Table 2.B1—Federal benefit rates, by living arrangement, 1974–2013

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	[†] 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
	January 1, 2007	623.00	934.00
	January 1, 2008	637.00	956.00
	January 1, 2009	674.00	1,011.00
	January 1, 2010	674.00	1,011.00
	January 1, 2011	674.00	1,011.00
	January 1, 2012	698.00	1,048.00
	January 1, 2013	710.00	1,066.00

(Continued)

Table 2.B1—Federal benefit rates, by living arrangement, 1974–2013—*Continued*

Act	Effective date	Amount [a] (dollars)	
		Individual	Couple
		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, 2012; regulations issued under the Act; and precedential case decisions (rulings). Social Security Administration, Office of the Chief Actuary, "SSI Federal Payment Amounts," http://www.socialsecurity.gov/OACT/COLA/SSIamts.html. See the Social Security Program Rules page (http://www.socialsecurity.gov/regulations/index.htm) for specific laws, regulations, rulings, legislation, and a link to the *Federal Register*.

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).

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Table 2.C1—Medicare cost sharing and premium amounts, 1966–2014 [a]

Effective date [b]	Hospital Insurance (Medicare Part A)					Supplementary Medical Insurance (Medicare Parts B and D)								
						Part B					Part D [c]			
	All expenses in "benefit period" covered except—							Monthly premium (dollars)						
	Inpatient hospital deductible (IHD) covers first 60 days (dollars)	Inpatient hospital daily coinsurance		Skilled nursing facility daily coinsurance for days 21 through 100 (1/8 x IHD) (dollars)	Monthly premium [d] (dollars)	Annual deductible [e] (dollars)	Coinsurance [e] (percent)	For enrollee [h] (aged and disabled)	Government amounts for—		Annual deductible [f] (dollars)	Initial coverage limit [f] (dollars)	Out-of-pocket threshold [f] (dollars)	Base beneficiary monthly premium [g] (dollars)
		Days 61 through 90 (1/4 x IHD) (dollars)	Lifetime reserve days after 90 days (1/2 x IHD)						Aged	Disabled				
1966	40	10	. . .	. . .	. . .	50	20	3.00	3.00	. . .	. . .	. . .	. . .	. . .
1967	40	10	. . .	5.00	. . .	50	20	3.00	3.00	. . .	. . .	. . .	. . .	. . .
1968	40	10	20	5.00	. . .	[i] 50	[i] 20	[j] 4.00	[j] 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	[k] 20	5.80	5.80	. . .	. . .	. . .	. . .	. . .
1973	72	18	36	9.00	33	60	20	[l] 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	[m,n] 60	[n] 20	11.00	34.20	62.20	. . .	. . .	. . .	. . .
1982	260	65	130	32.50	113	[o] 75	[o] 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	[p] 560	p	p	[q] 25.50	156	75	20	[r] 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	245	100	20	41.10	82.50	111.10	. . .	. . .	. . .	. . .
1995	716	179	358	89.50	261	100	20	46.10	100.10	165.50	. . .	. . .	. . .	. . .
1996	736	184	368	92.00	289	100	20	42.50	127.30	167.70	. . .	. . .	. . .	. . .
1997	760	190	380	95.00	311	100	20	43.80	131.40	177.00	. . .	. . .	. . .	. . .
1998	764	191	382	95.50	309	100	20	43.80	132.00	150.40	. . .	. . .	. . .	. . .
1999	768	192	384	96.00	309	100	20	45.50	139.10	160.50	. . .	. . .	. . .	. . .
2000	776	194	388	97.00	301	100	20	45.50	138.30	196.70	. . .	. . .	. . .	. . .
2001	792	198	396	99.00	300	100	20	50.00	152.00	214.40	. . .	. . .	. . .	. . .
2002	812	203	406	101.50	319	100	20	54.00	164.60	192.20	. . .	. . .	. . .	. . .
2003	840	210	420	105.00	316	100	20	58.70	178.70	223.30	. . .	. . .	. . .	. . .
2004	876	219	438	109.50	343	100	20	66.60	199.80	284.40	s	s	s	s

(Continued)

