Appendices

APPENDIX A
MEDICARE TIMELINE, 1965–2005

January 1965 President Johnson's first legislative message to the 89th Congress, *Advancing the Nation's Health,* detailed a program including hospital insurance for the aged under Social Security and health care for needy children.

March–July 1965 The House of Representatives (307-116) and the Senate (70-24) passed "the Mills Bill" (H.R. 6675), a package of health benefits and Social Security improvements.

July 30, 1965 President Johnson signed H.R. 6675 (Public Law 89-97) to establish Medicare for the elderly and Medicaid for the indigent in Independence, Missouri, in the presence of Harry S. Truman who advocated for such legislation in a message to Congress in 1945.

President Truman was the first to enroll in Medicare.

Medicare Part A deductible: $40/year
Medicare Part B premium: $3/month

1966 The Social Security Administration announced the selection of private insurance companies to perform the major administrative functions of bill processing and benefit payment functions for Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) of the Medicare program.

July 1, 1966 Medicare coverage began. All persons age 65 and over were automatically covered under Part A. Coverage began for seniors who signed up for the voluntary medical insurance program (Part B). More than 19 million individuals ages 65 and older were enrolled in Medicare.

1969 The Task Force on Prescription Drugs, chaired by Dr. Philip Lee, released its final report on the costs and feasibility of adding prescription drug coverage to Medicare.

1970 Medicare Part A deductible: $52/year
Medicare Part B premium: $4/month
Total Medicare population: 20.4 million beneficiaries

October 30, 1972 President Nixon signed the Social Security Amendments of 1972 (P.L. 92-603), the first major adjustment to Medicare after its enactment. Medicare eligibility was extended to individuals under age 65 with long-term disabilities (who were receiving SSDI payments for two years) and to individuals with end-stage renal disease (ESRD). The amendments also established professional standards review organizations (PSROs) to review patient care, encouraged the use of health maintenance organizations (HMOs), and gave Medicare the authority to conduct demonstration programs.

Medicare benefits were expanded to include some chiropractic services, speech therapy, and physical therapy.

1973 Medicare coverage began for individuals receiving Social Security Disability Insurance (SSDI) cash payments for two or more years. Nearly 2 million people under age 65 with long-term disabilities or ESRD were covered.

1975 Medicare Part A deductible: $92/year
Medicare Part B premium: $6.70/month
Total Medicare population: 24.9 million beneficiaries

1977 Joe Califano, Secretary of the Department of Health, Education and Welfare, created the Health Care Financing Administration (HCFA) to administer both the Medicare and Medicaid programs. About 1,500 employees were transferred to HCFA from the Social Security Administration.

1980 The Omnibus Reconciliation Act of 1980 expanded home health services by eliminating the limit on the number of home health visits, the prior hospitalization requirement, and the deductible for any Part B benefits. It also required the Secretary to develop a list of surgical procedures that could be done on an outpatient basis in an ambulatory surgical center and would be reimbursed on a prospective payment system. The "Baucus Amendments" brought Medicare supplemental insurance, also called "Medigap," under federal oversight and established a voluntary certification program for Medigap policies.

Medicare Part A deductible: $180/year
Medicare Part B premium: $8.70/month
Total Medicare population: 28.4 million beneficiaries

1981 The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) included provisions to slow the growth in Medicare spending, including a change that resulted in an increase in the inpatient hospital deductible.

1982 The Tax Equity and Fiscal Responsibility Act (TEFRA) increased the Part B premium to cover 25% of program costs as part of policies designed to slow the growth of Medicare spending. Hospice services for the terminally ill were added to Medicare's covered benefits. TEFRA facilitated HMOs' participation in the Medicare program and established a risk-based prospective payment system for these plans. The Act also expanded HCFA's quality oversight efforts by replacing Professional Standards Review Organizations (PSROs) with Peer Review Organizations (PROs). TEFRA imposed a ceiling on the amount Medicare would pay for a hospital discharge and required HHS to submit a plan for prospective payments to hospitals and nursing homes. TEFRA required federal employees to begin paying the HI payroll tax.

