# MEDICARE

## A PRIMER

2009

THE HENRY J. KAISER FAMILY FOUNDATION

# Medicare: A Primer

## January 2009

# INTRODUCTION

Established in 1965, Medicare is a social insurance program, like Social Security, that provides health and financial security for individuals age 65 and older and for younger people with permanent disabilities. Prior to 1965, roughly half of all seniors lacked medical insurance; today, virtually all seniors have health insurance under Medicare. Medicare provides health insurance coverage to 45 million people – approximately 38 million people age 65 and older and another 7 million people with permanent disabilities who are under age 65. The program helps to pay for many important health care services, including hospitalizations, physician services, and prescription drugs. Individuals contribute payroll taxes to Medicare throughout their working lives and generally become eligible for Medicare when they reach age 65, regardless of their income or health status.

Comprising an estimated 13 percent of the federal budget and 19 percent of total national health expenditures in 2009, Medicare is often a significant part of discussions about how to moderate the growth of both federal spending and health care spending in the U.S.[1] With the dual challenges of providing needed and increasingly expensive medical care to an aging population and keeping the program financially secure for the future, discussions about Medicare are likely to remain prominent on the nation's agenda in the years ahead.

[1] The Medicare share of the federal budget is from Office of Management and Budget (OMB), FY 2009 Mid-Session Review, Budget of the U.S. Government, July 2008. The Medicare share of national health expenditures is from Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT), National Health Expenditure Projections 2007-2017, February 2008.

# MEDICARE: A PRIMER

# WHAT IS MEDICARE?

**Medicare is the nation's health insurance program for Americans age 65 and older, and for younger adults with permanent disabilities.**

Established in 1965 under Title XVIII of the Social Security Act, Medicare was initially established to provide health insurance to individuals age 65 and older, regardless of income or medical history. The program was expanded in 1972 to include individuals under age 65 with permanent disabilities and people suffering from end-stage renal disease (ESRD). In 2001, Medicare eligibility expanded further to cover people with amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease). As of 2008, 45 million people rely on Medicare for their health insurance coverage: 38 million people age 65 and over and 7 million people under age 65 with disabilities.

**Medicare consists of four parts, each covering different benefits.**

**PART A,** also known as the Hospital Insurance (HI) program, covers inpatient hospital services, skilled nursing facility, home health, and hospice care. Part A is funded by a dedicated tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each). In 2008, Part A accounted for approximately 40 percent of Medicare benefit spending.[2] An estimated 44.5 million people were enrolled in Part A in 2008.

**PART B,** the Supplementary Medical Insurance (SMI) program, helps pay for physician, outpatient, home health, and preventive services. Part B is funded by general revenues and beneficiary premiums ($96.40 per month in 2009). In 2008, Part B accounted for 27 percent of benefit spending.[3] Medicare beneficiaries who have higher annual incomes (over $85,000 per individual; $170,000 per couple in 2009) pay a higher, income-related monthly Part B premium, ranging from $134.90 to $308.30 in 2009 depending on income. Part B is voluntary; some beneficiaries (such as the working aged who receive employer-sponsored health care) delay enrollment until they retire. An estimated 41.6 million people were enrolled in Part B in 2008.

**PART C**, also known as the Medicare Advantage program, allows beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan. These plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in most cases, prescription drug benefits. Part C is not separately financed, and accounted for 21 percent of benefit spending in 2008. As of October 2008, 10.2 million beneficiaries are enrolled in Medicare Advantage plans.

**PART D** is the outpatient prescription drug benefit, delivered through private plans that contract with Medicare, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. Authorized by the Medicare Modernization Act of 2003 (MMA) and launched in 2006, Part D plans are required to provide a "standard" benefit (or one that is equivalent) and may provide enhanced benefits. Individuals with modest income and assets are eligible for additional assistance with premiums and cost-sharing amounts. Part D is funded by general revenues, beneficiary premiums, and state payments, and accounted for 11 percent of benefit spending in 2008. As of October 2008, nearly 26 million beneficiaries are enrolled in a Part D plan, the majority of whom (17.4 million) are enrolled in stand-alone PDPs.

[2] Congressional Budget Office (CBO), Medicare Baseline, March 2008.
[3] CBO, Medicare Baseline, March 2008.

# WHO IS ELIGIBLE FOR MEDICARE?

**Most people age 65 and older are automatically entitled to Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years (40 quarters).**

Individuals age 65 and over qualify for Medicare if they are U.S. citizens or permanent legal residents. Individuals do not need to meet an income or asset test to qualify for Medicare. Adults under age 65 with permanent disabilities who receive Social Security Disability Income (SSDI) payments for 24 months are eligible for Medicare before they turn 65, even if they have not made payroll tax contributions for 40 quarters. People with end-stage renal disease (ESRD) or Lou Gehrig's disease are eligible for Medicare benefits as soon as they begin receiving SSDI payments, without having to wait 24 months. Individuals who are entitled to Part A do not pay premiums for covered services. Individuals age 65 and over who are not entitled to Part A, such as those who did not pay enough Medicare taxes during their working years, can pay a monthly premium to enroll.

**Individuals entitled to Part A and others age 65 and older may elect to enroll in Part B.**

Part B is voluntary, but about 95 percent of beneficiaries with Part A are also enrolled in Part B. For most individuals who become entitled to Part A, enrollment in Part B is automatic unless the individual declines enrollment. Individuals age 65 and older who are not entitled to Part A may enroll in Part B. With the exception of the working aged who may delay enrollment because they receive employment-based coverage, those who do not sign up for Part B when they are first eligible typically pay a penalty for late enrollment, in addition to the regular monthly premium, for the duration of their enrollment in Part B.

**Individuals are eligible for Part C, or Medicare Advantage, if they are entitled to Part A and enrolled in Part B**.

Beneficiaries may generally elect to enroll in a Medicare Advantage plan on an annual basis between November 15 and March 31 of the following year.

**Individuals are eligible for prescription drug coverage under a Part D plan if they are entitled to benefits under Part A and/or enrolled in Part B.**

To get Part D benefits, beneficiaries may enroll in a stand-alone prescription drug plan (PDP) or Medicare Advantage prescription drug plan. The enrollment period for stand-alone prescription drug plans runs from November 15 to December 31 of each year. Individuals can enroll in a Medicare Advantage drug plan from November 15 through March 31 of the following year. Similar to Part B, there is a permanent premium penalty for late enrollment for individuals who go for an extended period of time without drug coverage that is at least comparable to the Part D standard benefit (known as "creditable coverage").

# WHAT ARE THE CHARACTERISTICS OF PEOPLE WITH MEDICARE?

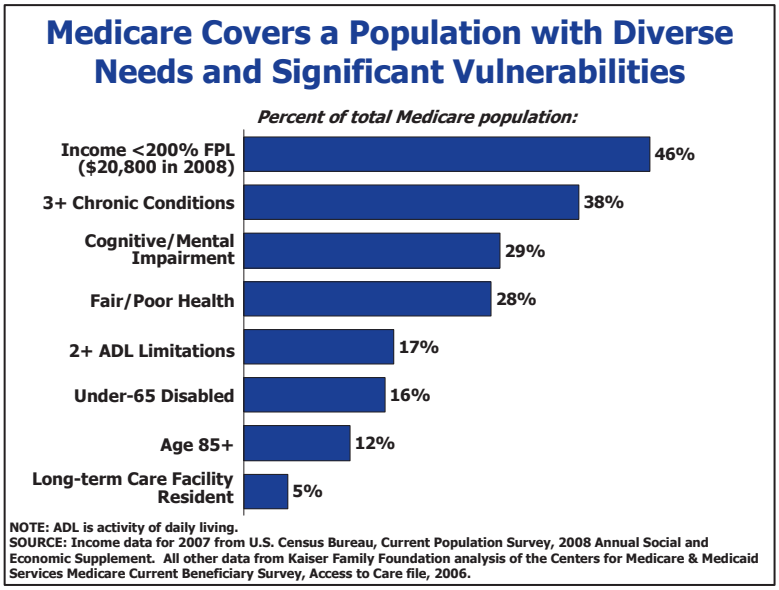
**Medicare covers a population with diverse needs and circumstances. While many beneficiaries enjoy good health, a quarter or more have serious health problems and live with multiple chronic conditions, including cognitive and functional impairments.**

**Many Medicare beneficiaries live on modest incomes and most depend on Social Security as their primary source of income.**

Almost half of all Medicare beneficiaries (46 percent) have an income below 200 percent of poverty ($20,800/individual and $28,000/couple in 2008), and 16 percent have an income below 100 percent of the poverty level.

**There is a high prevalence of chronic conditions, cognitive impairments, and functional limitations among the Medicare population.**

More than one-third (38 percent) of all Medicare beneficiaries lives with three or more chronic conditions. Among the most common conditions are hypertension and arthritis.




More than a quarter (29 percent) of all beneficiaries have a cognitive or mental impairment that limits their ability to function independently.

Approximately one in six (17 percent) beneficiaries have multiple functional limitations, as defined as two or more limitations in activities of daily living, such as eating or bathing.

**Although the majority of the Medicare population is age 65 or over, 16 percent are under age 65 and permanently disabled.**

These individuals tend to have lower incomes than other beneficiaries. About 40 percent are dually eligible for both Medicare and Medicaid. Because of their disabilities, they tend to have relatively high rates of health problems, including functional limitations and cognitive impairments.

