .	. . .
1984	356	89	178	44.50	155	75	20	14.60	43.80	94.00	. . .	. . .	. . .	. . .
1985	400	100	200	50.00	174	75	20	15.50	46.50	89.90	. . .	. . .	. . .	. . .
1986	492	123	246	61.50	214	75	20	15.50	46.50	66.10	. . .	. . .	. . .	. . .
1987	520	130	260	65.00	226	75	20	17.90	53.70	88.10	. . .	. . .	. . .	. . .
1988	540	135	270	67.50	234	75	20	24.80	74.40	72.40	. . .	. . .	. . .	. . .
1989	[q] 560	[q]	[q]	[r] 25.50	156	75	20	[s] 31.90	83.70	40.70	. . .	. . .	. . .	. . .
1990	592	148	296	74.00	175	75	20	28.60	85.80	59.60	. . .	. . .	. . .	. . .
1991	628	157	314	78.50	177	100	20	29.90	95.30	82.10	. . .	. . .	. . .	. . .
1992	652	163	326	81.50	192	100	20	31.80	89.80	129.80	. . .	. . .	. . .	. . .
1993	676	169	338	84.50	221	100	20	36.60	104.40	129.20	. . .	. . .	. . .	. . .
1994	696	174	348	87.00	[t] 245	100	20	41.10	82.50	111.10	. . .	. . .	. . .	. . .
1995	716	179	358	89.50	[t] 261	100	20	46.10	100.10	165.50	. . .	. . .	. . .	. . .
1996	736	184	368	92.00	[t] 289	100	20	42.50	127.30	167.70	. . .	. . .	. . .	. . .
1997	760	190	380	95.00	[t] 311	100	20	43.80	131.40	177.00	. . .	. . .	. . .	. . .
1998	764	191	382	95.50	[t] 309	100	20	43.80	132.00	150.40	. . .	. . .	. . .	. . .
1999	768	192	384	96.00	[t] 309	100	20	45.50	139.10	160.50	. . .	. . .	. . .	. . .
2000	776	194	388	97.00	[t] 301	100	20	45.50	138.30	196.70	. . .	. . .	. . .	. . .
2001	792	198	396	99.00	[t] 300	100	20	50.00	152.00	214.40	. . .	. . .	. . .	. . .
2002	812	203	406	101.50	[t] 319	100	20	54.00	164.60	192.20	. . .	. . .	. . .	. . .
2003	840	210	420	105.00	[t] 316	100	20	58.70	178.70	223.30	. . .	. . .	. . .	. . .
2004	876	219	438	109.50	[t] 343	100	20	66.60	199.80	284.40	[u]	[u]	[u]	[u]
2005	912	228	456	114.00	[t] 375	110	20	78.20	234.60	305.40	[u]	[u]	[u]	[u]
2006	952	238	476	119.00	[t] 393	124	20	88.50	265.30	318.90	250	2,250	[v] 3,600	[w] 32.20
2007	992	248	496	124.00	[t] 410	131	20	[x] 93.50	[y] 280.50	[y] 301.10	265	2,400	[v] 3,850	[w] 27.35

SOURCE: Centers for Medicare & Medicaid Services.

NOTES: The structure of Medicare has become increasingly complex over the years. This table provides a summary of Medicare cost sharing and premium provisions. It should be used as an overview and general guide. It is not intended to explain fully all of the provisions or exclusions of the applicable Medicare laws, regulations, and rulings. Original sources of authority should be researched and utilized.

. . . = not applicable.

a. The deductible and coinsurance amounts begin in January unless otherwise noted. The monthly premium amounts were effective in July through 1983 and in January for 1984 and succeeding years.

Table 2.C1—Medicare cost sharing and premium amounts, 1966–2007—*Continued*

b. Standard premium rate for voluntary enrollment by certain aged and disabled individuals not otherwise entitled to Hospital Insurance (HI). (Most individuals aged 65 and older and many disabled individuals under age 65 are insured for HI benefits without payment of any premium.) In most (but not all) cases, a surcharge applies for those beneficiaries who enroll after their initial enrollment period.