1983 The Social Security amendments of 1983 established an inpatient hospital prospective payment system (PPS) for the Medicare program. The PPS is based on diagnosis-related groups, or DRGs, a pre-determined payment for treating a specific condition. The system was adopted to replace cost-based payments.

1984 The Deficit Reduction Act of 1984 (DEFRA) froze physician fees, established the Participating Physicians' Program, and established fee schedules for laboratory services, all of which were intended to slow the growth of Medicare's spending and constrain the federal deficit.

1985 The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) made Medicare coverage mandatory for newly hired state and local government employees. In addition, COBRA established the Emergency Medical Treatment and Labor Act (EMTALA), which required hospitals participating in Medicare that operate active emergency rooms to provide appropriate medical screenings and stabilizing treatments.

The Emergency Extension Act of 1985 froze PPS payment rates for inpatient hospital care and continued physician payment freezes to slow the growth of Medicare spending.

Medicare Part A deductible: $400/year
Medicare Part B premium: $15.50/month
Total Medicare population: 31.1 million beneficiaries

1986 The Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) revised several of the payment procedures for various Medicare services in order to help slow the growth in Medicare spending.

1987 The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) imposed quality standards for Medicare- and Medicaid-certified nursing homes—in response to well-documented quality problems facing seniors in nursing homes. OBRA 87 also modified payments to providers under Medicare as part of the deficit reduction legislation.

The Medicare and Medicaid Patient and Program Protection Act of 1987 was enacted to improve antifraud efforts and strengthen beneficiary protection programs.

The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 froze Medicare payment rates in an attempt to slow Medicare spending.

1988 The Medicare Catastrophic Coverage Act of 1988, the largest expansion of the program since the enactment of Medicare, provided an outpatient prescription drug benefit, placed a cap on beneficiaries' out-of-pocket expenses, and expanded hospital and skilled nursing facility benefits. Medicaid began coverage of Medicare premiums and cost-sharing for Medicare beneficiaries with incomes below 100% of the federal poverty level, known as Qualified Medicare Beneficiaries (QMBs). The U.S. Bipartisan Commission on Comprehensive Health Care (which became known as the Pepper Commission after the late Congressman Claude Pepper of Florida) was established to assess the feasibility of a long-term care benefit under Medicare.

The Clinical Laboratory Improvement Amendments were enacted to strengthen quality performance requirements for clinical laboratories to provide more accurate and reliable laboratory tests.

1989 The Medicare Catastrophic Coverage Repeal Act of 1989 retracted the major provisions of the Medicare Catastrophic Coverage Act of 1988, including both the outpatient drug benefit and the out-of-pocket expense limit. QMB benefits were retained.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) established the Resource-Based Relative Value Scale (RBRVS) for physicians, replacing charge-based payments. Limits were placed on physician balance billing. Physicians were prohibited from referring Medicare patients to clinical laboratories in which they have a financial interest. OBRA 1989 also included a number of other provisions designed to slow the growth in Medicare spending.

1990 The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) established the Specified Low-Income Medicare Beneficiary (SLMB) eligibility group requiring state Medicaid programs to cover premiums for beneficiaries with incomes between 100% and 120% of the federal poverty level. Medicare was expanded to cover screening mammography and partial hospitalization services in community mental health centers. Federal standards were established for Medigap policies, including standardized benefit packages and minimum loss ratios, replacing the voluntary certification system.

The U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) recommended the creation of a new Medicare long-term care program that would provide nursing home and home- and community-based services. These recommendations were not enacted.

Medicare Part A deductible: $592/year
Medicare Part B premium: $28.60/month
Total Medicare population: 34.3 million beneficiaries

1993 The Omnibus Budget Reconciliation Act of 1993 modified payments to Medicare providers, as part of overall deficit reduction legislation, and lifted the cap on the amount of wages subject to the HI payroll tax.

