NOTE: This is a reconstructed document created from a scanned copy of the report using optical character recognition (OCR). Although many OCR conversion errors have been corrected, many OCR conversion errors remain in this document. Since later issues of the report are used as a template, artifacts from later reports may be present in this document. The content is presented in essentially the same order as the original document, but the formatting, page layout, pagination are different.

1989 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

COMMUNICATION

From

**THE BOARD OF TRUSTEES,
FEDERAL HOSPITAL INSURANCE
TRUST FUND**

Transmitting

**THE 1989 ANNUAL REPORT OF THE BOARD,
PURSUANT TO
SECTION 1817(b) OF THE SOCIAL SECURITY ACT,
AS AMENDED**

LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE TRUST FUND
Washington, D.C, December 5, 1989

HONORABLE THOMAS S. FOLEY
Speaker of the House of Representatives
Washington, D.C.

HONORABLE DAN QUALE
President of the Senate
Washington, D.C.

We have the honor of transmitting to you the 1989 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (the 24th such report), pursuant to the provisions of section 1817(b) of the Social security Act.

The enactment of the Medicare catastrophic Coverage Act of 1988 (P.L. 100-360) has resulted in a substantial delay in the completion of the 1989 report. The additional time was needed in order to solve the technical problems associated with long-range projections of revenue derived from the new supplemental premiums created by the catastrophic coverage legislation and the allocation of the supplemental premium revenue among the various trust funds according to the complex formulas in the legislation.

The Medicare catastrophic coverage Repeal Act of 1989, recently passed by the Congress but not yet signed into law, has overridden the usefulness of long-range projections of the supplemental premiums, since supplemental premiums would no longer be a consideration in the financing of the Federal Hospital Insurance Trust Fund. However, because the Medicare Catastrophic Coverage Repeal Act of 1989 has not yet become law, and because the long-range impact of the act has not yet been fully evaluated, we are transmitting the attached abbreviated report, which presents the operations of the Federal Hospital Insurance Trust Fund for the previous fiscal year, the current fiscal year, and the next two fiscal years, as required by section 1817(b) of the Social Security Act. We expect that a full long-range assessment of the actuarial status of the fund, including the impact of the Medicare catastrophic Coverage Repeal Act of 1989, can be provided in the 1990 report.

In addition, because section 1841A of the Social Security Act has been repealed by the Medicare catastrophic Coverage Repeal Act of 1989, the report required by that section on the operations of the Federal Catastrophic Drug Insurance Trust Fund is not being transmitted.

Respectfully,

NICHOLAS F. BRADY,
Secretary of the Treasure, and
Managing Trustee of the Trust Fund

ELIZABETH DOLE,
Secretary of Labor, and Trustee

LOUIS W. SULLIVAN, M.D.,
Secretary of Health and
Human Services and Trustee

PUBLIC TRUSTEE
Vacant

PUBLIC TRUSTEE
Vacant

LOUIS B. HAYS.,
Acting Administrator of the Health Care Financing Administration, and Secretary, Board of Trustees

CONTENTS

TABLES

1989 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

THE BOARD OF TRUSTEES

The Federal Hospital Insurance Trust Fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1817(b) of the Social Security Act, as amended. The Board currently has three members. They serve in an ex officio capacity. These members are the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services. The Board also includes positions for two members of the public as Trustees. The two Public Trustees served under recess appointments which expired when the Congress adjourned on November 22, 1989.

By law, the Secretary of the Treasury is designated as the Managing Trustee and the Administrator of the Health Care Financing Administration is designated as Secretary of the Board. The Board of Trustees reports to the Congress each year on the operation and status of the trust fund, in compliance with section 1817(b)(2) of the Social Security Act. This is the 1989 annual report, the 24th such report.

SOCIAL SECURITY AMENDMENTS SINCE THE 1988 REPORT

Since the 1988 Annual Report was transmitted to Congress, several laws affecting the hospital insurance (HI) program (also known as Medicare Part A) have been enacted. The more important legislative changes, from an actuarial standpoint, are described below.

The Medicare catastrophic Coverage Act of 1988 (Public Law 100-360) was enacted on July 1, 1988, and contained the following changes:

(1) The scope of benefits is expanded beginning. January 1, 1989. The spell of illness concept has been eliminated for hospital and extended care services. As a result, HI will pay for an unlimited number of hospital days and for 150 days of skilled nursing facility (SNF) care per calendar year for covered services. In addition, there is no longer a requirement for prior hospitalization to obtain SNF coverage, and hospice care can be extended beyond the 210-day cap with a physician certification that the patient is terminally ill. The requirement that days spent in a psychiatric hospital during the 150-day period preceding Medicare entitlement be counted in a spell of illness is deleted.

(2) Beginning January 1, 1989, beneficiaries are responsible for only one inpatient hospital deductible each year. Beneficiaries who pay a deductible for hospitalizations beginning during the month of December will not be required to pay an additional deductible for hospitalizations beginning in January of the following year.

Beneficiaries enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) whose Medicare contracts are terminated during a year will not be charged an inpatient deductible for the remainder of that year if they had a hospital admission during that year that was paid for by the HMO or CMP.

(3) The coinsurance requirements are eliminated for inpatient hospital stays; however, for extended care services, beneficiaries are liable for coinsurance equal to 20 percent of the national average per diem reasonable cost (as estimated and promulgated in September of the prior calendar year) for the first eight days of SNF care.

(4) Home health services have been extended, effective January 1, 1990, by changing the definition of intermittent services from no more than four days per week to less than seven days per week and by specifying that daily care may now be provided up to 38 consecutive days.

(5) The Part A premium for individuals who do not automatically qualify for Medicare is revised. Effective January 1989, it is 1/12 of the estimated actuarial value of the average per capita amount payable for the year from the HI trust fund for incurred benefits and related administrative costs for individuals age 65 and older who are entitled to Part A benefits (as estimated and promulgated in September of the prior calendar year). Each year the Secretary must issue a public statement detailing the actuarial assumptions used in calculating the actuarial rate for the premium.

(6) Several transition and conforming provisions are included in the Act. Among these is the provision that the Secretary must take into consideration reductions in beneficiary payments to hospitals, as a result of the elimination of the day limitation, when adjusting payment rates, outlier cutoff points and weighting factors for prospective payment system (PPS) hospitals, and the target amount for non-PPS hospitals. These payment adjustments are effective for discharges (or cost reporting periods for non-PPS hospitals) occurring on or after October 1, 1988.

(7) Most Medicare beneficiaries who are eligible for Medicare Part A for more than 6 months in a calendar year and whose tax liability is $150 or more are subject to a supplemental catastrophic coverage premium. Individuals who are entitled to Part A benefits solely by payment of a premium, who reside in a foreign country for at least 330 days during the taxable year, or who reside in Puerto Rico, the Virgin Islands, or possessions of the United States with no U. S. income tax liability are not subject to this premium. The statute specifies the catastrophic coverage premium rates (per $150 of adjusted Federal income tax liability) and maximum annual

amounts per individual for 1989 to 1993, and methodologies for calculating the premium rates after 1993.