**Most beneficiaries live at home, but 5 percent live in a long-term care setting.**

Five percent of Medicare beneficiaries (2.2 million) live in a long-term care setting, such as a nursing home or assisted living facility, but a larger share of beneficiaries who are age 85 or older (19 percent).[4] Two-thirds of beneficiaries living in long-term care settings are women.

[4] Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services (CMS) Medicare Current Beneficiary Survey Cost and Use file, 2005.

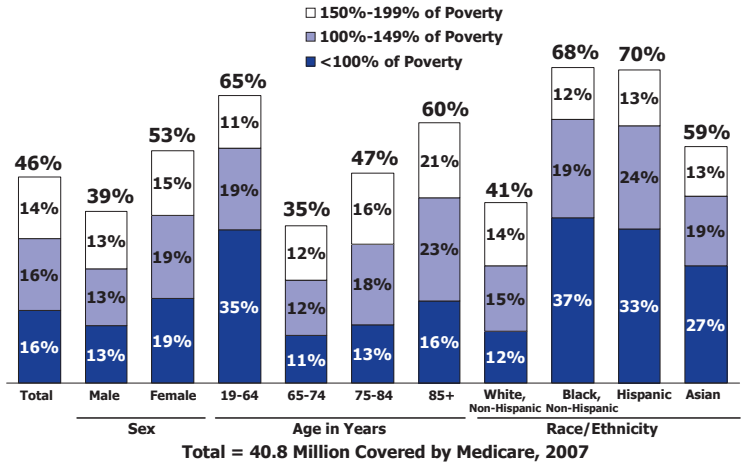
**Nearly half of all Medicare beneficiaries have incomes below 200 percent of the federal poverty level (FPL), but poverty rates are especially high among those in racial/ethnic minority groups, women, people under-65 with disabilities, and those ages 85 and older.**

More than two-thirds of African American and Hispanic beneficiaries live on an income below twice the poverty level, and more than one-third of these beneficiaries have incomes below the poverty level. By contrast, 41 percent of White beneficiaries have an income below twice the poverty level and 12 percent have incomes below poverty.

Nearly two-thirds of all Medicare beneficiaries with disabilities under the age of 65 live on income below twice the poverty level, and more than a third live in poverty. Among people on Medicare age 65 and older, poverty rates increase with age. Six in ten beneficiaries age 85 and older live on income below twice the poverty level.

Poverty rates are substantially higher among women on Medicare than men. More than half of all female Medicare beneficiaries live on income below twice the poverty level, substantially higher than the rate for men on Medicare.

## Poverty Among the Medicare Population, 2007




**Total = 40.8 Million Covered by Medicare, 2007**

**NOTE: In 2007, the federal poverty level was $10,210 for an individual and $13,690 for a couple.**
**SOURCE: Kaiser Family Foundation and Urban Institute analysis of the U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement.**

# WHAT DOES MEDICARE COVER AND HOW MUCH DO BENEFICIARIES PAY FOR BENEFITS?

**Medicare provides coverage of basic health services including care in hospitals and other settings, physician services, diagnostic tests, preventive services, and an outpatient prescription drug benefit. Beneficiaries generally pay varying deductibles and coinsurance amounts that are indexed to increase annually.** ***(See page 18 for more detail about Medicare benefits and cost-sharing requirements for 2009.)***

**PART A** helps pay for inpatient care provided to beneficiaries in hospitals and short-term stays in skilled nursing facilities, and also covers hospice care, post-acute home health care, and pints of blood received at a hospital or skilled nursing facility.

- Most beneficiaries do not pay a monthly premium for Part A services, but pay a deductible before Medicare coverage begins. In 2009, the Part A deductible for each "spell of illness" is $1,068 for an inpatient hospital stay.

- Beneficiaries typically pay a coinsurance for benefits covered under Part A, including extended inpatient stays in a hospital ($267 per day for days 61-90) or skilled nursing facility ($133.50 per day for days 21-100). There is no copayment for home health visits.

**PART B** helps pay for outpatient services, such as outpatient hospital care, physician visits, and other medical services, including preventive services such as mammography and colorectal screening. Part B also covers ambulance services, clinical laboratory services, durable medical equipment (such as wheelchairs and oxygen), kidney supplies and services, outpatient mental health care, and diagnostic tests, such as x-rays and magnetic resonance imaging.

- Beneficiaries enrolled in Part B are generally required to pay a monthly premium ($96.40 in 2009). Some beneficiaries with low incomes and assets are not required to pay the monthly Part B premium (or cost-sharing requirements), because they qualify for additional assistance under the Medicare Savings Programs (MSPs) *(see page 12 for additional information on MSPs).*

- Beneficiaries with a higher annual income – greater than $85,000 for an individual or $170,000 for a couple in 2009 – pay a higher, income-related monthly Part B premium, ranging from $134.90 to $308.30 in 2009. The income thresholds are indexed annually to limit the number of beneficiaries who would be subject to the higher premium in subsequent years.

- Part B benefits are subject to an annual deductible ($135 in 2009).

- Most Part B services are subject to a coinsurance of 20 percent.

**PART C** (Medicare Advantage) plans generally pay for all benefits covered under Medicare Part A, Part B, and Part D. Private fee-for-service plans are not required to cover prescription drugs. *(See pages 9-10 for additional information about Medicare Advantage.)*

**PART D** helps pay for outpatient prescription drug coverage through private health plans. Plans are required to provide a "standard" benefit or one that is actuarially equivalent, and may offer more generous benefits. In general, individuals who sign up for a Part D plan pay a monthly premium, along with cost-sharing amounts for each prescription. *(See pages 7-8 for additional information about Part D.)*

**Despite the important protections provided by Medicare, there are significant gaps in Medicare's benefit package.**

In addition to the fairly high cost-sharing requirements for covered benefits, Medicare does not pay for many relatively expensive services and supplies that are often needed by the elderly and younger beneficiaries with disabilities.

Most notably, Medicare does not pay for custodial long-term care services either at home or in an institution, such as a nursing home or assisted living facility. In addition, Medicare does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids. Although many beneficiaries have supplemental insurance to help cover these expenses, they may face significant out-of-pocket costs to meet their medical and long-term care needs. Unlike typical large employer plans, Medicare does not have a stop-loss benefit that limits annual out-of-pocket spending.

# WHAT IS THE PART D DRUG BENEFIT AND HOW MANY BENEFICIARIES HAVE PART D COVERAGE?

**Medicare beneficiaries have access to outpatient prescription drug coverage offered by private health plans, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs.**

In 2009, 1,689 stand-alone prescription drug plans (PDPs) are available nationwide, up from 1,429 in 2006 (excluding the territories). Beneficiaries in most states have a choice of at least 50 stand-alone PDPs and multiple MA-PD plans.

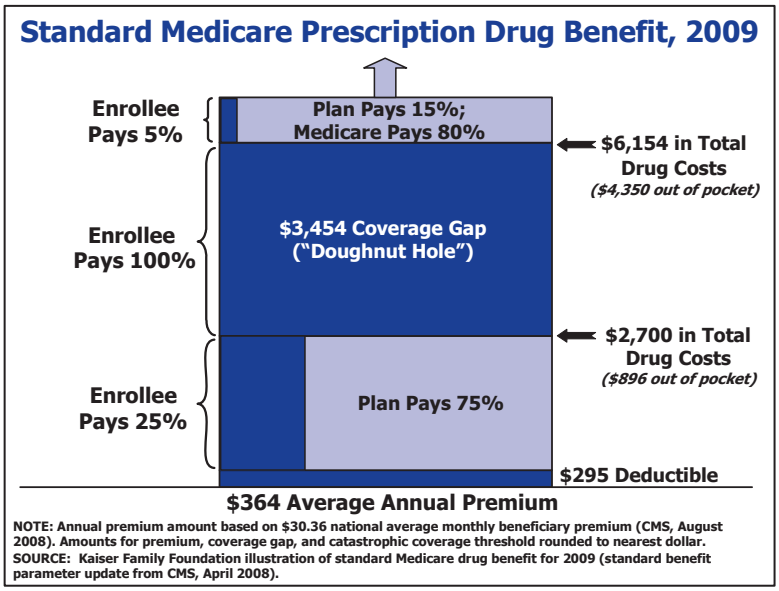
**Part D plans are required to offer either the standard benefit that is defined in law, or an alternative that is equal in value ("actuarially equivalent"). Plans can also offer enhanced benefits.**

The standard benefit in 2009 has a $295 deductible and 25 percent coinsurance up to an initial coverage limit of $2,700 in total drug costs, followed by a coverage gap (the so-called "doughnut hole").

Enrollees with at least $2,700 in total costs pay 100 percent of their drug costs until they have spent $4,350 out of pocket (excluding premiums). At that point, the individual pays 5 percent of the drug cost or a copayment ($2.40/generic or $6.00/brand for each prescription) for the rest of the year.

The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.

In 2009, only 10 percent of PDPs offer the standard benefit, most charge copayments instead of 25 percent coinsurance, and 55 percent do *not* have a deductible, while 34 percent charge the full $295 deductible amount. Plans vary widely in terms of formularies (the list of covered drugs), the placement of drugs on formulary tiers, cost-sharing requirements, and utilization management tools (such as prior authorization requirements).