States started to cover Medicare Part B premiums for SLMBs.

1995 Medicare Part A deductible: $716/year
Medicare Part B premium: $46.10/month
Total Medicare population: 37.6 million beneficiaries

1996 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Medicare Integrity Program, which dedicated funds for program integrity activities.

1997 The Balanced Budget Act of 1997 (BBA) included a broad range of changes in provider payments to slow the growth in Medicare spending as part of legislation to balance the federal budget. It also established the Medicare+Choice program, a new structure for Medicare HMOs and other private health plans offered to beneficiaries. The BBA also required HCFA to develop and implement five new Medicare prospective payment systems: inpatient rehabilitation hospital or unit services; skilled nursing facility services; home health services; hospital outpatient services; and outpatient rehabilitation services. The law also provided additional assistance with Medicare Part B premiums for beneficiaries with incomes between 120% and 135% of poverty (QI-1s) through a first-come first-served block grant program administered by state Medicaid programs. The law provided for partial assistance with premiums for beneficiaries with incomes between 135% and 175% of poverty (QI-2s). The BBA also established the National Advisory Commission on the Future of Medicare and the Medicare Payment Advisory Commission (which replaced both the Prospective Payment Assessment Commission and the Physician Payment Review Commission).

1998 The internet site www.Medicare.gov was launched to provide updated information about Medicare.

1999 The toll-free number, 1-800-MEDICARE (1-800-633-4227), was made available nationwide. The first annual *Medicare & You* handbook was mailed to all Medicare beneficiary households.

The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work.

The Balanced Budget Refinement Act of 1999 (BBRA) increased payments for some Medicare providers and reduced or froze payment rates for other Medicare services. BBRA also increased payments to Medicare+Choice plans.

The National Advisory Commission on the Future of Medicare completed its work on Medicare reform but lacked sufficient votes to report out a formal recommendation.

2000 The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 further increased Medicare payments to providers and Medicare+Choice plans, reduced certain Medicare beneficiary copayments, and added coverage for certain preventive services. BIPA also enabled people with amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) to enroll in Medicare upon diagnosis instead of having to satisfy the 24-month waiting period.

Medicare Part A deductible: $776/year
Medicare Part B premium: $54.40/month
Total Medicare population: 39.7 million beneficiaries

2001 Secretary of Health and Human Services, Tommy Thompson, renamed HCFA, as the Centers for Medicare and Medicaid Services (CMS).

Medicare began covering people with ALS.

2002 The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, along with other public health measures, temporarily moved deadlines for submitting Medicare+Choice plan information. The law stated that in 2005, individuals enrolled in M+C plans would only be able to make and change elections to an M+C plan on a more limited basis, which was later changed by the Medicare Modernization Act of 2003.

2003 The Consolidated Appropriations Resolution (CAR) of 2003 increased payments for some hospitals, updated the physician fee schedule, and extended payment of the Part B premium for QI-1s.

QI-2 beneficiaries no longer received assistance from Medicaid in paying their Part B premiums.

December 8, 2003 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was passed by the House (220-215) and the Senate (54-44) in November and signed into law (P.L. 108-173) by President Bush on December 8, 2003, providing a new outpatient prescription drug benefit under Medicare beginning in 2006. For 2004 and 2005, it established a temporary prescription drug discount card and transitional assistance program. The MMA also established a new income-related Part B premium for beneficiaries with higher incomes (beginning in 2007), indexed the Part B deductible, created regional PPOs under the Medicare Advantage program (previously called Medicare+Choice), and established financial and other incentives for private health plans to contract with Medicare. The MMA also established a new way of assessing Medicare's financial status by measuring general revenue as a share of total Medicare spending.

2004 A temporary Medicare-Approved Drug Discount Card Program began, along with a transitional assistance program to provide a $600 annual credit to low-income Medicare beneficiaries without prescription drug coverage in 2004 and 2005.