(8) A new trust fund, to be known as the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (the HI reserve fund), is established. Beginning in 1989, supplemental catastrophic coverage premiums are appropriated to the HI reserve fund, but not exceeding the amount of outlays from the HI trust fund that are attributable (on an estimated basis) to the catastrophic coverage provisions. Transfers of the supplemental catastrophic coverage premiums to the HI reserve fund are to be made not less frequently than monthly, with adjustments made in subsequent transfers to take account of more current estimates of the HI costs attributable to the catastrophic coverage provisions. Supplemental catastrophic coverage premium rate receipts not appropriated to the HI reserve fund are appropriated to the Federal Supplementary Medical Insurance (SMI) Trust Fund. No expenditures from the HI reserve fund are permitted, but it is anticipated that Congress may at some future time transfer funds from the HI reserve fund to the HI trust fund.

(9) The Medicare Catastrophic Coverage Account is established under this legislation. No funds shall be transferred into or out of this account, but amounts credited to it shall be considered receipts of the account and amounts debited to it shall be considered outlays from the account. It will be credited with the receipts of the SMI trust fund attributable to catastrophic coverage, receipts of the HI reserve fund, and interest on any positive average balance in the account. It will be debited with outlays attributable to the catastrophic coverage from the HI and SMI trust funds, as well as with interest on any negative average balance in the account.

The Technical and Miscellaneous Revenue Act of 1988 (Public Law 100-647) was enacted on November 10, 1988, and extended the Medicare payment adjustment for hospitals which serve a disproportionate share of low-income patients. The disproportionate share adjustment, which had been in place for discharges occurring before October 1, 1990, is now in place for discharges occurring before October 1, 1995.

The Medicare Catastrophic Coverage Repeal Act of 1989 and the Omnibus Budget Reconciliation Act of 1989 were passed by Congress, but as of December 5, 1989, had not been signed into law by the President. The financial impact of this legislation is not included in this report. Therefore, a detailed description of this legislation will be presented in the 1990 report.

Detailed information regarding these changes and other less significant changes can be found in documents prepared by and for the Congress.

NATURE OF THE TRUST FUND

The Federal Hospital Insurance Trust Fund was established on July 30, 1965, as a separate account in the United States Treasury. All the financial operations of the hospital insurance program are handled through this fund.

The primary source of income to the trust fund is amounts appropriated to it under permanent authority on the basis of contributions paid by workers, their employers, and individuals with self-employment income, in work covered by the hospital insurance program. Beginning January 1, 1987, these appropriated amounts include contributions paid by, or on behalf of, workers employed by State and local governments and their employers, with respect to work covered by the program through State agreements. (Prior to 1987, such contributions were deposited directly into the trust fund.) The coverage of the hospital insurance program includes workers covered under the old-age, survivors, and disability insurance (OASDI) program, those covered under the railroad retirement program, and Federal employees.

All employees, and their employers, in employment covered by the program are required to pay contributions with respect to the wages of individual workers, including cash tips. (Prior to 1978, employees paid contributions with respect to cash tips but employers did not. From 1978 to 1987, employers paid contributions on that part of the tip income deemed to be wages under the Federal minimum wage law.) All covered self-employed persons are required to pay contributions with respect to their self-employment income.

In general, an individual's contributions are computed on annual wages or self-employment income, or both wages and self-employment income combined, up to a specified maximum annual amount, with the contributions being determined first on the wages and then on any self-employment income up to the maximum annual amount.

The hospital insurance contribution rates applicable to taxable earnings in each of the calendar years 1966 and later are shown in table 1. For 1990 and later, the contribution rates shown are the rates scheduled in the provisions of present law. The maximum amount of annual earnings taxable in each year 1966-89 are also shown. For 1975-78, the contribution and benefit bases were determined under the automatic increase provisions in section 230 of the Social Security Act. In 1979, 1980, and 1981, the bases increased to the specified amounts as provided under the 1977 amendments. After 1981, the automatic increase provisions are again applicable.

All contributions are collected by the Internal Revenue Service and deposited in the general fund of the Treasury as internal revenue collections. The contributions received are automatically appropriated to

the trust fund, on an estimated basis. The exact amount of contributions received is not known initially since HI contributions, OASDI contributions, and individual income taxes are not separately identified in collection reports received by the Treasury Department. Periodic adjustments are subsequently made to the extent that the estimates are found to differ from the amounts of contributions actually payable on the basis of reported earnings.

Prior to May 1983 and after June 1984, the estimated internal revenue collections were transferred to the trust funds immediately upon receipt. For May 1983 through June 1984, estimated total collections for each month were credited to the trust funds on the first day of the month. As the actual collections were received during the month, they were deposited in the general fund of the Treasury and remained there. The trust funds paid interest to the general fund to reimburse it for the interest lost because of this provision.

An employee who worked for more than one employer during the course of a year and paid contributions on wages in excess of the statutory maximum can receive a refund of the contributions he paid on such excess wages. The amount of contributions subject to refund for any period is a charge against the trust fund.

As discussed in the section entitled "Social Security Amendments Since the 1988 Report," the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) intended that the receipts of the Federal Hospital Insurance Catastrophic coverage Reserve Fund would be available as a source of revenue for the Federal Hospital Insurance Trust Fund. However, such transfers of funds would require a change in the law, and so have not been included in this report.

Another substantial source of trust fund income is interest received on investments held by the fund. The investment procedures of the fund are described later in this section.

The income and expenditures of the trust fund are also affected by the provisions of the Railroad Retirement Act which provide for a system of coordination and financial interchange between the railroad retirement program and the hospital insurance program.

Sections 217(g) and 229(b) of the Social Security Act, prior to modification by the Social Security Amendments of 1983, authorized annual reimbursement from the general fund of the Treasury to the hospital insurance trust fund for costs arising from the granting of deemed wage credits for military service prior to 1957, according to quinquennial determinations made by the Secretary of Health and Human Services. These sections, as modified by the Social Security Amendments of 1983, provided for a lump sum transfer in 1983 for costs arising from such wage credits. In addition, the lump sum transfer

included combined employer-employee HI taxes on the noncontributory wage credits for military service after 1965 and before 1984. After 1983, HI taxes on military wage credits are credited to the fund on July 1 of each year. The Social Security Amendments of 1983 also provided for (1) quinquennial adjustments to the lump sum amount transferred in 1983 for costs arising from pre-1957 deemed wage credits and (2) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on noncontributory wage credits.

Section 231 of the Social Security Act authorizes reimbursement from the general fund of the Treasury to the hospital insurance trust fund for any costs arising from the granting of deemed wage credits to individuals who were interned during World War II at a place within the United States operated by the Federal Government for the internment of persons of Japanese ancestry.

Under section 103 of the Social Security Amendments of 1965, hospital insurance benefits are provided to certain uninsured persons aged 65 and over. Such payments are made initially from the hospital insurance trust fund, with reimbursement from the general fund of the Treasury for the costs, including administrative expenses, of the payments. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.