**Most Part D plans have a coverage gap.**

In 2009, 75 percent of PDPs offer no gap coverage, while for the 25 percent of PDPs offering gap coverage, this coverage is limited primarily to generic drugs only. In 2009, less than 1 percent of PDPs (3 plans in Florida, Michigan, and Wisconsin) cover some brand-name drugs in the gap in addition to generic drugs. An estimated 3.4 million Medicare beneficiaries (14 percent of all Part D enrollees) reached the coverage gap in 2007 and faced the full cost of their prescriptions.[5]

[5] Hoadley J, Hargrave E, Cubanski J, and Neuman P, "The Medicare Part D Coverage Gap: Costs and Consequences in 2007," Kaiser Family Foundation, August 2008.

**Monthly Part D premiums are not uniform nationwide, but vary across plans and regions.**

In 2009, the national average monthly Part D premium is $30.36 (unweighted by enrollment), but actual premiums vary across plans and regions, ranging from a low of $10.30 for a standard benefit PDP in New Mexico to a high of $136.80 for a PDP with enhanced benefits in New York.[6]

**Individuals with modest incomes and assets may qualify for additional assistance with Part D premiums and cost-sharing requirements.**

Beneficiaries with income below 150 percent of poverty ($15,600 for an individual; $21,000 for a couple in 2008) and limited assets ($11,990/individual; $23,970/couple) are eligible for the low-income subsidy (LIS), or "extra help", which can increase beneficiaries' cost savings by paying for all or some of the Part D monthly premium, annual deductible, and drug co-payments.

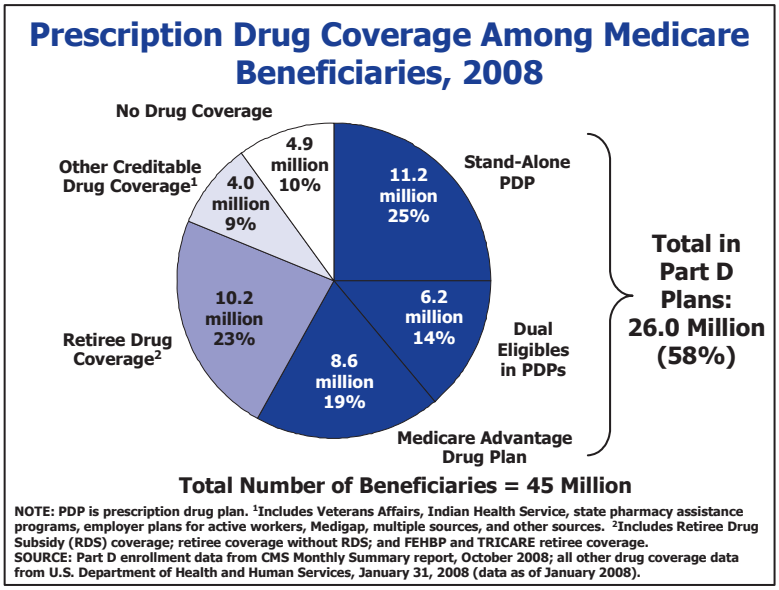
As of January 2008, the Centers for Medicare & Medicaid Services (CMS) estimates that of the 12.5 million beneficiaries potentially eligible for low-income subsidies, 2.6 million beneficiaries were not yet receiving them.[7]

**Approximately 90 percent of all Medicare beneficiaries have "creditable" prescription drug coverage.**

Nearly 26 million Medicare beneficiaries are enrolled in a Part D plan. Of this total, two-thirds (67 percent) are enrolled in stand-alone prescription drug plans. This includes more than 6 million dual eligibles, many of whom were automatically enrolled in stand-alone drug plans.

Almost a quarter of all Medicare beneficiaries (10.2 million) continue to receive prescription drug coverage from a creditable employer or union plan.

As of January 2008, approximately 1 in 10 beneficiaries lack a known source of creditable drug coverage.




[6] The national average monthly premium amount is from CMS, "Release of the 2009 Part D National Average Monthly Bid Amount, the Medicare Part D Base Beneficiary Premium, the Part D Regional Low-Income Premium Subsidy Amounts, and the Medicare Advantage Regional PPO Benchmarks," August 14, 2008.

[7] U.S. Department of Health and Human Services (DHHS), "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop," Press Release, January 31, 2008.

# WHAT IS MEDICARE ADVANTAGE?

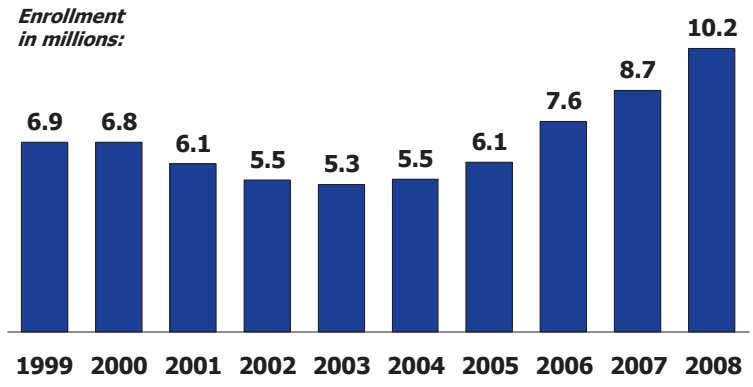
**Medicare Advantage (MA), also known as Medicare Part C, is a program that allows beneficiaries to enroll in private health plans to receive Medicare-covered benefits.**

Private plans, such as health maintenance organizations (HMOs), have been an option under Medicare since the 1970s. In addition to HMOs, Medicare now contracts with a variety of other types of private health plans, including preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, high deductible plans linked to medical savings accounts (MSAs), and special needs plans (SNPs) for individuals dually eligible for Medicare and Medicaid, the institutionalized, or those with certain severe and disabling conditions.

**In recent years, the number of Medicare Advantage plans and beneficiaries enrolled in these plans has increased rapidly.**

Private plans are playing a larger role in Medicare through a revitalization of the Medicare Advantage program attributed to increased payments to plans and new marketing and outreach opportunities associated with the Medicare drug benefit. After a steep decline between 1999 and 2003, the program has recently seen a rapid increase in both the number of plans and enrollees. The number of Medicare enrollees in private health plans increased from 5.3 million in 2003 to 10.2 million as of October 2008. Between 2005 and 2008, the number of enrollees in PFFS plans increased dramatically, from about 209,000 enrollees to 2.3 million enrollees.

**Total Medicare Private Health Plan Enrollment, 1999-2008**




NOTE: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS plans, Cost contracts, Demonstrations, HCPP, and PACE contracts.
SOURCE: Mathematica Policy Research, Inc. analysis of CMS Monthly Summary Report data from December (1999-2007) and October (2008).

**Enrollment rates in Medicare Advantage plans vary widely across states.**

In 2008, less than 5 percent of beneficiaries in 3 states (Alaska, Delaware, and Vermont) were enrolled in Medicare Advantage plans while at least 30 percent of beneficiaries in 9 states (Arizona, California, Colorado, Hawaii, Minnesota, Nevada, Oregon, Pennsylvania, and Rhode Island) were in such plans. Nationwide, half of all Medicare Advantage enrollees lived in 6 states (California, Florida, New York, Ohio, Pennsylvania, and Texas) in 2008.

**Medicare Advantage plans generally provide all benefits covered under traditional Medicare, but many plans offer additional benefits.**

Medicare Advantage plans receive payments from the federal government to provide benefits to enrollees, and plans are required to use any savings between the payments they receive and their costs to reduce enrollee premiums or improve benefits offered. Plans may also offer supplemental benefits, for which they are permitted to charge enrollees a supplemental premium. Examples of these benefits include vision, hearing, preventive dental care, podiatry, and chiropractic services.

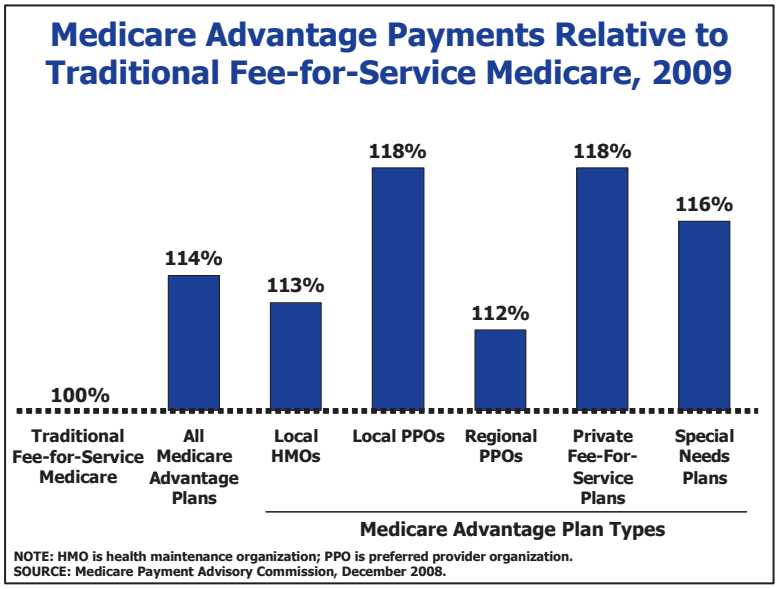
**The majority of Medicare Advantage plans provide prescription drug coverage.**

Medicare Advantage plan sponsors are generally required to offer at least one plan with basic drug coverage, and in 2008 most Medicare Advantage plans offered drug coverage. Private fee-for-service plans are not required to provide drug coverage; in 2008, about 60 percent of PFFS plans elected to offer it. The Medicare Medical Savings Account plans are not permitted to offer prescription drug coverage. About half of all Medicare Advantage drug plans offer some coverage in the coverage gap, mainly for generic drugs only; just one percent of all Medicare Advantage drug plans cover all brand-name and generic drugs in the coverage gap.