2005 Medicare began covering a "Welcome to Medicare" physical, along with other preventive services, such as cardiovascular screening blood tests and diabetes screening tests. Medicare also began education and outreach activities for beneficiaries related to the prescription drug benefit beginning on January 1, 2006.

Medicare Part A deductible: $912/year
Medicare Part B premium: $78.20/month
Total Medicare population: 42.3 million beneficiaries

Appendix B
Medicare Beneficiary Premiums, Deductibles, and Coinsurance, 1966–2014

		Part A					Part B		Part D	
	Year	Inpatient Hospital Deductible	Daily Coinsurance (61st–90th Day)	60 Lifetime Reserve Days Daily Coinsurance	SNF Daily Coinsurance* (21st–100th Day)	Full Part A Monthly Premiums**	Monthly Premium***	Annual Deductible	Monthly Premium	Annual Deductible
Actual	1966	$40	$10	-	-	-	$3.00	$50	-	-
	1971	$60	$15	$30	$7.50	-	$5.60	$50	-	-
	1976	$104	$26	$52	$13.00	$45	$7.20	$60	-	-
	1981	$204	$51	$102	$25.50	$89	$11.00	$60	-	-
	1987	$520	$130	$260	$65.00	$226	$17.90	$75	-	-
	1988	$540	$135	$270	$67.50	$234	$24.80	$75	-	-
	1989	$560	N/A	N/A	$25.50	$156	$31.90	$75	-	-
	1990	$592	$148	$296	$74.00	$176	$28.60	$75	-	-
	1991	$628	$157	$314	$78.50	$177	$29.90	$100	-	-
	1992	$652	$163	$326	$81.50	$192	$31.80	$100	-	-
	1993	$676	$169	$338	$84.50	$221	$36.60	$100	-	-
	1994	$696	$174	$348	$87.00	$245 ($184)	$41.10	$100	-	-
	1995	$716	$179	$358	$89.50	$261 ($183)	$46.10	$100	-	-
	1996	$736	$184	$368	$92.00	$289 ($188)	$42.50	$100	-	-
	1997	$760	$190	$380	$95.00	$311 ($187)	$43.80	$100	-	-
	1998	$764	$191	$382	$95.50	$309 ($170)	$43.80	$100	-	-
	1999	$768	$192	$384	$96.00	$309 ($170)	$45.50	$100	-	-
	2000	$776	$194	$388	$97.00	$301 ($166)	$45.50	$100	-	-
	2001	$792	$198	$396	$99.00	$300 ($165)	$50.00	$100	-	-
	2002	$812	$203	$406	$101.50	$319 ($175)	$54.00	$100	-	-
	2003	$840	$210	$420	$105.00	$316 ($174)	$58.70	$100	-	-
	2004	$876	$219	$438	$109.50	$343 ($189)	$66.60	$100	-	-
	2005	$912	$228	$456	$114.00	$375 ($206)	$78.20	$110	-	-
Projected	2006	$956	$239	$478	$119.50	$386 ($212)	$87.70	$123	$37.37	$250
	2007	$1,004	$251	$502	$125.50	$403 ($222)	$87.70	$123	$41.22	$270
	2008	$1,056	$264	$528	$132.00	$421 ($232)	$87.70	$123	$43.73	$290
	2009	$1,108	$277	$554	$138.50	$438 ($241)	$89.30	$125	$46.31	$310
	2010	$1,164	$291	$582	$145.50	$457 ($251)	$92.00	$129	$48.94	$331
	2011	$1,220	$305	$610	$152.50	$476 ($262)	$94.80	$133	$51.58	$352
	2012	$1,276	$319	$638	$159.50	$494 ($272)	$99.70	$140	$55.45	$373
	2013	$1,336	$334	$668	$167.00	$514 ($283)	$107.10	$150	$59.74	$404
	2014	$1,396	$349	$698	$174.50	$533 ($293)	$114.70	$161	$64.26	$437