Table 2.C1—Medicare cost sharing and premium amounts, 1966–2014 [a]—*Continued*

Effective date [b]	Hospital Insurance (Medicare Part A)					Supplementary Medical Insurance (Medicare Parts B and D)									
						Part B						Part D [c]			
	All expenses in "benefit period" covered except—							Monthly premium (dollars)							
	Inpatient hospital deductible (IHD) covers first 60 days (dollars)	Inpatient hospital daily coinsurance		Skilled nursing facility daily coinsurance for days 21 through 100 (1/8 x IHD) (dollars)	Monthly premium [d] (dollars)	Annual deductible [e] (dollars)	Coinsurance [e] (percent)	For enrollee [h] (aged and disabled)	Government amounts for—		Annual deductible [f] (dollars)	Initial coverage limit [f] (dollars)	Out-of-pocket threshold [f] (dollars)	Base beneficiary monthly premium [g] (dollars)
		Days 61 through 90 (1/4 x IHD) (dollars)	Lifetime reserve days after 90 days (1/2 x IHD)						Aged	Disabled				
2005	912	228	456	114.00	375	110	20	78.20	234.60	305.40	s	s	s	s
2006	952	238	476	119.00	393	124	20	88.50	265.30	318.90	250	2,250	[t] 3,600	32.20
2007	992	248	496	124.00	410	131	20	[u] 93.50	[v] 280.50	[v] 301.10	265	2,400	[t] 3,850	27.35
2008	1,024	256	512	128.00	423	135	20	[u] 96.40	[v] 289.00	[v] 323.00	275	2,510	[t] 4,050	27.93
2009	1,068	267	534	133.50	443	135	20	[u] 96.40	[v] 289.00	[v] 352.00	295	2,700	[t] 4,350	30.36
2010	1,100	275	550	137.50	461	155	20	[u,w] 110.50	[v] 331.50	[v] 430.30	310	2,830	[t] 4,550	31.94
2011	1,132	283	566	141.50	450	162	20	[u,x] 115.40	[v] 346.00	[v] 417.20	310	2,840	[t] 4,550	[y] 32.34
2012	1,156	289	578	144.50	451	140	20	[u] 99.90	[v] 299.70	[v] 285.10	320	2,930	[t] 4,700	[y] 31.08
2013	1,184	296	592	148.00	441	147	20	[u] 104.90	[v] 314.70	[v] 366.10	325	2,970	[t] 4,750	[y] 31.17
2014	1,216	304	608	152.00	426	147	20	[u] 104.90	[v] 314.70	[v] 332.90	310	2,850	[t] 4,550	[y] 32.42

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 consulted for specific details.

Values for certain 2014 premiums, copayments, and out-of-pocket thresholds not shown in the table are provided in footnotes as applicable. Corresponding values for prior years are available in previous editions of this table.

. . . = not applicable.

a. As of November 1, 2013.

b. Deductible and coinsurance amounts begin in January unless otherwise noted. Monthly premium amounts took effect in July through 1983 and in January beginning in 1984.

c. Enrollment in Part D is voluntary. Substantial premium and cost-sharing subsidies and waivers are available for Part D beneficiaries who meet certain low-income and limited-resources criteria. Subsidy levels vary.

d. 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.) Beginning in 1994, a reduced premium is available to premium-paying HI enrollees with at least 30 quarters of Medicare-covered employment (either their own or through a current or former spouse if the marriage meets certain duration criteria). In most cases, a surcharge applies for beneficiaries who enroll after their initial enrollment period.

e. Most services under Part B are subject to the annual deductible and coinsurance percentages shown. Some noteworthy exceptions are footnoted; others 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 but phases down to 20 percent over the 5-year period 2010–2014; 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.

f. Under the standard Part D benefit design, the beneficiary pays an initial deductible and 25 percent of the remaining costs until reaching the initial coverage limit. Between the initial coverage limit and the out-of-pocket threshold is a "coverage gap." Beneficiaries in the coverage gap paid the full cost of their prescription drugs from 2006 to 2009. Beneficiaries in the coverage gap (excluding low-income enrollees eligible for cost-sharing subsidies and enrollees in employer plans that receive Medicare's retiree drug subsidy) received, in 2010, a $250 rebate; in 2011, a 50-percent manufacturer discount on applicable brand-name prescription drugs and a 7-percent drug plan benefit on covered generic drugs; in 2012, a 50-percent manufacturer discount on applicable brand-name prescription drugs and a 14-percent drug plan benefit on covered generic drugs; and in 2013, a 50-percent manufacturer discount and a 2.5-percent drug plan benefit on applicable brand-name prescription drugs and a 21-percent drug plan benefit on covered generic drugs. In 2014, they will receive a 50-percent manufacturers discount and a 2.5-percent drug plan benefit on applicable brand-name prescription drugs and a 28-percent drug plan benefit on covered generic drugs. In determining out-of-pocket costs, costs reimbursed through insurance are not counted toward the out-of-pocket threshold, except for cost-sharing assistance provided to low-income enrollees by Part D and State Pharmacy Assistance programs and, starting in 2011, the 50-percent manufacturer discount on applicable brand-name drugs purchased by enrollees in the Part D coverage gap. For costs incurred after the out-of-pocket threshold is reached, "catastrophic coverage" requires enrollees to pay the greater of a 5-percent coinsurance or a small copayment (for 2014, $2.55 for generic or preferred multi-source drugs and $6.35 for other drugs). Many Part D plans differ from this standard coverage design; in fact, the majority of beneficiaries are enrolled in plans with low or no deductibles, flat payments for covered drugs, and, in some cases, additional partial coverage in the coverage gap.