c. Most (but not all) services under Part B are subject to the annual deductible and coinsurance percentages shown. Some noteworthy exceptions are footnoted. Noteworthy exceptions in recent years, as of this writing, include (1) clinical lab tests, home health agency services, and certain prescribed preventive care services, which are not subject to the deductible or coinsurance and for which the beneficiary pays nothing; (2) outpatient psychiatric services, for which the coinsurance is 50 percent; and (3) most services reimbursed under the outpatient hospital prospective payment system, for which the coinsurance percentage varies by service but currently falls in the range of 20 percent to 50 percent. Original sources of authority, such as the laws, regulations, and rulings for Part B, should be consulted if specific details are required.

d. There are substantial premium and cost-sharing subsidies for Part D beneficiaries who meet certain low-income and limited-resources criteria. Subsidy levels vary on the basis of dual-eligibility status (that is, coverage by both Medicaid and Medicare), income level, asset level, and institutionalized/noninstitutionalized status. Premiums and cost-sharing amounts for beneficiaries meeting the criteria may be reduced or waived. (The subsidies are financed by certain payments from the general fund of the U.S. Treasury and from the states.) Original sources of authority, such as the laws, regulations, and rulings for Part D, should be consulted if specific details are required.

e. Under the standard Part D benefit design, there is an initial deductible. After meeting the deductible, the beneficiary pays 25 percent of the remaining costs until the initial coverage limit is reached. The beneficiary is then responsible for all costs until the out-of-pocket threshold is reached. (Included in the total out-of-pocket expenditures are the deductible, the 25 percent of costs that is paid by the beneficiary after the deductible is met until the initial coverage limit is reached, and the 100 percent the beneficiary pays for costs above the initial coverage limit. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exception to this "true out-of-pocket" provision is cost-sharing assistance from the low-income subsidies provided under Part D and from State Pharmacy Assistance programs.) For costs thereafter, there is catastrophic coverage that requires enrollees to pay the greater of 5 percent coinsurance or a small defined copayment amount ($2 in 2006 and $2.15 in 2007 for generic or preferred multisource drugs, and $5.00 in 2006 and $5.35 in 2007 for other drugs). Many Part D plans offer alternative coverage that differs from the standard coverage described above. In fact, the majority of beneficiaries are not enrolled in the standard benefit design but rather in plans with low or no deductibles, flat payments for covered drugs, and, in some cases, partial coverage in the coverage gap. Covered drugs may vary by plan. Original sources of authority, such as the laws, regulations, and rulings for Part D, should be consulted if more specific details are required.

f. Part D base beneficiary premium. The actual Part D premiums paid by individual beneficiaries equal the base beneficiary premiums adjusted by a number of factors. Premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. A surcharge for enrollment after an individual's initial enrollment period may apply. (Late enrollment penalties do not apply to enrollees who have maintained creditable prescription drug coverage.) Enrollment in Part D is voluntary.

g. Standard premium rate for voluntary enrollment in Part B. While this will be the amount paid by most Part B beneficiaries, there are three provisions that can alter the premium rate for certain enrollees. First, in most (but not all) cases, a surcharge applies for those beneficiaries who enroll after their initial enrollment period. Second, beginning in 2007, beneficiaries whose income is above certain thresholds are required to pay an income-related monthly adjustment amount, in addition to their standard monthly premium; see footnote x. Finally, a "hold-harmless" provision, which prohibits increases in the standard Part B premium from exceeding the dollar amount of an individual's Social Security cost-of-living adjustment, lowers the premium rate for certain individuals who have their premiums deducted from their Social Security checks.

h. Beginning in July 1973 for the disabled.

i. Benefit not provided.

j. Professional inpatient services of pathologists and radiologists not subject to deductible or coinsurance, beginning in April 1968.

k. Beginning in April 1968.

l. Home health services not subject to coinsurance, beginning in January 1973.

m. Standard monthly premiums for July and August 1973 were reduced to $5.80 and $6.10, respectively, by the Cost of Living Council.

n. Home health services not subject to deductible, beginning July 1, 1981.

o. Professional inpatient services of pathologists and radiologists not subject to deductible or coinsurance, beginning in April 1968, but only when physician accepts assignment.

p. Effective October 1, 1982, professional inpatient services of pathologists and radiologists are subject to deductible and coinsurance.

q. Unlike all other years, the 1989 deductible was applied on an annual, rather than a benefit period, basis. Once the deductible was paid by the beneficiary, Medicare paid the balance of expenses for covered hospital services, regardless of the number of days of hospitalization (except for psychiatric hospital care, which was still limited by the 190-day lifetime maximum).