Note: *In 1989, the SNF coinsurance applied to days 1-8 of the 150 days allowed annually; for the other years, it applies to days 21–100 of the 100 days allowed per benefit period.
**Amount in parentheses is for people who have paid Medicare taxes during at least 30 of the 40 quarters required to be fully insured.
***Part B premium was originally 50% of projected costs. Congress set it at 25% permanently in 1997.
N/A is not applicable. SNF is skilled nursing facility.
SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Appendix C
Characteristics of the Medicare Population, 2002

		Total Community	Aged Community (No ESRD)	Disabled Community (No ESRD)	ESRD* Community	Total Facility
Number of Beneficiaries		39,424,106	33,731,915	5,363,555	328,636	2,384,285
Gender	Male	44.6%	42.8%	55.4%	59.5%	33.2%
	Female	55.4%	57.2%	44.6%	40.5%	66.8%
Age	Under 65	14.1%	N/A	100.0%	57.2%	15.9%
	65–74	44.9%	52.2%	N/A	24.3%	11.0%
	75–84	31.3%	36.4%	N/A	14.8%	31.1%
	85 and over	9.7%	11.3%	N/A	3.8%	42.1%
Living Arrangement	Lives alone	30.7%	31.6%	25.0%	29.0%	N/A
	Lives with spouse	52.1%	54.2%	39.7%	46.1%	N/A
	Lives with children	9.5%	9.3%	11.2%	7.2%	N/A
	Lives with others	7.7%	4.9%	24.0%	17.7%	N/A
	Lives in long-term care facility	N/A	N/A	N/A	N/A	100.0%
Race/Ethnicity	White, non-Hispanic	78.7%	80.8%	67.1%	50.8%	89.4%
	African American, non-Hispanic	9.4%	8.0%	17.0%	30.2%	9.0%
	Hispanic	7.6%	7.0%	10.6%	10.3%	4.6%
	Asian	2.0%	2.2%	1.1%	1.4%	0.6%
	Other	2.3%	1.9%	4.2%	7.4%	0.3%
Marital Status	Married	53.6%	55.6%	40.7%	49.8%	19.0%
	Widowed	28.8%	32.5%	7.1%	11.1%	50.5%
	Divorced/Separated	10.3%	8.6%	27.8%	26.4%	9.0%
	Never married	6.0%	3.1%	23.7%	12.7%	21.0%
Lives in a Metropolitan Area	Yes	76.3%	76.8%	72.7%	80.7%	76.6%
	No	23.6%	23.1%	26.9%	19.3%	23.4%
Education	8th grade or less	15.0%	14.5%	15.0%	15.7%	25.7%
	Some high school	16.2%	15.6%	19.4%	18.9%	17.1%
	High school graduate	29.8%	29.7%	31.1%	25.3%	22.5%
	Some college or 2-year degree	23.8%	23.3%	26.4%	27.2%	14.9%
	College graduate or more	15.2%	16.4%	8.1%	12.9%	7.3%
Income	$10,000 or less	20.0%	16.6%	40.4%	37.2%	46.3%
	$10,001–$20,000	29.5%	29.6%	28.8%	28.3%	31.2%
	$20,001–$30,000	21.2%	22.7%	14.2%	13.8%	12.8%
	$30,001–$40,000	10.8%	11.6%	6.3%	3.0%	3.6%
	More than $40,000	18.3%	19.5%	10.4%	17.8%	6.1%
Supplemental Insurance Coverage	No supplemental coverage	11.6%	9.7%	24.0%	8.9%	23.5%
	Medicare HMO	14.9%	15.9%	8.6%	7.5%	8.1%
	Employer-sponsored	37.0%	39.2%	23.2%	39.5%	4.0%
	Medigap	22.4%	25.4%	4.6%	6.4%	3.3%
	Medicaid	14.1%	9.9%	39.7%	37.6%	61.3%
Self-Reported Health Status	Poor	8.7%	5.5%	27.1%	37.8%	18.2%
	Fair	19.3%	16.6%	35.8%	22.5%	40.0%
	Good	31.2%	32.3%	23.8%	30.7%	28.7%
	Very good	26.0%	28.9%	8.9%	6.2%	9.6%
	Excellent	14.4%	16.2%	4.1%	0.5%	2.9%