g. The Part D premiums paid by individual beneficiaries equal the base beneficiary premium adjusted by a number of factors. Premiums vary significantly from one plan to another and seldom equal the base beneficiary premium. The estimated average monthly premium for 2014, as calculated prior to the start of the year (based on the bids submitted by Part D plans, the specific plan-by-plan premiums, and the estimated number of beneficiaries in each plan) is $31. A surcharge for enrollment after the initial enrollment period may apply.

h. Represents standard premium for voluntary enrollment in Part B. This is the amount paid by most beneficiaries in most years (2010 and 2011 are notable exceptions). Three factors can alter the premium paid by a beneficiary: enrollment after the initial enrollment period, for which a surcharge may apply; adjustments for beneficiaries whose income is above certain thresholds; and a "hold-harmless" provision that prohibits Part B premium increases that exceed the dollar amount of a beneficiary's Social Security cost-of-living adjustment. See also footnotes u, w, and x.

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

(Continued)

Table 2.C1—Medicare cost sharing and premium amounts, 1966–2014 [a]—*Continued*

j. Beginning in April 1968.

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

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

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

n. Professional inpatient services of pathologists and radiologists not subject to deductible or coinsurance, but only when physician accepts assignment.

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

p. The 1989 deductible was applied on an annual basis rather than a benefit-period basis. Once the beneficiary paid the deductible, 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 to 190 days).

q. In 1989 the coinsurance amount was equal to 20 percent of the estimated national average daily cost of covered skilled nursing facility care, the beneficiary paid the coinsurance amount for the first 8 days of care during the year, and benefits were available for up to 150 days of care during the year.

r. Includes the standard monthly Part B premium and a supplemental monthly flat premium under the Medicare Catastrophic Coverage Act of 1988. Persons enrolled in Part B only and residents of Puerto Rico and other territories and commonwealths paid lower supplemental flat premiums.

s. A temporary Medicare-endorsed prescription drug discount card program was offered. See the Medicare section of "Program Descriptions and Legislative History" (page 54 in this Supplement).

t. Under the defined standard benefit design, the out-of-pocket threshold of $4,550 for 2014 is equivalent to an estimated $6,690.77 in total covered drug costs for enrollees not eligible for low-income cost-sharing subsidies. (This estimated amount is based on an average blend of brand-name and generic drugs used while in the Part D coverage gap. In determining out-of-pocket costs, the dollar value of the 50-percent manufacturer discount on applicable brand-name drugs is included, even though the beneficiary does not pay it. The dollar values of the 28-percent drug plan benefit on covered generic drugs and the 2.5-percent drug plan benefit on applicable brand-name drugs do not count toward out-of-pocket spending.) For enrollees eligible for low-income cost-sharing subsidies, the 2014 out-of-pocket threshold is equivalent to $6,455.00 in total covered drug costs. See previous editions of this table for prior years' equivalent total covered drug costs.

u. See footnote h. The 2014 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" (page 41 in this Supplement). See previous editions of the Supplement for prior years' adjustment and premium amounts.

v. For beneficiaries paying an income-related adjustment, the government amounts are to be reduced accordingly. See also footnotes h and u.

w. Most Part B enrollees are protected by a "hold-harmless" provision prohibiting Part B premium increases that exceed the dollar amount of an individual's Social Security cost-of-living adjustment (COLA). Because the 2010 COLA equaled 0 percent, about 73 percent of Part B enrollees continued to pay the 2009 premium amount in 2010.

x. See footnote w. Because the 2011 COLA again equaled 0 percent, most Part B enrollees continued to pay the same premium amount they paid in 2010.

y. See footnote g. The 2014 Part D income-related monthly adjustment 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" (page 42 in this Supplement). See previous editions of the Supplement for prior years' adjustment amounts.