r. The coinsurance amount in 1989 was equal to 20 percent of the estimated national average daily cost of covered skilled nursing facility care, rather than 1/8 of the inpatient hospital deductible. The beneficiary paid the coinsurance amount for the first 8 days of care in 1989, rather than for days of care 21 to 100 in a benefit period as in all other years. Skilled nursing facility benefits were available for up to 150 days of care per year in 1989, rather than for up to 100 days of care per benefit period as in all other years.

s. Includes the standard monthly Part B premium and a supplemental monthly flat premium under the Medicare Catastrophic Coverage Act of 1988. Amount shown is for most Part B enrollees. Residents of Puerto Rico and other territories and commonwealths, as well as persons enrolled in Part B only, paid different supplemental flat premiums, resulting in a smaller premium than that shown.

t. A reduced premium is available to individuals aged 65 and older who are not otherwise entitled to HI but who have (or who were married to, widowed, or divorced from a spouse for certain periods of time who has or had) at least 30 quarters of Medicare-covered employment. The reduced premium is $184, $183, $188, $187, $170, $170, $166, $165, $175, $174, $189, $206, $216, and $226, for 1994 to 2007, respectively.

u. A temporary Medicare-endorsed prescription drug discount card program was offered. For eligible beneficiaries voluntarily enrolling and paying up to $30 annually, discounts on certain prescription drugs were available, as specified by card sponsors. Under a Transitional Assistance (TA) provision, drug-card eligible beneficiaries whose incomes did not exceed 135 percent of the federal poverty level and who did not have third-party prescription drug coverage were eligible for (1) financial assistance of up to $600 per year for purchasing prescription drugs and (2) a subsidized enrollment fee for the discount card. Enrollment began May 2004, discount availability began June 2004, and the program phases out during 2006, as full Part D becomes available in January 2006.

v. The 2006 out-of-pocket threshold of $3,600 is equivalent to total covered drug costs of $5,100. The 2007 out-of-pocket threshold of $3,850 is equivalent to total covered drug costs of $5,451.25.

w. See footnote f. As of this writing, it is estimated that the average enrollee premium for basic Part D coverage, which reflects the specific plan-by-plan premiums and the actual number of beneficiaries in each plan, is about $24 in 2006 and will be less than $24 for 2007.

x. See footnote g. The 2007 Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries, according to income level and filing status, are shown in the Medicare section of "Program Descriptions and Legislative History" in this *Supplement*, page 41.

y. Beginning January 2007 for Part B beneficiaries meeting certain income thresholds and thus paying income-related adjustment amounts in addition to their standard Part B premiums (see footnotes g and x), the government amounts are supposed to be reduced accordingly.

CONTACT: Sol Mussey (410) 786-6386.

Table 2.C2—Federal medical assistance percentage and enhanced federal medical assistance percentage, by state or other area, 2005–2007