**A recent analysis shows that Medicare pays private plans more per enrollee than average costs would be in the Medicare fee-for-service program.**

An analysis by the Medicare Payment Advisory Commission (MedPAC) found that Medicare payments to private health plans on behalf of enrollees in 2009 average 114 percent of Medicare fee-for-service costs for the counties where MA enrollees reside.[8] PFFS plans were paid 118 percent of traditional Medicare fee-for service costs, before adjusting for enrollee risk.

Recently-passed legislation, the Medicare Improvements for Patients and Providers Act of 2008, adjusted future payments to Medicare Advantage plans, but did not fully eliminate the disparity in payment levels between Medicare Advantage and fee-for-service Medicare.

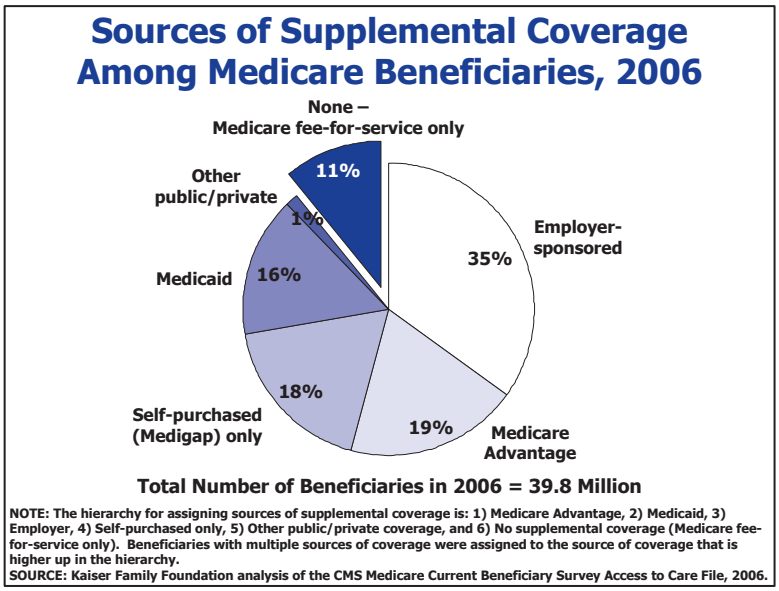



[8] Medicare Payment Advisory Commission (MedPAC), "Medicare Advantage Program," Presentation at the MedPAC Public Meeting, December 5, 2008.

# WHAT TYPES OF SUPPLEMENTAL INSURANCE DO BENEFICIARIES HAVE?

**Many Medicare beneficiaries have some type of supplemental insurance coverage to help fill the gaps in Medicare's benefit package and help with Medicare's cost-sharing requirements.**

**Employer and union-sponsored plans are a leading source of supplemental coverage, providing health benefits to about one in three Medicare beneficiaries.**




In 2006, 35 percent of Medicare beneficiaries had coverage from an employer-sponsored health plan. The vast majority of these beneficiaries received supplemental coverage as part of a retiree health benefits plan. For retirees on Medicare, employer plans remain an important source of health benefits, including prescription drug coverage. Employer plans also often provide additional benefits, including limits on retirees' out-of-pocket health expenses. For an estimated 1.2 million Medicare beneficiaries who are working, employer plans are their primary source of health insurance coverage.[9] For these individuals, Medicare is the secondary payer.

According to the government, in early 2008 an estimated 10.2 million Medicare beneficiaries received prescription drug benefits under an employer or union-sponsored retiree health plan, including FEHB for federal retirees and TRICARE for military retirees.[10] However, the availability of retiree health benefits is on the decline. The share of large firms offering retiree health benefits has dropped by more than half over the past two decades, from 66 percent in 1988 to 31 percent in 2008.[11]

**Medicare Advantage plans are a source of supplemental coverage for people on Medicare.**

Enrollment in private Medicare Advantage health plans has been increasing in recent years. In 2006, 19 percent of Medicare beneficiaries (about 8 million people) were enrolled in a Medicare Advantage plan, but by October 2008, Medicare Advantage enrollment had increased to more than 10 million.[12] Most Medicare Advantage plan enrollees (84 percent) receive prescription drug coverage through their plan. Many receive additional benefits and face lower cost-sharing requirements than they would under traditional Medicare.

[9] DHHS, January 2008.
[10] DHHS, January 2008.
[11] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.
[12] CMS Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations Monthly Summary Report, October 2008.

**Medigap policies – also called Medicare supplements – are sold by private insurance companies and help cover Medicare's cost-sharing requirements and fill gaps in the benefit package.**

Medigap policies assist beneficiaries with their coinsurance, copayments, and deductibles for Medicare-covered services. In 2006, nearly 20 percent of all Medicare beneficiaries had an individually-purchased Medicare supplemental insurance policy.[13] Prior to implementation of the Medicare drug benefit in 2006, Medigap insurers sold policies that helped pay for outpatient prescription drugs. Beneficiaries may renew Medigap policies offering prescription drug coverage if they were purchased prior to 2006, although that coverage is not comparable to the standard Part D drug benefit and insurers are now prohibited from issuing new Medigap policies with prescription drug coverage.

**Medicaid, the federal-state program that provides health and long-term care coverage to low-income Americans, is a source of supplemental coverage for nearly 8 million Medicare beneficiaries with low incomes and modest assets in 2008. These beneficiaries are known as *dual eligibles* because they are dually eligible for Medicare and Medicaid.**

Medicaid helps to make Medicare affordable for low-income beneficiaries, given gaps in the benefit package, premiums, deductibles and other cost-sharing requirements. Most dual eligibles—6.2 million in 2008—qualify for full Medicaid benefits, including long-term care and dental services.[14] Dual eligibles also get help with Medicare's premiums and cost-sharing requirements, and receive subsidies that help pay for drug coverage under Medicare Part D plans.

Some dual eligibles—1.7 million in 2008—do not qualify for full Medicaid benefits, but get help with Medicare premiums and some cost-sharing requirements through the Medicare Savings Programs (MSP), administered under Medicaid.[15] Eligibility for this assistance is based on a beneficiary's income and resources.

**Medicaid and Medicare Savings Programs Eligibility Pathways and Benefits for Medicare Beneficiaries**

| Pathway | Income Eligibility Levels[1] (individual/couple) | Asset Limit[2] (individual/couple) | Covered Costs and Services |
|---|---|---|---|
| Full Medicaid | <74% of poverty (SSI income eligibility; varies by state) | $2,000/ $3,000 (varies by state) | Medicaid benefits, Medicare Part A and Part B premiums and cost-sharing |
| Qualified Medicare Beneficiary (QMB) | <100% of poverty ($10,400/$14,000) | $4,000/ $6,000 | Medicare Part B premiums and cost-sharing |
| Specified Low-Income Medicare Beneficiary (SLMB) | 100%-120% of poverty ($12,480/$16,800) | $4,000/ $6,000 | Medicare Part B premiums |
| Qualified Individual (QI) | 120%-135% of poverty ($14,040/$18,900) | $4,000/ $6,000 | Medicare Part B premiums |
| Qualified Disabled and Working Individual (QDWI) | <200% of poverty ($20,800/$28,000) | $4,000/ $6,000 | Medicare Part A premiums |

NOTE: [1]Applicants are allowed a $20 disregard from any income before their income is measured against the poverty levels. [2]Beginning in 2010, asset limits each year for QMB, SLMB, and QI will conform to amount for Part D low-income subsidy eligibility. SSI is Supplemental Security Income.

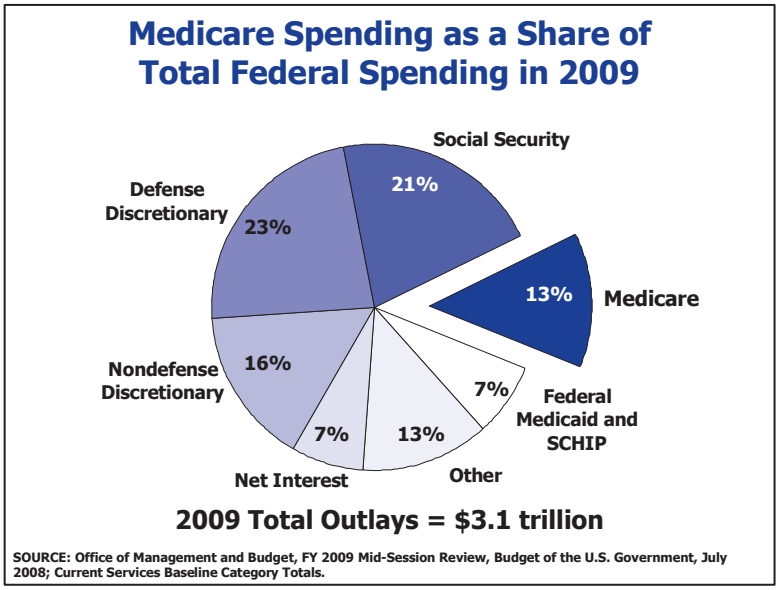
**Another 1.6 million beneficiaries receive supplemental assistance (including prescription drug benefits) through the Veterans Administration and other government programs.[16]**

[13] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care file, 2006.
[14] DHHS, January 2008.
[15] DHHS, January 2008.
[16] DHHS, January 2008.