Note: *ESRD (end-stage renal disease) includes aged and disabled beneficiaries with ESRD, and those eligible for Medicare due to ESRD.
N/A is not applicable. Numbers may not sum to 100% due to rounding or exclusion of missing/don't know/refused responses in same categories.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

continued on next page

Appendix C
Characteristics of the Medicare Population, 2002 (continued)

	Total Community	Aged (No ESRD)	Disabled (No ESRD)	Ages 65–84 (No ESRD)	Ages 85+ (No ESRD)	ESRD* Community	Total Facility
Number of Beneficiaries	39,424,106	33,731,915	5,363,555	30,046,796	3,825,895	328,636	2,384,285
Presence of Chronic Conditions				**Percentage of Beneficiaries with Health Condition**			
No Chronic Conditions**	13.0%	12.3%	18.5%	12.9%	6.9%	90.0%	23.7%
1 Chronic Condition	23.8%	24.0%	22.8%	24.3%	21.4%	11.7%	26.6%
2 or more Chronic Conditions	63.2%	63.7%	58.7%	62.8%	71.7%	87.4%	49.7%
3 or more Chronic Conditions	36.1%	36.0%	35.7%	35.2%	42.9%	55.6%	24.1%
4 or more Chronic Conditions	16.1%	15.9%	17.1%	15.3%	20.4%	29.1%	9.0%
5 or more Chronic Conditions	5.6%	5.4%	6.6%	5.3%	6.8%	8.3%	2.3%
Hypertension	59.5%	60.2%	53.0%	59.9%	63.5%	94.7%	39.4%
Emphysema	15.7%	14.4%	23.4%	14.8%	11.7%	13.1%	8.9%
Diabetes	20.1%	19.4%	22.2%	20.2%	14.8%	56.0%	20.5%
Heart Condition***	42.2%	42.6%	38.4%	41.3%	54.2%	58.2%	30.9%
Arthritis	58.0%	58.9%	52.2%	58.1%	65.3%	54.4%	19.1%
Osteoporosis	18.2%	18.7%	15.1%	18.3%	21.8%	13.3%	12.3%
Broken Hip	3.5%	3.6%	2.8%	2.7%	10.7%	8.9%	3.4%
Parkinson's Disease	1.3%	1.5%	60.0%	1.4%	1.7%	0.0%	5.8%
Stroke	11.8%	11.7%	11.7%	11.2%	16.7%	14.7%	14.1%
Alzheimer's Disease	3.1%	3.4%	1.5%	2.5%	10.2%	2.6%	18.0%
Skin Cancer	17.7%	19.5%	6.9%	18.8%	25.3%	12.4%	70.0%
Other Types of Cancer	18.0%	19.0%	12.7%	18.8%	20.3%	9.0%	4.7%
Urinary Incontinence****	8.8%	9.1%	7.1%	8.0%	17.4%	5.7%	44.8%
Cognitive/Mental Impairment*****	25.9%	20.5%	59.4%	19.1%	31.9%	32.3%	77.6%
1 or more Limitations in Activities of Daily Living (ADLs)	31.8%	27.8%	49.0%	24.9%	51.1%	45.3%	N/A