Section 1818 of the Social Security Act provides that certain persons not eligible for hospital insurance protection either on an insured basis or on the uninsured basis described in the previous paragraph may obtain protection by enrolling in the program and paying a monthly premium.

Section 20l(i) of the social Security Act authorizes the Managing Trustee to accept and deposit in the trust fund unconditional money gifts or bequests made for the benefit of the fund or any activity financed through the fund.

Expenditures for benefit payments and administrative expenses under the hospital insurance program are paid from the trust fund. All expenses incurred by the Department of Health and Human Services and by the Treasury Department in carrying out the provisions of title XVIII of the Social Security Act pertaining to the hospital insurance program and of the Internal Revenue Code relating to the collection of contributions are charged to the trust fund. The Secretary of Health and Human Services certifies benefit payments to the Managing Trustee, who makes the payments from the trust fund in accordance therewith.

Prior to fiscal year 1984, hospitals, at their option, were permitted to combine their billing for both hospital and physician components of radiology and pathology services rendered to hospital inpatients by

hospital-based physicians. Where hospitals elected this billing procedure, payments were made initially from the hospital insurance trust fund. The reimbursements so made were on a provisional basis and are subject to adjustment, with appropriate interest allowance.

The Social Security Amendments of 1967 and 1972 authorize the Secretary of Health and Human Services to develop and conduct a broad range of experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under the hospital insurance and supplementary medical insurance programs. A sizable portion of the costs of such experiments and demonstration projects is paid from the hospital insurance and supplementary medical insurance trust funds.

Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of the hospital insurance program. Both the capital costs of construction financed directly through the trust funds and the rental and lease, or purchase contract costs of acquiring facilities are included in trust fund expenditures. In 1972-75, construction of several large facilities was authorized under purchase contract authority, wherein initial capital costs were borne by the private sector. Under this method of facilities acquisition, trust fund expenditures for use and ultimate Government ownership of a facility are made over periods of from 10 to 30 years. Whatever the manner of acquisition, the net worth of facilities and other fixed capital assets is not carried in the statement of the assets of the trust fund presented in this report. This is because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and, therefore, is not viewed as being a consideration in assessing the actuarial status of the funds.

That portion of the trust fund which, in the judgment of the Managing Trustee, is not required to meet current expenditures for benefits and administration, is invested, on a daily basis, in interest-bearing obligations of the U.S. Government (including special public-debt obligations described below), in obligations guaranteed as to both principal and interest by the United States, or in certain federally sponsored agency obligations that are designated in the laws authorizing their issuance as lawful investments for fiduciary and trust funds under the control and authority of the United States or any officer of the United States. These obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price.

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall bear interest at a rate

based on the average market yield (computed on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United states forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such month. These special issue securities are always redeemable at par value, and so are not subject to the uncertainty of price fluctuations as interest rates change.

From December 29, 1981, until January 1, 1988, the Social Security Act authorized borrowing among the OASI, DI, and HI trust funds when necessary "to best meet the need for financing the benefit payments" from the three funds. Interfund loans under the borrowing authority were made to the OASI trust fund from the DI and HI trust funds in 1982, and were fully repaid by May 1986. In this report, the assets of the HI trust fund at the end of 1982 through 1985, inclusive, do not include the amounts owed to the trust fund. This procedure is followed because the borrowed amounts were available to the borrowing fund for the payment of benefits or other obligations, while such amounts were not readily available to the lending fund.

TABLE 1.—CONTRIBUTION RATES AND MAXIMUM TAXABLE AMOUNT OF ANNUAL EARNINGS

Calendar years	Maximum taxable amount of annual earnings	Contribution rate (Percent or taxable earnings)	
		Employees and employers, each	Self-employed
Past experience:			
1966	$6,600	0.35%	0.35%
1967	6,600	0.50	0.50
1968-71	7,800	0.60	0.60
1972	9,000	0.60	0.60
1973	10,800	1.00	1.00
1974	13,200	0.90	0.90
1975	14,100	0.90	0.90
1976	15,300	0.90	0.90
1977	16,500	0.90	0.90
1978	17,700	1.00	1.00
1979	22,900	1.05	1.05
1980	25,900	1.05	1.05
1981	29,700	1.30	1.30
1982	32,400	1.30	1.30
1983	35,700	1.30	1.30
1984	37,800	1.30	2.60
1985	39,600	1.35	2.70
1986	42,000	1.45	2.90
1987	43,800	1.45	2.90
1988	45,000	1.45	2.90
1989	48,000	1.45	2.90
Changes scheduled in present law:			
1990 & later	Subject to automatic adjustment	1.45	2.90

SUMMARY OF THE OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1988

A statement of the income and disbursements of the Federal Hospital Insurance Trust Fund in fiscal year 1988, and of the assets of the fund at the beginning and end of the fiscal year, is presented in table 2.

The total assets of the trust fund amounted to $50,596 million on September 30, 1987. During fiscal year 1988, total receipts amounted to $68,010 million, and total disbursements were $52,730 million. The assets of the trust fund thus increased $15,281 million during the year to a total of $65,877 million on September 30, 1988.

Included in total receipts during fiscal year 1988 was $62,091 million representing contributions appropriated to the trust fund. As an offset, $147 million was transferred from the trust fund into the Treasury as repayment for the estimated amount of contributions subject to refund to employees who worked for more than one employer during the course of a year and paid contributions on wages in excess of the statutory maximum earnings base, and $42 million was transferred from the trust fund to state and local governments for refunds of overpayments from previous State agreements for coverage of State and local government employees.

Net contributions amounted to $61,901 million, representing an increase of 7.1 percent over the amount of $57,820 million for the preceding 12-month period. This growth in contribution income resulted primarily from (1) the higher level of earnings in covered employment and (2) the two increases in the maximum annual amount of earnings taxable from $42,000 to $43,800 and from $43,800 to $45,000 that became effective January 1, 1987, and January 1, 1988, respectively.

The section entitled "Nature of the Trust Fund" referred to provisions under which the hospital insurance trust fund is to be reimbursed from the general fund of the Treasury for costs of paying benefits under this program on behalf of certain uninsured persons. The reimbursement in fiscal year 1988 amounted to $475 million, consisting of $465 million for benefit payments, $8 million for administrative expenses, and $2 million for interest on adjustments to costs in prior fiscal years.

The section entitled "Nature of the Trust Fund" referred to provisions of the Social Security Act under which certain persons aged 65 and over but not otherwise eligible for hospital insurance protection may obtain such protection by enrolling in the program and paying a monthly premium. Premiums collected from such voluntary participants in fiscal year 1988 amounted to about $42 million.

In accordance with the provisions of the Railroad Retirement Act which coordinate the railroad retirement and the hospital insurance programs and which govern the financial interchange arising from the

allocation of costs between the two systems, the Railroad Retirement Board and the Secretary of Health and Human Services determined that a transfer of about $332 million from the railroad retirement account to the hospital insurance trust fund would place this fund in the same position, as of September 30, 1987, in which it would have been if railroad employment had always been covered under the social Security Act. This amount, together with interest to the date of transfer amounting to about $31 million, was transferred to the trust fund in June 1988.