State or area	Federal medical assistance percentage [a]			Enhanced federal medical assistance percentage [b]		
	2005 [c]	2006 [d]	2007 [e]	2005 [c]	2006 [d]	2007 [e]
Alabama	70.83	69.51	68.85	79.58	78.66	78.20
Alaska	57.58	50.16	51.07	70.31	65.11	65.75
Arizona	67.45	66.98	66.47	77.22	76.89	76.53
Arkansas	74.75	73.77	73.37	82.33	81.64	81.36
California	50.00	50.00	50.00	65.00	65.00	65.00
Colorado	50.00	50.00	50.00	65.00	65.00	65.00
Connecticut	50.00	50.00	50.00	65.00	65.00	65.00
Delaware	50.38	50.09	50.00	65.27	65.06	65.00
District of Columbia	70.00	70.00	70.00	79.00	79.00	79.00
Florida	58.90	58.89	58.76	71.23	71.22	71.13
Georgia	60.44	60.60	61.97	72.31	72.42	73.38
Hawaii	58.47	58.81	57.55	70.93	71.17	70.29
Idaho	70.62	69.91	70.36	79.43	78.94	79.25
Illinois	50.00	50.00	50.00	65.00	65.00	65.00
Indiana	62.78	62.98	62.61	73.95	74.09	73.83
Iowa	63.55	63.61	61.98	74.49	74.53	73.39
Kansas	61.01	60.41	60.25	72.71	72.29	72.18
Kentucky	69.60	69.26	69.58	78.72	78.48	78.71
Louisiana	71.04	69.79	69.69	79.73	78.85	78.78
Maine	64.89	62.90	63.27	75.42	74.03	74.29
Maryland	50.00	50.00	50.00	65.00	65.00	65.00
Massachusetts	50.00	50.00	50.00	65.00	65.00	65.00
Michigan	56.71	56.59	56.38	69.70	69.61	69.47
Minnesota	50.00	50.00	50.00	65.00	65.00	65.00
Mississippi	77.08	76.00	75.89	83.96	83.20	83.12
Missouri	61.15	61.93	61.60	72.81	73.35	73.12
Montana	71.90	70.54	69.11	80.33	79.38	78.38
Nebraska	59.64	59.68	57.93	71.75	71.78	70.55
Nevada	55.90	54.76	53.93	69.13	68.33	67.75
New Hampshire	50.00	50.00	50.00	65.00	65.00	65.00
New Jersey	50.00	50.00	50.00	65.00	65.00	65.00
New Mexico	74.30	71.15	71.93	82.01	79.81	80.35
New York	50.00	50.00	50.00	65.00	65.00	65.00
North Carolina	63.63	63.49	64.52	74.54	74.44	75.16
North Dakota	67.49	65.85	64.72	77.24	76.10	75.30
Ohio	59.68	59.88	59.66	71.78	71.92	71.76
Oklahoma	70.18	67.91	68.14	79.13	77.54	77.70
Oregon	61.12	61.57	61.07	72.78	73.10	72.75
Pennsylvania	53.84	55.05	54.39	67.69	68.54	68.07
Rhode Island	55.38	54.45	52.35	68.77	68.12	66.65
South Carolina	69.89	69.32	69.54	78.92	78.52	78.68
South Dakota	66.03	65.07	62.92	76.22	75.55	74.04
Tennessee	64.81	63.99	63.65	75.37	74.79	74.56
Texas	60.87	60.66	60.78	72.61	72.46	72.55
Utah	72.14	70.76	70.14	80.50	79.53	79.10
Vermont	60.11	58.49	58.93	72.08	70.94	71.25
Virginia	50.00	50.00	50.00	65.00	65.00	65.00
Washington	50.00	50.00	50.12	65.00	65.00	65.08
West Virginia	74.65	72.99	72.82	82.26	81.09	80.97
Wisconsin	58.31	57.65	57.47	70.82	70.36	70.23
Wyoming	57.90	54.23	52.91	70.53	67.96	67.04

(Continued)

Table 2.C2—Federal medical assistance percentage and enhanced federal medical assistance percentage, by state or other area, 2005–2007—*Continued*

State or area	Federal medical assistance percentage [a]			Enhanced federal medical assistance percentage [b]		
	2005 [c]	2006 [d]	2007 [e]	2005 [c]	2006 [d]	2007 [e]
Outlying areas						
American Samoa	[f] 50.00	[f] 50.00	[f] 50.00	[f] 65.00	[f] 65.00	[f] 65.00
Guam	[f] 50.00	[f] 50.00	[f] 50.00	[f] 65.00	[f] 65.00	[f] 65.00
Northern Mariana Islands	[f] 50.00	[f] 50.00	[f] 50.00	[f] 65.00	[f] 65.00	[f] 65.00
Puerto Rico	[f] 50.00	[f] 50.00	[f] 50.00	[f] 65.00	[f] 65.00	[f] 65.00
Virgin Islands	[f] 50.00	[f] 50.00	[f] 50.00	[f] 65.00	[f] 65.00	[f] 65.00

SOURCE: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

a. Section 1905(b) of the Social Security Act (the Act) specifies the method to be used to compute the federal medical assistance percentage. From this section the following formula is derived: N = 3-year average national per capita personal income; S = 3-year average state per capita personal income. Federal medical assistance percentage: State share = $(S^2/N^2) \times 45$ or $(45/N^2) \times S^2$; Federal share = 100 – state share with 50–83 percent limits.

b. This is the Title XXI enhanced federal medical assistance percentage rate specified in section 2105(b) of the Act. The enhanced federal medical assistance percentage is limited to no more than 85 percent.

c. Effective October 1, 2004, through September 30, 2005.

d. Effective October 1, 2005, through September 30, 2006.

e. Effective October 1, 2006, through September 30, 2007.

f. For purposes of section 1118 of the Social Security Act, the federal medical assistance percentage used under titles I, X, XIV, and XVI, and part A of title IV will be 75 percent.

CONTACT: Adelle Simmons (202) 401-6119.