Note: *ESRD (end-stage renal disease) includes aged and disabled beneficiaries with ESRD, and those eligible for Medicare due to ESRD.
**The count for chronic conditions includes diagnosis with arthritis, diabetes, emphysema, hypertension, osteoporosis, Parkinson's disease, stroke, incontinence, broken hip, and/or angina/chronic heart disease.
***Heart condition is defined as diagnosis with hardening of arteries, angina, myocardial infarction, congestive heart failure, or problem with heart valves or heart rhythm.
****Urinary incontinence is defined as loss of urine control more than once per week in the last 12 months.
*****Cognitive/mental impairment is defined as presence of mental retardation, mental disorder, Alzheimer's disease, or memory loss that interferes with daily activity. For facility residents, definition also includes presence of schizophrenia and/or dementia.
N/A is not applicable. Numbers may not sum to 100% due to rounding or exclusion of missing/don't know/refused responses in some categories.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Appendix D
Characteristics of the Medicare Population, by State, Selected Years

	Number of Medicare Beneficiaries (2003)	Projected Age 65+ (2030)	Age 65+ (2003)	Under Age 65 (2003)	Residing in Rural Areas (2004)	Income <100% of Poverty (2002–2003)	Income 100%–199% of Poverty (2002–2003)	Enrolled in Medicaid (2002)	Enrolled in Medicare Advantage Plans (2004)
United States Total	40,172,605 (14% of U.S. Population)	20% of U.S. Population	85% of U.S. Medicare Population	15% of U.S. Medicare Population	24% of U.S. Medicare Population	12% of U.S. Medicare Population	32% of U.S. Medicare Population	18% of U.S. Medicare Population	11% of U.S. Medicare Population
STATE	**Medicare Beneficiaries with Characteristic as a Percent of State Medicare Population**								
Alabama	719,246 (16%)	21%	79%	21%	35%	15%	32%	23%	6%
Alaska	47,749 (7%)	15%	82%	18%	42%	11%	21%	20%	0%
Arizona	728,885 (13%)	22%	86%	14%	16%	8%	32%	9%	26%
Arkansas	452,676 (17%)	20%	80%	20%	61%	17%	36%	27%	0%
California	4,078,426 (11%)	18%	87%	13%	4%	11%	30%	23%	29%
Colorado	493,454 (11%)	17%	86%	14%	23%	11%	26%	15%	21%
Connecticut	522,403 (15%)	22%	88%	12%	9%	10%	27%	16%	5%
Delaware	119,302 (15%)	24%	85%	15%	29%	9%	26%	13%	0%
District of Columbia	73,794 (13%)	13%	86%	14%	0%*	19%	29%	26%	0%
Florida	2,920,971 (17%)	27%	88%	12%	8%	12%	33%	14%	18%
Georgia	973,794 (11%)	16%	81%	19%	39%	14%	30%	19%	1%
Hawaii	174,633 (14%)	22%	90%	10%	28%	16%	29%	16%	11%
Idaho	177,700 (13%)	18%	86%	14%	71%	6%	31%	7%	6%
Illinois	1,661,454 (13%)	18%	87%	13%	21%	13%	30%	13%	4%
Indiana	877,954 (14%)	18%	85%	15%	31%	12%	36%	15%	0%
Iowa	482,340 (16%)	22%	88%	12%	62%	9%	30%	14%	1%
Kansas	394,206 (14%)	20%	87%	13%	50%	10%	33%	12%	3%
Kentucky	648,400 (16%)	20%	77%	23%	56%	13%	35%	33%	2%
Louisiana	620,196 (14%)	20%	81%	19%	27%	13%	38%	23%	10%
Maine	226,696 (17%)	27%	81%	19%	62%	10%	41%	22%	0%
Maryland	674,448 (12%)	18%	87%	13%	10%	12%	26%	14%	1%
Massachusetts	965,943 (15%)	21%	85%	15%	2%	13%	34%	22%	16%
Michigan	1,444,987 (14%)	20%	84%	16%	22%	12%	31%	15%	1%
Minnesota	676,156 (13%)	19%	88%	12%	39%	10%	32%	15%	6%
Mississippi	436,677 (15%)	21%	77%	23%	72%	18%	36%	32%	0%
Missouri	884,449 (16%)	20%	84%	16%	38%	9%	32%	18%	11%
Montana	142,457 (16%)	26%	86%	14%	77%	9%	35%	11%	0%
Nebraska	257,171 (15%)	21%	88%	12%	58%	13%	27%	15%	3%
Nevada	273,724 (12%)	19%	86%	14%	14%	11%	30%	11%	11%

continued on next page

Appendix D
Characteristics of the Medicare Population, by State, Selected Years *(continued)*