In accordance with provisions for the appropriation to the trust fund of HI taxes on noncontributory military wage credits as discussed in the section entitled "Nature of the Trust Fund," the trust fund was credited on July 1, 1988 with $80 million for calendar year 1988 taxes on wage credits.

The remaining $5,148 million of receipts consisted almost entirely of interest on the investments of the trust fund.

Of the $52,730 million in total disbursements, $52,022 million represented benefits paid directly from the trust fund for health services covered under title XVIII of the Social Security Act. Benefit payments increased 4.1 percent in fiscal year 1988 over the corresponding amount of $49,967 million paid during the preceding 12 months.

The remaining $707 million of disbursements was for net administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds -- old-age and survivors insurance, disability insurance, hospital insurance, and supplementary medical insurance -- on the basis of provisional estimates. Similarly, the expenses of administering other programs of the Health Care Financing Administration are also allocated and charged directly to the general fund of the Treasury on a provisional basis. Periodically, as actual experience develops and is analyzed, adjustments to the allocations of administrative expenses and costs of construction for prior periods are effected by interfund transfers, including transfers between the hospital insurance and supplementary medical insurance trust funds and the program management general fund account, with appropriate interest allowances.

Table 3 compares the actual experience in fiscal year 1988 with the estimates presented in the 1987 and 1988 annual reports. The section entitled "Nature of the Trust Fund" referred to the appropriation of contributions to the trust funds on an estimated basis, with subsequent periodic adjustments to account for differences from the amounts of contributions actually payable on the basis of reported earnings. In interpreting the figures in table 3, it should be noted that the "actual" amount of contributions in fiscal year 1988 reflects the aforementioned type of adjustments to contributions for prior fiscal years. On the other

hand, the "actual" amount of contributions for fiscal year 1988 does not reflect adjustments to contributions for fiscal year 1988 that were to be made after September 30, 1988.

The assets of the hospital insurance trust fund at the end of fiscal year 1987 totaled $50,596 million, consisting of $50,770 million in the form of obligations of the U.S. Government or of federally-sponsored agency obligations and, as an offset, an extension of credit of $173 million against securities to be redeemed. The assets of the hospital insurance trust fund at the end of fiscal year 1988 totaled $65,877 million, consisting of $66,080 million in the form of obligations and, as an offset, an extension of credit of $203 million against securities to be redeemed. Table 4 shows the total assets of the fund and their distribution at the end of fiscal years 1987 and 1988.

New securities at a total par value of $85,756 million were acquired during the fiscal year through the investment of receipts and the reinvestment of funds made available from the redemption of securities. The par value of securities redeemed during the fiscal year was $70,457 million. Thus, the net increase in the par value of the investments held by the fund during fiscal year 1988 amounted to $15,299 million.

The effective annual rate of interest earned by the assets of the hospital insurance trust fund during the 12 months ending on June 30, 1988, was 9.9 percent. (This period is used because interest on special issues is paid semiannually on June 30 and December 31.) The interest rate on public-debt obligations issued for purchase by the trust fund in June 1988 was 9.25 percent, payable semiannually.

TABLE 2.—STATEMENT OF OPERATIONS OF THE HI TRUST FUND DURING FISCAL YEAR 1988
(In thousands of dollars)

Total assets of the trust fund, beginning of period	$50,596,354
Receipts:	
Appropriation of employment taxes	$62,090,579
Refunds of employment taxes	-147,350
Deposits arising from State agreements	-42,181
Interest on Investments	5,124,353
Amortization of premium and discount (Net)	10,771
Premiums collected from voluntary participants	42,202
Transfer from railroad retirement account	332,400
Transitional uninsured coverage	475,000
Military service credits of 1988	80,000
Interest on reimbursements, SSA[1]	11,832
Interest on reimbursements, HCFA[1]	1,047
Interest on reimbursements, Railroad	31,408
Other (Gifts)	2
Total receipts	$68,010,062
Disbursements:	
Benefit payments	$52,022,064
Administrative expenses:	
Treasury administrative expenses	54,614
Salaries and expenses, SSA	239,135
Salaries and expenses. HCFA[2]	378,462
Salaries and expenses, Office of Secretary	14,711
Construction	15,939
Professional Standards Review Organization	-558
Reimbursement of SSA expenses	0
Reimbursement of HCFA expenses	0
Payment Assessment Committee	3,053
Public Health Service	2,099
Other	-8
Total disbursements	52,729,511
Total assets of the trust fund, end of period	$65,876,905

[1]A positive figure represents a transfer to the hospital insurance trust fund from the other trust funds. A negative figure represents a transfer from the hospital insurance trust fund to the other trust funds.
[2]Includes administrative expenses of the intermediaries.

NOTE: Totals do not necessarily equal the sums of rounded components.

TABLE 3.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, FISCAL YEAR 1988
(Dollar amounts in millions)

		Comparison of actual experience with estimates for fiscal year 1990 published in–			
		1981 report[1]		1987 report[1]	
Item	Actual amount	Estimated amount[1]	Actual as percentage of estimate	Estimated amount[2]	Actual as percentage of estimate
Net contributions	$61,901	$61,508	101	$60,544	102
Benefit payments	$52,022	$51,832	100	$53,031	98

[1]Alternative II-B

TABLE 4.—ASSETS OF THE HOSPITAL INSURANCE TRUST FUND, BY TYPE, AT THE END OF FISCAL YEARS 1987 AND 1988 [1]

	September 30, 1987	September 30, 1988
Investments In public-debt obligations sold only to the trust funds (special Issues):		
Certificates of Indebtedness:		
9 -percent, 1988	$4,367,948,000.00	—
9 1/4-percent, 1989	—	$5,581,465,000.00
Bonds:		
8 1/4-percent, 1993	622,286,000.00	622,286,000.00
8 3/8-percent, 1989	1,231,586,000.00	—
8 3/8-percent, 1990-2001	15,297,664,000.00	15,297,664,000.00
8 5/8-percent, 1989	686,250,000.00	—
8 5/8-percent, 1990-2002	11,430,404,000.00	11,430,404,000.00
8 3/4-percent, 1993-1994	972,757,000.00	972,757,000.00
9 1/4-percent, 1990-2003	—	17,678,981,000.00
9 3/4-percent, 1993-1995	1,240,090,000.00	1,240,090,000.00
10 3/8-percent, 1988	420,032,000.00	—
10 3/8-percent, 1989-2000	3,839,700,000.00	3,839,700,000.00
10 3/4-percent, 1988	588,410,000.00	—
10 3/4-percent, 1989-1998	2,942,050,000.00	2,942,050,000.00
13 -percent, 1993-1996	1,770,094,000.00	1,770,094,000.00
13 1/4-percent, 1993-1997	2,541,541,000.00	2,541,541,000.00
13 3/4-percent, 1988	262,135,000.00	—
13 3/4-percent, 1989-1999	2,161,216,000.00	2,161,216,000.00
Total public-debt obligations sold only to the trust funds (special issues)	$50,374,163,000.00	$66,078,248,000.00
Investments in federally-sponsored agency obligations:		
Participation certificates:		
Federal Assets liquidation Trust-Government National Mortgage Association:		
6.40-percent, 1987	75,000,000.00	—
6.05-percent, 1988	65,000,000.00	—
6.45-percent, 1988	35,000,000.00	—
6.20-percent, 1988	230,000,000.00	—
Unamortized Premium & Discount (Net)	-9,455,552.40	1,315,002.00
Total Investments	$50,769,707,447.60	$66,079,563,002.00
Undisbursed balance	-173,353,560.84	-202,658,416.91
Total assets	$50,596,353,886.76	$65,876,904,585.09

[1] Certificates of indebtedness and bonds are carried at par value, which is the same as book value. Book value for participation certificates is par value plus net unamortized premium and discount.

EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND DURING THE PERIOD OCTOBER 1, 1988 to DECEMBER 31, 1991

The expected operations of the trust fund during fiscal years 1989-91 are shown in table 5, together with the past experience of the program. The projection shown in table 5 — and the entirety of this section — is based on two intermediate sets of projection assumptions· labeled "Alternative II-A" and "Alternative II-B," which are presented in detail in appendix A.

Income received through the financial interchange between the railroad retirement account and the trust fund under the provisions of the Railroad Retirement Act is estimated on the same basis as income

from hospital insurance contributions. Estimates of the corresponding outgo are included in the disbursement items.

Estimated income to the trust fund which is appropriated from general revenues to reimburse the program for the cost of coverage of noninsured persons is the same as the estimates of disbursements for such persons, net of corrections for differences between costs and amounts transferred for previous years. Premium income and disbursements for other noninsured persons over age 65 who may enroll in the hospital insurance program on a voluntary basis are based on an estimated enrollment of 18,000 in fiscal year 1989.

The transfers from general revenues for military wage credits are based on provisions of the Social Security Amendments of 1983 (Public Law 98-21), as described in the "Nature of the Trust Fund" section.

The investment of new assets received during fiscal years 1989-91 is assumed to be in the form of special public-debt obligations bearing interest rates ranging from 8.25 percent to 9.375 percent, payable semiannually. The average effective annual rate of interest on the assets held by the hospital insurance trust fund on September 30, 1988, was 9.7 percent.

The income estimates in table 5 and 6 do not include income from the supplemental catastrophic coverage premiums which are appropriated to the Federal Hospital Insurance catastrophic coverage Reserve Fund (the HI reserve fund). These premiums were established by Public Law 100-360 to cover the cost of the catastrophic coverage benefits created in that legislation. Although Public Law 100-360 intended that the receipts of the HI reserve fund would be available as a source of revenue for the HI trust fund, such transfers would require a change in the law and have not been included in tables 5 and 6.

Disbursements for benefits are projected to increase in fiscal years 1989-91, primarily as a result of the increase in hospital payment rates and hospital admissions under the program. The expenditures for benefit payments shown in table 5 differ from those shown in the 1990 Federal Budget. These estimates are based on more recent demographic and economic projections, and they do not reflect the implementation of proposed changes in regulations which were included in the budget. The expenditures for benefit payments shown in this section are based on the assumption that for fiscal years 1991 and later, the prospective payment rates will be increased in accordance with Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987; for fiscal year 1990, it is assumed that the prospective payment rates that have already been determined, and the sequester required by the Gramm-Rudman-Hollings Act, will remain in effect (while Congress continues to consider changes to these rates). For fiscal years through 1989, the prospective payment rates have already been determined.

The actual operations of the hospital insurance program are organized, in general, on a calendar year basis. Earnings subject to taxation and the applicable tax rates are established by calendar year, as are the inpatient hospital deductible and other cost-sharing amounts. The projected operations of the trust fund on a calendar year basis are shown in table 6, according to the same assumptions as used in table 5. A preliminary estimate of the December 1990 lump sum transfer, to be determined in the 1990 quinquennial Military Service Determination, is also included; the provisions prescribing this transfer are described in the "Nature of the Trust Fund" section. The ratios of assets in the trust fund at the beginning of each calendar year to total disbursements during that year are shown in table 7 for past years and as projected through 1991.

A presentation of the long-range actuarial status of the trust fund does not appear in this report, and the projections presented herein do not reflect the recent enactment of the Medicare Catastrophic Coverage Repeal Act of 1989 and the Omnibus Budget Reconciliation Act of 1989. When the impact of this legislation has been fully evaluated, long-range projections of the actuarial status of the program will be included in the 1990 report.

TABLE 5.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING FISCAL YEARS 1967-91

(In millions)

	Income							Disbursements						Trust Fund	
								Benefit payments		Administrative expenses					
Fiscal year[1]	Payroll taxes	Railroad retirement account transfers	Reimburse-ment for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest on investments and other income[2]	Total Income	Basic[3]	Catastro-phic Coverage	Basic[4]	Catastro-phic Coverage	Total disburse-ments	Interfund borrowing transfers[5]	Net increase in fund	Fund at end of year
Historical Data:															
1967	2,689	$16	$327	—	$11	$46	$3,089	$2,508		$89		$2,597	—	$492	$1,343
1968	3,514	44	273	—	11	61	3,902	3,736		79		3,815	—	88	1,431
1969	4,423	54	749	—	22	96	5,344	4,654		104		4,758	—	586	2,017
1970	4,785	64	617	—	11	137	5,614	4,804		149		4,953	—	661	2,677
1971	4,898	66	863	—	11	180	6,018	5,442		150		5,592	—	426	3,103
1972	5,226	66	503	—	48	188	6,031	6,108		167		6,276	—	-245	2,859
1973	7,663	63	381	—	48	196	8,352	6,648		194		6,842	—	1,510	4,369
1974	10,602	99	451	$4	48	405	11,610	7,806		259		8,065	—	3,545	7,914
1975	11,291	132	481	6	48	609	12,568	10,353		259		10,612	—	1,956	9,870
1976	12,031	138	610	8	48	709	13,544	12,267		312		12,579	—	966	10,836
T.Q.	3,366	143	0[6]	2	0	5	3,516	3,315		89		3,404	—	112	10,948
1977	13,649	0[7]	803[6]	11	141	770	15,374	14,906		301		15,207	—	167	11,115
1978	16,677	214[7]	688	12	143[8]	809	18,543	17,411		451		17,862	—	681	11,796
1979	19,927	191	734	17	141	901	21,910	19,891		452		20,343	—	1,567	13,363
1980	23,244	244	697	17	141	1,072	25,415	23,790		497		24,288	—	1,127	14,490
1981	30,425	276	659	21	141	1,341	32,863	28,907		353		29,260	—	3,603	18,093
1982	34,390	351	808	25	207	1,829	37,611	34,343		521		34,864	—	2,747	20,840
1983	36,387	358	878	26	3,663[9]	2,629	43,940	38,102		522		38,624	-$12,437	-7,121	13,719
1984	41,364	351	752	35	250	2,812	45,563	41,476		633		42,108	—	3,455	17,174
1985	46,490	371	766	38	86	3,182	50,933	47,841		813		48,654	1,824	4,103	21,277
1986	53,020	364	566	40	-714[10]	3,167	56,442	49,018		667		49,685	10,613	17,370	38,648
1987	57,820	368	447	40	94	3,982	62,751	49,967		836		50,803	—	11,949	50,596
1988	61,901	364	475	42	80	5,148	68,010	52,022		707		52,730	—	15,281	65,877
Projection:															
Alternative II-A															
1989	67,527	379	515	42	86	6,567	75,116[13]	55,481	$1,952	740	$64	58,238	—	16,878	82,755
1990	71,669	358	413	43	92	8,001	80,576[13]	60,629	4,841	899	74	66,443	—	14,133	96,888
1991	76,023	339	506	44	-477[11]	9,176	85,611[13]	67,488	5,325	964	79	73,856	—	11,755	108,643
Alternative II-B															
1989	67,527	379	515	42	86	6,567	75,116[13]	55,481	$1,952	740	64	58,238	—	16,878	82,755
1990	71,331	358	413	43	92	7,998	80,235[13]	60,635	4,841	897	74	66,447	—	13,788	96,543
1991	75,737	337	507	44	-268[12]	9,212	85,569[13]	67,802	5,331	965	79	74,177	—	11,392	107,935