# HOW MUCH DOES MEDICARE COST AND HOW IS THE MONEY SPENT?

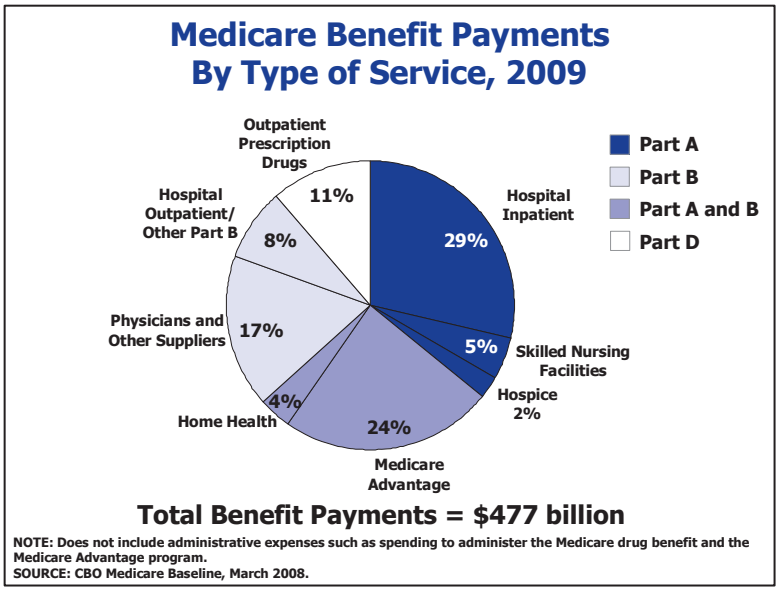
**Spending on Medicare is estimated to account for 13 percent of total federal spending in 2009.**

Medicare represents a large share of the federal budget. Federal spending for fiscal year 2009 is expected to total slightly more than $3 trillion, with spending on Medicare comprising 13 percent of that amount. Of the three main entitlement programs—Social Security, Medicare, and Medicaid—Medicare is second largest in terms of the share of federal spending on each program. Social Security is largest, at 21 percent of federal spending in 2009. Federal spending on Medicaid and SCHIP (State Children's Health Insurance Program) represents 7 percent of total spending.




**Medicare benefit payments are estimated to total $477 billion in 2009.**

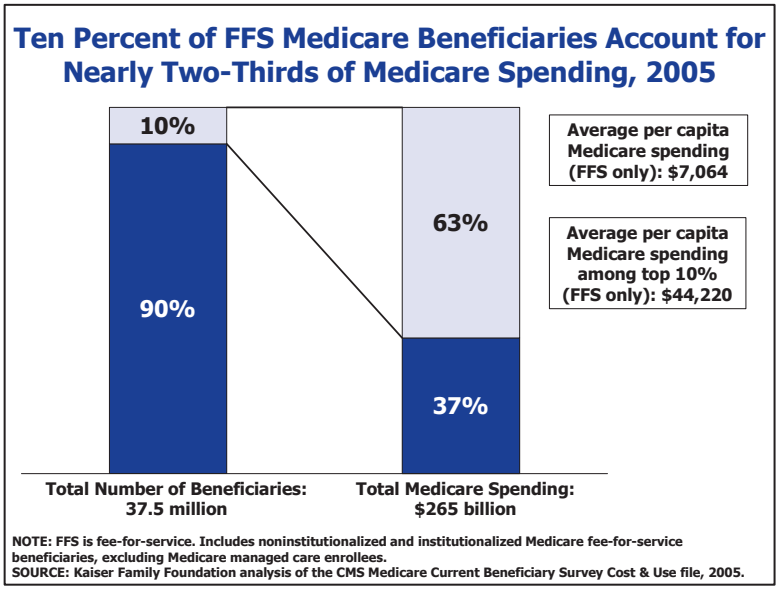
Inpatient hospital services comprise the largest share of Medicare benefit payments (29 percent), followed by payments to Medicare Advantage plans (24 percent), and physician and other outpatient services (17 percent). Spending on the Part D prescription drug benefit accounts for 11 percent of total benefit payments in 2009. CBO projects that by 2018, Medicare Advantage payments will account for 25 percent of Medicare benefit payments and prescription drugs another 16 percent of Medicare benefit payments.[17]




[17] CBO, Medicare Baseline, March 2008.

**Medicare spending is highly concentrated among a small share of beneficiaries, and varies by eligibility category.**

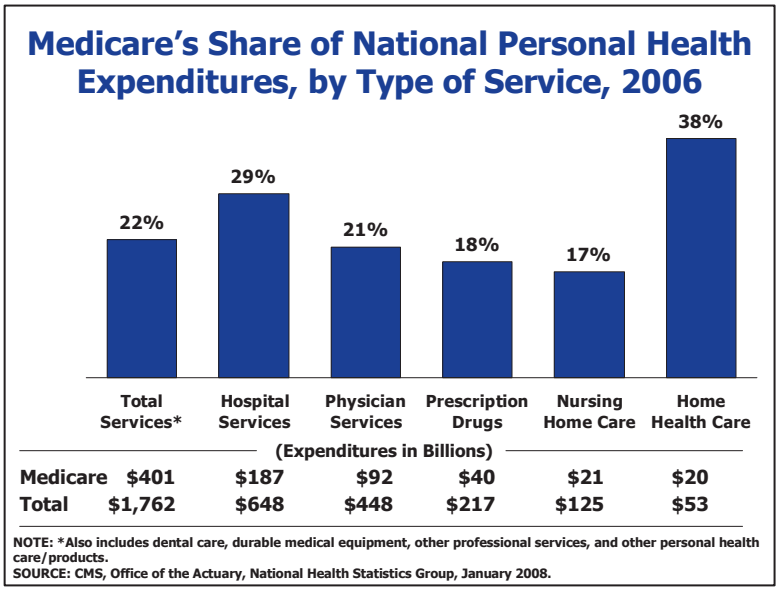
A small share of Medicare beneficiaries accounts for a majority of Medicare spending. Ten percent of beneficiaries in the fee-for-service program accounted for nearly two-thirds of Medicare spending in 2005. At the other end of the spectrum, 28 percent of all fee-for-service beneficiaries had total spending less than $1,000, accounting for just 2 percent of total expenditures, and 14 percent of beneficiaries incurred no expenditures at all.[18]




In 2005, Medicare spending for each fee-for-service beneficiary averaged $7,064. Per capita payments were higher for people age 65 or older ($6,740) than for beneficiaries under age 65 with disabilities ($5,970). Per capita spending was highest for those beneficiaries with ESRD – $52,379 on average in 2005 – who comprise less than one percent of the total Medicare population.[19]

**Medicare spending accounted for more than one-fifth of the $1.8 trillion in personal health care expenditures in the U.S in 2006.**

Medicare's share of national personal health care expenditures varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2006, Medicare paid for 38 percent of home health care spending, 29 percent of all hospital spending, and 18 percent of prescription drug costs. This represents a significant increase from just 2 percent of national expenditures for prescription drugs in 2005, the year before the Part D drug benefit went into effect.

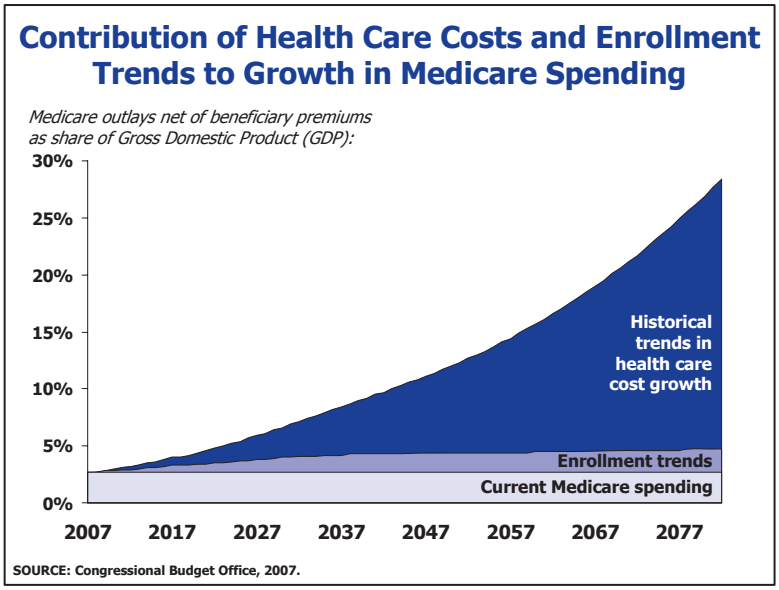



[18] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2005.
[19] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2005.