	Number of Medicare Beneficiaries (2003)	Projected Age 65+ (2030)	Age 65+ (2003)	Under Age 65 (2003)	Residing in Rural Areas (2004)	Income <100% of Poverty (2002–2003)	Income 100%–199% of Poverty (2002–2003)	Enrolled in Medicaid (2002)	Enrolled in Medicare Advantage Plans (2004)
United States Total	40,172,605 (14% of U.S. Population)	20% of U.S. Population	85% of U.S. Medicare Population	15% of U.S. Medicare Population	24% of U.S. Medicare Population	12% of U.S. Medicare Population	32% of U.S. Medicare Population	18% of U.S. Medicare Population	11% of U.S. Medicare Population
STATE	**Medicare Beneficiaries with Characteristic as a Percent of State Medicare Population**								
Alabama	719,246 (16%)	21%	79%	21%	35%	15%	32%	23%	6%
New Hampshire	179,564 (14%)	21%	85%	15%	45%	10%	39%	11%	1%
New Jersey	1,219,935 (14%)	20%	88%	12%	0%*	12%	31%	14%	7%
New Mexico	250,113 (13%)	26%	84%	16%	45%	15%	33%	16%	14%
New York	2,763,299 (14%)	20%	85%	15%	9%	13%	31%	22%	15%
North Carolina	1,205,466 (14%)	18%	81%	19%	39%	15%	36%	23%	4%
North Dakota	103,220 (16%)	25%	89%	11%	65%	11%	33%	15%	0%
Ohio	1,727,096 (15%)	20%	86%	14%	20%	12%	31%	13%	11%
Oklahoma	521,286 (15%)	19%	85%	15%	46%	10%	31%	18%	7%
Oregon	513,253 (14%)	18%	87%	13%	36%	8%	31%	14%	23%
Pennsylvania	2,110,470 (17%)	23%	87%	13%	17%	10%	35%	16%	23%
Rhode Island	172,474 (16%)	21%	84%	16%	8%	12%	39%	19%	33%
South Carolina	606,323 (15%)	22%	80%	20%	33%	17%	30%	20%	0%
South Dakota	121,777 (16%)	23%	88%	12%	70%	12%	36%	15%	0%
Tennessee	871,938 (15%)	19%	81%	19%	39%	10%	35%	29%	7%
Texas	2,390,053 (11%)	16%	86%	14%	22%	19%	31%	21%	5%
Utah	220,221 (9%)	13%	88%	12%	30%	11%	28%	9%	0%
Vermont	92,724 (15%)	24%	84%	16%	74%	9%	32%	31%	0%
Virginia	946,470 (13%)	19%	84%	16%	25%	13%	27%	16%	0%
Washington	775,358 (13%)	18%	86%	14%	23%	9%	28%	14%	15%
West Virginia	347,459 (19%)	25%	78%	22%	59%	14%	40%	15%	1%
Wisconsin	803,678 (15%)	21%	87%	13%	38%	12%	30%	16%	3%
Wyoming	68,590 (14%)	27%	87%	13%	69%	7%	35%	13%	0%

Note: *There are no rural areas in the District of Columbia or the state of New Jersey.
SOURCE: CMS Statistics: Medicare State Enrollment; Census Bureau 2003 population estimates; State Interim Population Projections by Age and Sex: 2004-2030, Census Bureau; Mathematica Policy Research analysis of CMS State/County Market Penetration Files; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2002–2004 CPS; Urban Institute estimates based on data from MSIS prepared for Kaiser Commission on Medicaid and the Uninsured.