[1]Fiscal years 1976 and earlier consist of the 12 months ending on June 30 of each year; the three-month interval from July 1, 1976, through September 30, 1976, labeled "T.Q.," is the transition quarter; fiscal years 1977 and later consist of the 12 months ending on September 30 of each year.

[2]Other Income Includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and a small amount of miscellaneous Income.

[3]Includes costs of Peer Review Organizations (beginning with the implementation of the Prospective Payment System on October 1, 1983).

[4]Includes costs of experiments and demonstration projects.

[5]A negative amount is a loan to the OASI trust fund; a positive amount is a repayment of loan principal to the HI trust fund.

[6]The 1977 transfer is for benefits and administrative expenses during the five-quarter period covering the transition quarter and fiscal year 1977

[7]The 1978 transfer is for contributions during the five-quarter period covering the transition quarter and fiscal year 1977.

[8]Includes $2 million in reimbursement from the general revenues for costs arising from the granting of deemed wage credits to persons of Japanese ancestry who were interned during World War II.

[9]Includes the lump sum general revenue transfer of $3,456 million, as provided for by section 151 of P.L 98-21.

[10]Includes the lump sum general revenue adjustment of -$805 million, as provided for by section 151 of P.L 98-21.

[11]Includes the preliminary estimate of the lump sum general revenue adjustment of -$570 million, as provided for by section 151 of P.L. 98-21.

[12]Includes the preliminary estimate of the lump sum general revenue adjustment of -$381 million, as provided for by section 151 of P.L. 98-21.

[13]P.L. 100-360 intended that the receipts of the HI reserve fund would be available as a source of revenue for the HI trust fund. However, such transfers of funds would require a change in the law, and so have not been included here. It is estimated that in fiscal years 1989 to 1991, receipts to the HI reserve fund will be $563, $5,853, and $5,383 million under alternative II-A assumptions, and $563, $5,892, and $5,457 million under alternative II-B assumptions.

NOTE: Totals do not necessarily equal the sums of rounded components.

TABLE 6.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1966-91

(In millions)

	Income							Disbursements						Trust Fund	
								Benefit payments		Administrative expenses					
Calendar year	Payroll taxes	Railroad retirement account transfers	Reimburse-ment for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest on investments and other income[1]	Total Income	Basic[2]	Catastro-phic Coverage	Basic[3]	Catastro-phic Coverage	Total disburse-ments	Interfund borrowing transfers[4]	Net increase in fund	Fund at end of year
Historical Data:															
1966	$1,858	$16	$26	—	$11	$32	$1,943	$891		$108		$999	—	$944	$944
1967	3,152	44	301	—	11	51	3,559	3,353		77		3,430	—	129	1,073
1968	4,116	54	1,022	—	22	74	5,287	4,179		99		4,277	—	1,010	2,083
1969	4,473	64	617	—	11	113	5,279	4,739		118		4,857	—	422	2,505
1970	4,881	66	863	—	11	158	5,979	5,124		157		5,281	—	698	3,202
1971	4,921	66	503	—	48	193	5,732	5,751		150		5,900	—	-168	3,034
1972	5,731	63	381	—	48	180	6,403	6,318		185		6,503	—	-99	2,935
1973	9,944	99	451	$2	48	278	10,821	7,057		232		7,289	—	3,532	6,467
1974	10,844	132	471	5	48	523	12,024	9,099		272		9,372	—	2,652	9,119
1975	11,502	138	621	7	48	664	12,980	11,315		266		11,581	—	1,399	10,517
1976	12,727	143	0[5]	9	141	746	13,766	13,340		339		13,679	—	88	10,605
1977	14,114	0[6]	803[5]	12	143[7]	784	15,856	15,737		283		16,019	—	-163	10,442
1978	17,324	214[6]	688	13	141	834	19,213	17,682		496		18,178	—	1,035	11,477
1979	20,768	191	734	16	141	975	22,825	20,623		450		21,073	—	1,751	13,228
1980	23,848	244	697	18	141	1,149	26,097	25,064		512		25,577	—	521	13,749
1981	32,959	276	659	22	207	1,603	35,725	30,342		384		30,726	—	4,999	18,748
1982	34,586	351	808	24	207	2,022	37,998	35,631		513		36,144	-$12,437	-10,583	8,164
1983	37,259	358	878	27	3,456[8]	2,593	44,570	39,337		540		39,877	—	4,693	12,858
1984	42,288	351	752	33	250	3,046	46,720	43,257		629		43,887	—	2,834	15,691
1985	47,576	371	766	41	-719[9]	3,362	51,397	47,580		834		48,414	1,824	4,808	20,499
1986	54,583	364	566	43	91	3,619	59,267	49,758		664		50,422	10,613	19,458	39,957
1987	58,648	368	447	38	94	4,469	64,064	49,496		793		50,289	—	13,775	53,732
1988	62,449	364	475	41	80	5,830	69,239	52,517		815	$4	53,331	—	15,908	69,640
Projection:															
Alternative II-A															
1989	68,236	379	515	42	86	7,220	76,478[12]	56,220	$3,486	850	70	60,626	—	15,852	85,492
1990	72,630	358	413	43	-478[10]	8,454	81,420[12]	62,108	4,994	915	75	68,092	—	13,328	98,820
1991	77,056	339	506	45	93	9,514	87,553[12]	69,098	5,492	980	81	75,651	—	11,902	110,722
Alternative II-B															
1989	68,236	379	515	42	86	7,220	76,478[12]	56,220	$3,486	850	70	60,626	—	15,852	85,492
1990	72,295	358	413	43	-289[11]	8,450	81,270[12]	62,155	4,994	913	75	68,137	—	13,133	98,625
1991	76,810	337	507	45	93	9,553	87,345[12]	69,529	5,503	982	81	76,095	—	11,250	109,875

[1]0ther Income Includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and a small amount of miscellaneous Income.