**Medicare benefit spending is projected to nearly double from $477 billion in 2009 to $871 billion in 2018, according to CBO.**

The annual growth in Medicare spending is influenced by factors that affect health spending generally, including increasing volume and utilization of services and higher prices for health care services. Although Medicare spending increases each year, the average per capita spending growth rate between 1970 and 2006 was slightly lower for Medicare (8.7 percent) than for private health insurance (9.7 percent) for common benefits (excluding prescription drugs).[20]

The Congressional Budget Office has estimated that a larger share of future growth in Medicare spending as a share of the Gross Domestic Product will result from growth in health care costs rather than from growth in enrollment.




[20] CMS, OACT, National Health Statistics Group, 2007.

# HOW IS MEDICARE FINANCED AND WHAT ARE MEDICARE'S FUTURE FINANCING CHALLENGES?

**Funding for Medicare comes primarily from payroll tax revenues, general revenues, and premiums paid by beneficiaries.**

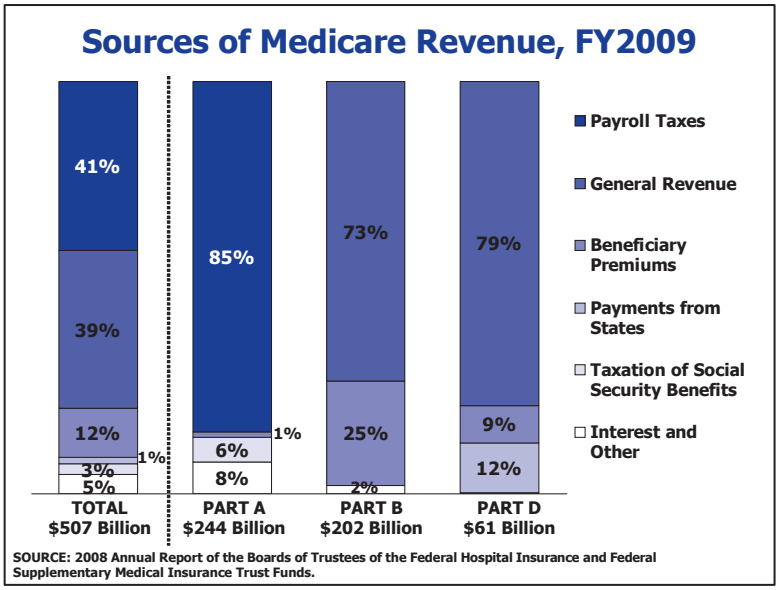
Medicare is funded as follows:

- **Part A,** the Hospital Insurance (HI) Trust Fund, is financed largely through a dedicated tax of 2.9 percent of earnings paid by employers and their employees (1.45 percent each). In 2009, these taxes are estimated to account for 85 percent of the $244 billion in revenue to the Part A Trust Fund.

- **Part B,** the Supplementary Medical Insurance (SMI) Trust Fund, is financed through a combination of general revenues and premiums paid by beneficiaries. Premiums are automatically set to cover 25 percent of revenues in the aggregate. In 2009, Part B revenue is estimated to be $202 billion.

- **Part C** is not separately financed.

- **Part D** is financed through general revenues, beneficiary premiums, and state payments for dual eligibles (who received drug coverage under state Medicaid programs prior to 2006). In 2009, Part D revenue is projected to be $61 billion, 79 percent of which will be from general revenues.




**Looking to the future, Medicare is expected to face significant financing challenges due to the aging of the U.S. population, the declining ratio of workers to beneficiaries, increasing health care costs, and various economic factors.**

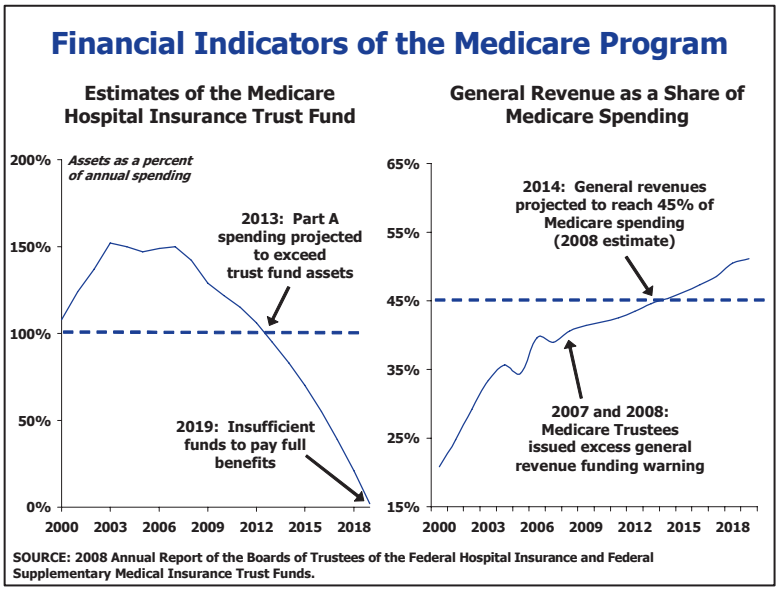
A number of measures are used to assess the long-term financial status of Medicare.

- **Medicare spending as a share of gross domestic product (GDP)** is one of several measures reported by the Medicare Trustees in their annual report to the Congress. This measure looks at expenditures over all parts of the Medicare program in the context of the U.S. economy as a whole. With the aging population and expected increases in overall health care costs, Medicare spending is projected to grow at a faster rate than the overall economy. If current trends continue, Medicare expenditures as a share of GDP are projected to rise from 3.3 percent of GDP in 2009 to 6.3 percent of GDP in 2030.[21]

[21] 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

- **Solvency of the Part A (Hospital Insurance, or HI) Trust Fund** is another measure that has been used to present a picture of Medicare's financial health. This indicator looks exclusively at Part A, and does not take into account spending or financing for other parts of the Medicare program. According to the Medicare Trustees, Part A spending is expected to exceed income in 2010, and the HI Trust Fund reserves are projected to be exhausted in 2019.[22]

  The projected insolvency of the Medicare HI Trust Fund has fluctuated from year to year mainly because the projections are highly sensitive to changes in both Medicare policy and the overall economy. For example, in 1997, the Trustees projected that the HI Trust Fund would be insolvent by 2001, yet by 2001, the Trustees projected that the trust fund would be solvent through 2029, due in part to economic growth, slower than expected expenditure growth, and decreased payments to Medicare managed care plans over the five-year period.




- **The amount of general revenues as a share of total Medicare spending** is a relatively new way to measure Medicare's fiscal health. Each year, the Medicare Trustees are required to examine general revenues as a share of total Medicare spending, and make a determination as to whether general revenues are projected to exceed 45 percent of total outlays within a seven-year timeframe. If the Trustees make this determination two years in row, a "Medicare funding warning" is issued, indicating that general revenues are becoming a substantial share of total financing for Medicare. In response, the President is required to submit proposed legislation to Congress, which must consider this legislation on an expedited basis.

  In 2008, for the third year in a row, the Medicare Trustees projected that general revenues will exceed 45 percent of total Medicare spending within seven years (by 2014) and a "Medicare funding warning" was issued. Also in 2008, the President was required by law to respond to the funding warning that was issued by the Medicare Trustees in 2007. The Administration's proposal was to implement a national system of electronic medical records and a provider pay-for-performance system in Medicare; provide cost and quality information to Medicare beneficiaries; amend the medical malpractice liability system to include a statute of limitations and limits to recovery of non-economic and punitive damages; and establish an income-related premium for the Part D drug benefit. In July 2008, the House of Representatives voted to suspend consideration of this legislation for the remainder of the year.

[22] 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, March 2008.

# MEDICARE BENEFITS AND COST-SHARING REQUIREMENTS, 2009

| PART A | |
|---|---|
| Deductible | $1,068 per benefit period |
| Inpatient hospital | |
| Days 1-60<br>Days 61-90<br>Days 91-150<br>After 150 Days | No coinsurance<br>$267 per day<br>$534 per day (for up to 60 lifetime reserve days)<br>Not covered |
| Skilled nursing facility | |
| Days 1-20<br>Days 21-100<br>After 100 Days | No coinsurance<br>$133.50 per day<br>Not covered |
| Home Health | No coinsurance; no limit on number of visits |
| Hospice | No coinsurance for hospice care; copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care |
| Inpatient psychiatric hospital | Up to 190 days in a lifetime |
| **PART B** | |
| Deductible | $135 |
| Premium | $96.40/month (higher for those with incomes above $85,000/single or $170,000/couple) |
| Physician and other medical services | |
| MD accepts assignment<br>MD does not accept assignment | 20% coinsurance<br>20% coinsurance, plus up to 15% above the Medicare-approved fee |
| Outpatient hospital care | 20% coinsurance |
| Ambulatory surgical services | 20% coinsurance |
| Diagnostic tests, X-rays, and lab services | 20% coinsurance |
| Durable medical equipment | 20% coinsurance |
| Physical, occupational, and speech therapy | 20% coinsurance; certain limits may apply |
| Clinical laboratory services | No coinsurance |
| Home health care | No coinsurance; no limit on number of visits |
| Outpatient mental health services | 50% coinsurance (decreasing to 20% by 2014) |
| One-time "Welcome to Medicare" physical exam | 20% coinsurance; covered within first 12 months of Part B enrollment; Part D deductible does not apply |
| Preventive services | |
| Flu shots, Pneumococcal vaccines | No coinsurance; one flu shot per flu season limit |
| Hepitis B vaccine; colorectal and prostate cancer screenings; pap smears; mammograms; abdominal aortic aneurysm (AAA) screenings | Deductible and coinsurance waived for certain preventive services such as colorectal cancer screenings and AAA screenings |
| Bone mass measurement, diabetes monitoring; glaucoma screening | 20% coinsurance |
| **PART D** | |
| Information below applies to the standard Part D benefit; benefits and cost-sharing requirements typically vary across plans. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts. | |
| Deductible | $295 |
| Premium | $30.36 national average monthly premium |
| Initial coverage<br>*(up to $2,700 in total drug costs)* | 25% coinsurance |
| Coverage gap<br>*(between $2,700 and $6,154 in total drug costs)* | 100% coinsurance (not covered) |
| Catastrophic coverage<br>*(above $4,350 in out-of-pocket spending)* | Minimum $2.40/generic, $6.00/brand; or 5% coinsurance |