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Table 2.C2—Federal medical assistance percentage and enhanced federal medical assistance percentage, by state or other area, 2012–2014

State or area	Federal medical assistance percentage [a]			Enhanced federal medical assistance percentage [b]		
	2012 [c]	2013 [d]	2014 [e]	2012 [c]	2013 [d]	2014 [e]
Alabama	68.62	68.53	68.12	78.03	77.97	77.68
Alaska	50.00	50.00	50.00	65.00	65.00	65.00
Arizona	67.30	65.68	67.23	77.11	75.98	77.06
Arkansas	70.71	70.17	70.10	79.50	79.12	79.07
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	54.17	55.67	55.31	67.92	68.97	68.72
District of Columbia [f]	70.00	70.00	70.00	79.00	79.00	79.00
Florida	56.04	58.08	58.79	69.23	70.66	71.15
Georgia	66.16	65.56	65.93	76.31	75.89	76.15
Hawaii	50.48	51.86	51.85	65.34	66.30	66.30
Idaho	70.23	71.00	71.64	79.16	79.70	80.15
Illinois	50.00	50.00	50.00	65.00	65.00	65.00
Indiana	66.96	67.16	66.92	76.87	77.01	76.84
Iowa	60.71	59.59	57.93	72.50	71.71	70.55
Kansas	56.91	56.51	56.91	69.84	69.56	69.84
Kentucky	71.18	70.55	69.83	79.83	79.39	78.88
Louisiana	61.09	61.24	60.98	72.76	72.87	72.69
Maine	63.27	62.57	61.55	74.29	73.80	73.09
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	66.14	66.39	66.32	76.30	76.47	76.42
Minnesota	50.00	50.00	50.00	65.00	65.00	65.00
Mississippi	74.18	73.43	73.05	81.93	81.40	81.14
Missouri	63.45	61.37	62.03	74.42	72.96	73.42
Montana	66.11	66.00	66.33	76.28	76.20	76.43
Nebraska	56.64	55.76	54.74	69.65	69.03	68.32
Nevada	56.20	59.74	63.10	69.34	71.82	74.17
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	69.36	69.07	69.20	78.55	78.35	78.44
New York	50.00	50.00	50.00	65.00	65.00	65.00
North Carolina	65.28	65.51	65.78	75.70	75.86	76.05
North Dakota	55.40	52.27	50.00	68.78	66.59	65.00
Ohio	64.15	63.58	63.02	74.91	74.51	74.11
Oklahoma	63.88	64.00	64.02	74.72	74.80	74.81
Oregon	62.91	62.44	63.14	74.04	73.71	74.20
Pennsylvania	55.07	54.28	53.52	68.55	68.00	67.46
Rhode Island	52.12	51.26	50.11	66.48	65.88	65.08
South Carolina	70.24	70.43	70.57	79.17	79.30	79.40
South Dakota	59.13	56.19	53.54	71.39	69.33	67.48
Tennessee	66.36	66.13	65.29	76.45	76.29	75.70
Texas	58.22	59.30	58.69	70.75	71.51	71.08
Utah	70.99	69.61	70.34	79.69	78.73	79.24
Vermont	57.58	56.04	55.11	70.31	69.23	68.58
Virginia	50.00	50.00	50.00	65.00	65.00	65.00
Washington	50.00	50.00	50.00	65.00	65.00	65.00
West Virginia	72.62	72.04	71.09	80.83	80.43	79.76
Wisconsin	60.53	59.74	59.06	72.37	71.82	71.34
Wyoming	50.00	50.00	50.00	65.00	65.00	65.00

(Continued)

Table 2.C2—Federal medical assistance percentage and enhanced federal medical assistance percentage, by state or other area, 2012–2014—*Continued*

State or area	Federal medical assistance percentage [a]			Enhanced federal medical assistance percentage [b]		
	2012 [c]	2013 [d]	2014 [e]	2012 [c]	2013 [d]	2014 [e]
Outlying areas						
American Samoa [g]	50.00	55.00	55.00	65.00	68.50	68.50
Guam [g]	50.00	55.00	55.00	65.00	68.50	68.50
Northern Mariana Islands [g]	50.00	55.00	55.00	65.00	68.50	68.50
Puerto Rico [g]	50.00	55.00	55.00	65.00	68.50	68.50
U.S. Virgin Islands [g]	50.00	55.00	55.00	65.00	68.50	68.50

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 cannot exceed 85 percent.

c. Effective October 1, 2011, through September 30, 2012.

d. Effective October 1, 2012, through September 30, 2013.

e. Effective October 1, 2013, through September 30, 2014.

f. The values for the District of Columbia (DC) in the table were set for the state plan under titles XIX and XXI and for capitation payments and Disproportionate Share Hospital (DSH) allotments under those titles. For other purposes, including programs remaining in Title IV of the Act, the percentage for DC is 50.00, unless otherwise specified by law.

g. 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.

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