[2]Includes costs of Peer Review Organizations (beginning with the implementation of the Prospective Payment System on October 1, 1983).

[3]Includes costs of experiments and demonstration projects.

[4]A negative amount is a loan to the OASI trust fund; a positive amount is a repayment of loan principal to the HI trust fund.

[5]No transfer is made in 1976 because of the change in transfer dates from December to March. The 1977 transfer is for benefits and administrative expenses during the 15-month period beginning July 1976 and ending September 1977.

[6]No transfer is made in 1977 because of the change in transfer dates from August to June. The 1978 transfer is for contributions during the 15-month period beginning July 1976 and ending September 1977.

[7]Includes $2 million in reimbursement from the general revenues for costs arising from the granting of deemed wage credits to persons of Japanese ancestry who were interned during World War II.

[8]The lump sum general revenue transfer, as provided for by section 151 of P.L 98-21.

[9]Includes the lump sum general revenue adjustment of -$805 million, as provided for by section 151 of P.L 98-21.

[10]Includes the preliminary estimate of the lump sum general revenue adjustment of -$570 million, as provided for by section 151 of P.L. 98-21.

[11]Includes the preliminary estimate of the lump sum general revenue adjustment of -$381 million, as provided for by section 151 of P.L. 98-21.

[12]P.L. 100-360 intended that the receipts of the HI reserve fund would be available as a source of revenue for the HI trust fund. However, such transfers of funds would require a change in the law, and so have not been included here. It is estimated that in calendar years 1989 to 1991, receipts to the HI reserve fund will be $563, $5,853, and $5,383 million under alternative II-A assumptions, and $563, $5,892, and $5,457 million under alternative II-B assumptions.

NOTE: Totals do not necessarily equal the sums of rounded components.

TABLE 7.—RATIO OF ASSETS IN THE FUND AT THE BEGINNING OF THE YEAR TO DISBURSEMENTS DURING THE YEAR FOR THE HOSPITAL INSURANCE TRUST FUND

(In percent)

Calendar Year	Ratio
Historical Data:	
1967	28%
1968	25
1969	43
1970	47
1971	54
1972	47
1973	40
1974	69
1975	79
1976	77
1977	66
1978	57
1979	54
1980	52
1981	45
1982	52
1983	20
1984	29
1985	32
1986	41
1987	79
1988	101
Projection:	
Alternative II-A	
1989	115
1990	126
1991	131
Alternative II-A	
1989	115
1990	125
1991	130

CONCLUSION

The balance in the Federal Hospital Insurance Trust Fund at the beginning of 1989 was at the level of 115 percent of estimated outgo for calendar year 1989. This is above the minimum 50 percent level recommended by the Board of Trustees. The tax rates specified in the law are sufficient, along with interest earnings and assets in the fund, to support program expenditures under the intermediate assumptions through at least 1991, the period covered in this report.

Although the uncertainty of the catastrophic coverage legislation has made it impossible to prepare a report portraying the long-range actuarial status of the HI program, it is expected that the actuarial deficit in the HI program would still be significant, and similar in magnitude to the actuarial deficit presented in the 1988 report. The HI

trust fund would probably still be exhausted shortly after the turn of the century under alternative II-B assumptions. It is expected that a full long- range assessment of the actuarial status of the fund can be provided in the 1990 report, when the long-range impact of the Medicare Catastrophic Coverage Act of 1988, the Medicare Catastrophic Coverage Repeal Act of 1989, and the Omnibus Budget Reconciliation Act of 1989 can be fully evaluated.

APPENDIX A

ACTUARIAL METHODOLOGY AND PRINCIPAL ASSUMPTIONS FOR THE HOSPITAL INSURANCE COST ESTIMATES

The basic methodology and assumptions for alternative II-A and alternative II-B used in the estimates for the hospital insurance program are described in this appendix. These alternatives reflect two different levels of expectation of future performance of the economy.

The economic and demographic assumptions underlying the alternative projections are described in detail in the 1989 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds.

The principal steps involved in projecting the future costs of the hospital insurance program are (1) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base: (2) projecting increases in payment amounts for inpatient hospital services under the program; (3) projecting increases in payment amounts for skilled nursing facility and home health agency services covered under the program; and (4) projecting increases in administrative costs. The major emphasis will be directed toward expenditures for inpatient hospital services, which account for approximately 92 percent of total benefits.

a. Projection Base

In order to establish a suitable base from which to project the future costs of the program, the incurred payments for services provided must be reconstructed for the most recent period for which a reliable determination can be made. To do this, payments to providers must be attributed to dates of service, rather than to payment dates. In addition, the nonrecurring effects of any changes in regulations, legislation, or administration of the program and of any items affecting only the timing and flow of payments to providers must be eliminated. As a result, the rates of increase in the incurred cost of the program differ from the increases in cash disbursement shown in tables 5 and 6.

For those expenses still reimbursed on a reasonable cost basis, the costs for covered services are determined on the basis of provider cost reports. Payments to a provider initially are made on an "interim" basis; to adjust interim payments to the level of retroactively determined costs, a series of payments or recoveries is effected through the course of cost settlement with the provider. The net amounts paid to date to providers in the form of cost settlements are known; however, the incomplete data available do not permit a precise determination of the exact amounts incurred during a specific period of time. Due to the time required to

obtain cost reports from providers, to verify these reports, and to perform audits (where appropriate), final settlements have lagged behind the liability for such payments of recoveries by as much as several years for some providers. Hence, the final cost of services reimbursed on a reasonable cost basis has not been completely determined for the most recent years of the program, and some degree of uncertainty remains even for earlier years.

Even for inpatient hospital operating payments paid for on the basis of diagnosis-related groups (DRGs), most payments are initially made on an interim basis, and final payments are determined on the basis of bills containing detailed diagnostic information which are later submitted by the hospital.

Additional problems are posed by changes in legislation or regulation, or in administrative or reimbursement policy, which have a substantial effect on either the amount or incidence of payment. The extent and timing of the incorporation of such changes into interim payment rates and cost settlement amounts cannot be determined precisely.

The process of allocating the various types of payments made under the program to the proper incurred period — using incomplete data and estimates of the impact of administrative actions — presents difficult problems, the solution to which can be only approximate. Under the circumstances, the best that can be expected is that the actual incurred cost of the program for a recent period can be estimated within a few percent. This increases the projection error directly, by incorporating any error in estimating the base year into all future years.

b. Payments for Inpatient Hospital Costs

Beginning with hospital accounting years starting on or after October 1, 1983, the hospital insurance program began paying almost all participating hospitals a prospectively-determined amount for providing covered services to beneficiaries. With the exception of certain expenses (such as capital-related and medical education expenses) reimbursed on a reasonable cost or per resident cost basis, as defined by law, the payment rate for each admission depends upon the DRG to which the admission belongs.