NOTE: This table does not include all Medicare-covered benefits; for a complete listing, see http://www.medicare.gov/Coverage/Home.asp.
SOURCE: CMS, "Medicare & You 2009."

# AGE AND INCOME AMONG MEDICARE BENEFICIARIES, 2007

| STATE | Total Number of Beneficiaries[1] | Age | | | | Income as Percent of Federal Povery Level (FPL)[2] | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 19-64 | 65-74 | 75-84 | 85 and older | <100% FPL | 100-150% FPL | 150-200% FPL | 200%+ FPL |
| *U.S. Total* | *44,417,991* | 6,559,890 | 17,690,870 | 12,435,540 | 4,150,280 | 6,798,453 | 6,750,920 | 5,748,170 | 22,076,251 |
| Alabama | 806,827 | 167,140 | 305,070 | 210,410 | NSD | 144,505 | 120,562 | 88,106 | 410,191 |
| Alaska | 60,052 | 12,320 | 25,360 | 10,550 | NSD | 3,641 | 8,624 | 4,249 | 34,036 |
| Arizona | 866,014 | 154,310 | 359,770 | 209,200 | 82,450 | 110,963 | 128,937 | 121,534 | 454,240 |
| Arkansas | 507,544 | 90,850 | 183,880 | 101,350 | 40,960 | 89,800 | 55,776 | 85,176 | 193,495 |
| California | 4,490,521 | 468,160 | 1,782,410 | 1,279,660 | 476,110 | 662,600 | 829,169 | 599,894 | 2,016,857 |
| Colorado | 579,032 | 76,740 | 231,580 | 137,950 | 49,520 | 67,635 | 65,519 | 69,670 | 307,649 |
| Connecticut | 548,114 | 63,040 | 205,280 | 162,050 | 65,630 | 55,606 | 74,454 | 58,481 | 309,309 |
| Delaware | 140,383 | 19,640 | 59,800 | 38,300 | 9,640 | 19,254 | 22,091 | 15,833 | 70,927 |
| District of Columbia | 74,970 | 11,870 | 28,470 | 19,070 | 8,330 | 16,086 | 13,721 | 7,270 | 34,511 |
| Florida | 3,198,093 | 410,340 | 1,354,130 | 1,043,820 | 321,160 | 533,301 | 446,181 | 427,858 | 1,823,012 |
| Georgia | 1,152,697 | 238,310 | 442,810 | 267,220 | NSD | 261,225 | 190,698 | 186,126 | 486,460 |
| Hawaii | 194,064 | 19,320 | 67,190 | 64,140 | 24,210 | 27,467 | 23,255 | 22,864 | 107,622 |
| Idaho | 213,790 | 21,510 | 94,630 | 71,940 | NSD | 19,009 | 33,544 | 31,702 | 129,349 |
| Illinois | 1,773,245 | 251,200 | 634,190 | 499,860 | 174,800 | 249,406 | 245,362 | 236,606 | 858,978 |
| Indiana | 961,382 | 139,110 | 335,310 | 274,090 | 89,640 | 87,833 | 147,935 | 136,049 | 488,016 |
| Iowa | 571,113 | 48,310 | 189,090 | 143,340 | 50,800 | 41,428 | 72,047 | 69,526 | 261,767 |
| Kansas | 462,268 | 46,170 | 160,840 | 132,960 | 41,960 | 34,997 | 69,281 | 45,318 | 220,530 |
| Kentucky | 726,720 | 182,460 | 274,030 | 165,190 | 51,220 | 115,809 | 135,645 | 137,206 | 345,790 |
| Louisiana | 655,237 | 121,820 | 282,890 | 169,230 | NSD | 136,728 | 140,219 | 81,216 | 259,442 |
| Maine | 253,269 | 37,270 | 90,830 | 74,040 | 22,100 | 29,217 | 41,177 | 35,047 | 127,830 |
| Maryland | 743,572 | 95,270 | 305,950 | 226,890 | 82,020 | 112,270 | 89,428 | 66,958 | 451,282 |
| Massachusetts | 1,017,722 | 134,850 | 367,860 | 300,740 | 101,440 | 161,648 | 153,220 | 124,814 | 477,449 |
| Michigan | 1,577,470 | 259,540 | 622,030 | 488,120 | 121,100 | 205,869 | 223,018 | 203,512 | 898,616 |
| Minnesota | 749,569 | 81,350 | 298,150 | 220,590 | 80,920 | 78,027 | 73,720 | 102,258 | 428,012 |
| Mississippi | 477,558 | 101,430 | 176,130 | 111,990 | NSD | 115,130 | 58,770 | 60,083 | 191,438 |
| Missouri | 964,441 | 181,940 | 430,440 | 246,660 | 62,850 | 123,371 | 173,641 | 100,626 | 534,577 |
| Montana | 160,373 | 27,130 | 56,740 | 46,180 | NSD | 21,181 | 23,284 | 20,723 | 86,185 |
| Nebraska | 271,198 | 27,760 | 87,520 | 87,040 | 19,240 | 26,935 | 36,249 | 15,666 | 134,540 |
| Nevada | 329,856 | 41,900 | 168,310 | 90,900 | 28,170 | 38,636 | 39,807 | 33,961 | 213,855 |
| New Hampshire | 205,148 | 22,650 | 81,250 | 56,350 | 16,280 | 17,248 | 25,383 | 23,343 | 104,925 |
| New Jersey | 1,281,391 | 141,850 | 493,730 | 373,320 | 135,220 | 203,618 | 173,781 | 161,107 | 652,121 |
| New Mexico | 293,712 | 38,070 | 117,770 | 78,120 | NSD | 55,272 | 34,997 | 28,704 | 133,378 |
| New York | 2,892,567 | 370,030 | 1,160,540 | 913,460 | 278,080 | 568,998 | 429,164 | 340,952 | 1,387,297 |
| North Carolina | 1,399,982 | 238,290 | 587,020 | 331,090 | 129,620 | 246,570 | 243,669 | 222,086 | 650,370 |
| North Dakota | 106,113 | 7,980 | 37,610 | 27,330 | 9,200 | 9,238 | 15,682 | 13,721 | 44,536 |
| Ohio | 1,835,141 | 231,880 | 651,780 | 531,510 | 125,120 | 203,980 | 252,998 | 216,275 | 828,140 |
| Oklahoma | 577,305 | 85,590 | 219,930 | 157,160 | 51,810 | 83,703 | 81,595 | 85,261 | 267,686 |
| Oregon | 582,843 | 64,370 | 220,920 | 163,990 | 59,200 | 83,131 | 67,653 | 72,031 | 292,100 |
| Pennsylvania | 2,218,620 | 288,250 | 802,990 | 720,070 | 220,080 | 270,304 | 376,173 | 323,817 | 1,127,549 |
| Rhode Island | 177,597 | 29,050 | 58,860 | 45,360 | 20,610 | 23,570 | 22,511 | 29,908 | 83,269 |
| South Carolina | 719,408 | 127,150 | 308,740 | 181,270 | 42,100 | 131,886 | 124,425 | 75,071 | 362,962 |
| South Dakota | 131,800 | 11,820 | 53,410 | 37,480 | 16,280 | 15,992 | 20,987 | 12,258 | 77,360 |
| Tennessee | 999,647 | 159,720 | 448,920 | 250,280 | 76,470 | 183,913 | 168,472 | 135,112 | 468,118 |
| Texas | 2,799,542 | 432,600 | 1,253,080 | 809,140 | 242,450 | 629,847 | 531,501 | 364,228 | 1,288,792 |
| Utah | 263,623 | 30,990 | 110,520 | 62,220 | NSD | 24,204 | 37,842 | 37,468 | 133,735 |
| Vermont | 104,950 | 15,480 | 39,450 | 28,160 | 9,040 | 15,089 | 19,584 | 12,862 | 51,309 |
| Virginia | 1,078,060 | 171,490 | 422,190 | 278,160 | 93,970 | 147,759 | 115,062 | 132,049 | 654,699 |
| Washington | 901,495 | 128,600 | 355,420 | 259,800 | 67,110 | 114,074 | 84,077 | 85,134 | 522,484 |
| West Virginia | 372,340 | 99,140 | 124,150 | 80,120 | 28,560 | 54,825 | 57,040 | 47,133 | 173,368 |
| Wisconsin | 873,511 | 98,630 | 298,030 | 247,040 | 82,700 | 116,120 | 120,451 | 130,923 | 376,488 |
| Wyoming | 76,102 | 9,070 | 37,060 | 23,190 | NSD | 9,535 | 12,539 | 10,395 | 39,600 |

NOTE: NSD is not sufficient data

[1]Excludes beneficiaries livinig in the territories and beneficiaries who were pending assignment to a particular state of residence.

[2]In 2007, the federal poverty level was $10,210 for an individual and $13,690 for a couple.

SOURCES: Total Number of Beneficiaries from CMS MA State/County Penetration File, October 2008. Age and income estimates from the U.S. Census Bureau, Current Population Survey, 2007 and 2008 Annual Social and Economic Supplements (pooled data from 2006 and 2007).

# PRESCRIPTION DRUG COVERAGE AMONG MEDICARE BENEFICIARIES, 2008

| STATE | Total Number of Beneficiaries[1] | Beneficiaries Enrolled in Part D Plans: Medicare Advantage Prescription Drug Plans[2] | Beneficiaries Enrolled in Part D Plans: Stand-Alone Prescription Drug Plans (PDPs)[3] | Beneficiaries Enrolled in Part D Plans: Dual Eligibles Enrolled in PDPs | Beneficiaries Enrolled in Part D Plans: Part D Low-Income Subsidy Recipients (Including Dual Eligibles) | Beneficiaries with Creditable Employer or VA Coverage[4] | Unknown/ No Source of Drug Coverage[5] |
|---|---|---|---|---|---|---|---|
| *U.S. Total* | *44,417,991* | *8,010,244* | *17,392,378* | *6,180,053* | *9,385,166* | *12,112,837* | *6,902,532* |
| Alabama | 806,827 | 116,564 | 329,711 | 88,887 | 223,873 | 244,952 | 115,600 |
| Alaska | 60,052 | 254 | 22,914 | 12,115 | 14,123 | 24,161 | 12,723 |
| Arizona | 866,014 | 290,550 | 217,315 | 104,190 | 151,059 | 220,309 | 137,840 |
| Arkansas | 507,544 | 43,026 | 255,092 | 63,857 | 132,230 | 128,234 | 81,192 |
| California | 4,490,521 | 1,420,472 | 1,585,286 | 1,045,340 | 1,151,602 | 839,132 | 645,631 |
| Colorado | 579,032 | 161,290 | 165,071 | 52,714 | 91,305 | 159,402 | 93,269 |
| Connecticut | 548,114 | 63,980 | 225,473 | 67,189 | 99,823 | 169,974 | 88,687 |
| Delaware | 140,383 | 2,717 | 64,772 | 10,109 | 24,132 | 50,260 | 22,634 |
| District of Columbia | 74,970 | 5,927 | 27,858 | 15,664 | 20,548 | 25,458 | 15,727 |
| Florida | 3,198,093 | 796,646 | 1,022,527 | 298,101 | 588,556 | 892,922 | 485,998 |
| Georgia | 1,152,697 | 102,623 | 554,151 | 138,611 | 290,386 | 292,805 | 203,118 |
| Hawaii | 194,064 | 60,579 | 62,693 | 25,738 | 35,081 | 39,148 | 31,644 |
| Idaho | 213,790 | 31,700 | 85,041 | 19,510 | 34,904 | 55,861 | 41,188 |
| Illinois | 1,773,245 | 110,729 | 853,431 | 242,841 | 337,857 | 512,825 | 296,260 |
| Indiana | 961,382 | 49,484 | 444,989 | 86,108 | 169,801 | 299,725 | 167,184 |
| Iowa | 571,113 | 37,513 | 291,116 | 57,227 | 82,429 | 103,218 | 139,266 |
| Kansas | 462,268 | 27,639 | 220,467 | 38,704 | 67,468 | 96,733 | 117,429 |
| Kentucky | 726,720 | 52,482 | 343,395 | 146,711 | 192,758 | 210,069 | 120,774 |
| Louisiana | 655,237 | 109,435 | 277,145 | 95,327 | 187,217 | 160,038 | 108,619 |
| Maine | 253,269 | 6,972 | 135,976 | 47,817 | 81,512 | 56,282 | 54,039 |
| Maryland | 743,572 | 43,944 | 270,136 | 61,931 | 121,704 | 289,031 | 140,461 |
| Massachusetts | 1,017,722 | 168,292 | 391,598 | 207,019 | 243,275 | 288,540 | 169,292 |
| Michigan | 1,577,470 | 252,875 | 505,869 | 195,288 | 268,807 | 553,784 | 264,942 |
| Minnesota | 749,569 | 188,510 | 299,812 | 97,753 | 125,648 | 157,393 | 103,854 |
| Mississippi | 477,558 | 18,408 | 283,253 | 74,379 | 159,999 | 100,435 | 75,462 |
| Missouri | 964,441 | 150,867 | 423,524 | 134,988 | 194,923 | 240,750 | 149,300 |
| Montana | 160,373 | 14,013 | 74,953 | 13,200 | 25,210 | 41,093 | 30,314 |
| Nebraska | 271,198 | 20,601 | 151,994 | 32,528 | 43,748 | 64,161 | 34,442 |
| Nevada | 329,856 | 95,315 | 82,341 | 20,407 | 46,858 | 92,884 | 59,316 |
| New Hampshire | 205,148 | 4,279 | 84,879 | 18,463 | 31,501 | 66,437 | 49,553 |
| New Jersey | 1,281,391 | 105,541 | 542,470 | 152,026 | 222,898 | 411,567 | 221,813 |
| New Mexico | 293,712 | 60,113 | 115,172 | 34,821 | 67,122 | 68,781 | 49,646 |
| New York | 2,892,567 | 620,818 | 988,173 | 558,058 | 721,725 | 794,213 | 489,363 |
| North Carolina | 1,399,982 | 161,955 | 635,716 | 219,955 | 339,266 | 379,170 | 223,141 |
| North Dakota | 106,113 | 4,142 | 69,800 | 9,901 | 17,495 | 20,126 | 12,045 |
| Ohio | 1,835,141 | 300,878 | 589,569 | 184,301 | 314,205 | 676,665 | 268,029 |
| Oklahoma | 577,305 | 59,212 | 271,304 | 80,796 | 122,182 | 145,209 | 101,580 |
| Oregon | 582,843 | 173,284 | 185,639 | 54,126 | 95,307 | 121,802 | 102,118 |
| Pennsylvania | 2,218,620 | 618,352 | 701,874 | 277,684 | 394,456 | 553,441 | 344,953 |
| Rhode Island | 177,597 | 57,165 | 58,471 | 30,036 | 41,081 | 36,089 | 25,872 |
| South Carolina | 719,408 | 64,168 | 309,484 | 114,149 | 169,978 | 227,680 | 118,076 |
| South Dakota | 131,800 | 9,904 | 75,633 | 11,926 | 21,935 | 29,786 | 16,477 |
| Tennessee | 999,647 | 164,442 | 449,574 | 186,085 | 284,669 | 233,341 | 152,290 |
| Texas | 2,799,542 | 386,680 | 1,136,370 | 340,961 | 680,572 | 813,173 | 463,319 |
| Utah | 263,623 | 46,262 | 90,721 | 23,722 | 33,672 | 77,517 | 49,123 |
| Vermont | 104,950 | 678 | 55,151 | 17,403 | 25,710 | 31,659 | 17,462 |
| Virginia | 1,078,060 | 78,413 | 453,431 | 104,805 | 199,720 | 341,712 | 204,504 |
| Washington | 901,495 | 114,449 | 339,831 | 101,462 | 149,135 | 250,870 | 196,345 |
| West Virginia | 372,340 | 54,021 | 165,538 | 42,372 | 87,104 | 99,817 | 52,964 |
| Wisconsin | 873,511 | 114,550 | 315,760 | 111,919 | 138,303 | 228,550 | 214,651 |
| Wyoming | 76,102 | 2,370 | 38,090 | 5,825 | 10,881 | 21,335 | 14,307 |

NOTE: [1]Excludes beneficiaries livinig in the territories and beneficiaries who were pending assignment to a particular state of residence.

[2]Includes 1.3 million beneficiaries who were auto-enrolled and 0.15 million additional beneficiaries receiving the low-income subsidy.

[3]Includes 5.3 million beneficiaries who were auto-enrolled and 2.6 million additional beneficiaries receiving the low-income subsidy.

[4]Includes beneficiaries with Retiree Drug Subsidy, FEHBP, TriCARE, VA and Active Workers.

[5]Estimates of unknown/no drug coverage are the residual difference between the Total column and the combined total of Medicare Advantage, PDP, and other creditable sources of drug coverage for each state.

SOURCE: Total Number of Beneficiaries from CMS MA State/County Penetration File, October 2008. State-level prescription drug coverage estimates from Centers for Medicare & Medicaid Services (CMS) Management Information Integrated Repository (MIIR), as of January 18, 2008.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