The law contemplates that the annual increase in the payment rate for each admission will be related to a hospital input price index, which measures the increase in prices for goods and services purchased by hospitals for use in providing care to hospital inpatients. For fiscal years through 1989, the prospective payment rates have already been determined. The projections contained in this report are based on the assumption that the prospective payment rates already determined for fiscal year 1990, and the sequester required by the Gramm-Rudman-Hollings Act, will remain in effect, and that for fiscal years 1991 and

later, the prospective payment rates will be increased in accordance with Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987.

Increases in aggregate payments for inpatient hospital care covered under the hospital insurance program can be analyzed into four broad categories:

(1) Labor factors — the increase in the hospital input price index which is attributable to increases in hospital workers' hourly earnings;

(2) Non-labor factors — the increase in the hospital input price index which is attributable to factors other than hospital workers' hourly earnings, such as the costs of energy, food, and supplies;

(3) Unit input intensity allowance — the increase in inpatient hospital payments per admission which are in excess of those attributable to increases in the hospital input price index; and

(4) Volume of services the increase in total output of units of service (as measured by hospital admissions covered by the hospital insurance program).

It has been possible to isolate some of these elements and to identify their roles in previous hospital cost increases. Table Al shows the values of the principal components of the increases for historical periods for which data are available and the projected trends used in the estimates. The following discussions apply to projections under both alternative II-A and alternative II-B, unless otherwise indicated.

Increases in hospital workers' hourly earnings can be analyzed and projected in terms of the assumed increases in hourly earnings in employment in the general economy and the difference between hourly earnings increases in the general economy and the proxy for hospital hourly earnings used in the hospital input price index.

Since the beginning of the hospital insurance program, the differential between the proxy for hospital workers' hourly earnings and hourly earnings in the general economy has fluctuated widely. Since 1975, this positive differential has averaged about 0.3 percent, as hospital workers' earnings have risen faster than general earnings. several factors contributing to this differential can be identified, including (1) growth in third-party reimbursement of hospitals through Medicare, Medicaid, and comprehensive private plans which is likely to have weakened hospital resistance to wage demands; (2) increased proportions of highly trained and more highly paid personnel; (3) an increased degree of labor organization and activity; and (4) the fact that hospital employees had historically earned less than similarly skilled workers in other industries. During the initial years of the prospective payment system, it appears that hospital hourly earnings were depressed relative to those in the general economy as hospitals adapted to the prospective payment

system. Over the short term, this differential is assumed to grow to a level of one percent.

Increases in hospital price input intensity, which are primarily the result of price increases for goods and services that hospitals purchase which do not parallel increases in the Consumer Price Index (CPI), are measured as the difference between the non-labor component of the hospital input price index and the CPI. Although the level has fluctuated erratically in the past, this differential has averaged about o.4 percent during 1975-1987. Over the short term, hospital price input intensity is assumed to grow to 1.7 percent and then decline to 1.0 percent under alternative II-A, and is assumed to be about one percent under alternative II-B.

Public Law 100-203 prescribes that future increases in payments to participating hospitals for covered admissions in most years will equal the increase in the hospital input price index. Thus, the unit input intensity allowance, as indicated in table A1, is assumed to equal zero in 1990 and 1991. For years prior to the beginning of the prospective payment system, the unit input intensity allowance has been set at one percent for illustrative purposes, with historical increases in excess of one percent allocated to other sources. For years after the beginning of the prospective payment system, the unit input intensity allowance is the allowance provided for in the prospective payment update factor.

Since the beginning of the prospective payment system, increases in inpatient hospital payments from other sources are primarily due to three factors: (1) the improvement in DRG coding as hospitals continue to adjust to the prospective payment system; (2) the trend toward treating less complicated (and thus, less expensive) cases in outpatient settings, resulting in an increase in the average prospective payment per admission; and (3) legislation affecting the payment rates. Expansions in hospital payments due to the Medicare Catastrophic Coverage Act of 1988 are reflected in other sources for 1989 and 1990. Also, for 1989 to 1991, the increase in payments from other sources reflects a two percent sequester in fiscal year 1990 required by the Gramm-Rudman-Hollings Act. For the years 1990 and 1991, a one percent increase also reflected in other sources is attributable to a continuation of the current trend toward treating less complicated cases in outpatient settings. The long-term average increase from other sources is due to payments for certain costs not included in the DRG payment increasing at a rate faster than the input price index. Possible other sources of both relative increases and decreases in payments include (1) a shift to more or less expensive admissions (DRGs) due to changes in the demographic characteristics of the covered population; (2) changes in medical practice patterns; and (3) adjustments in the relative payment levels for various DRGs or addition/deletion of DRGs in response to changes in technology. As experience under the prospective payment system develops and is

analyzed, it may be possible to establish a predictable trend for this component.

Other factors which contribute to increases in payments for inpatient hospital services include increases in units of service as measured by increases in inpatient hospital admissions covered under the hospital insurance program. Increases in admissions are attributable both to increases in enrollment under the hospital insurance program and to increases in admission incidence(admissions per beneficiary). The historical and projected increases in enrollment reflect the more rapid increase in the population aged 65 and over than in the total population of the United States, and the coverage of certain disabled beneficiaries and persons with end-stage renal disease. Increases in the enrollment are expected to continue, reflecting a continuation of the demographic shift into categories of the population which are eligible for hospital insurance protection. In addition, increases in the average age of beneficiaries lead to higher levels of admission incidence.

c. Skilled Nursing Facility and Home Health Agency Costs

Historical experience with the number of days of care covered in skilled nursing facilities under the hospital insurance program has been characterized by wide swings. The number of covered days dropped very sharply in 1970 and continued to decline through 1972. This was the result of strict enforcement of regulations separating skilled nursing care from custodial care. Because of the small fraction of nursing home care covered under the program, this reduction primarily reflected the determination that Medicare was not liable for payment rather than reduced usage of services. The 1972 amendments extended benefits to persons who require skilled rehabilitative services regardless of their need for skilled nursing services (the former prerequisite for benefits). This change and subsequent related changes in regulations have resulted in significant increases in the number of services covered by the program. More recently, changes made in 1988 to coverage guidelines for skilled nursing facility services resulted in about a 50 percent increase in utilization, and expansions and changes due to the Medicare Catastrophic Coverage Act of 1988, effective January 1, 1989, resulted in about a 200 percent increase in utilization of skilled nursing facility services. The projections contained in this report are based on the assumption that the skilled nursing facility provisions of the Medicare Catastrophic Coverage Act of 1988 remain intact. Modest increases in utilization are projected for years after 1989.

Increases in the average cost per day (where cost is defined to be the total of program reimbursement and beneficiary cost sharing) in skilled nursing facilities under the program are caused principally by increasing payroll costs for nurses and other skilled labor required. Projected rates of increase in cost per day are assumed to be about the same as increases

in general earnings throughout the projection period. Increases in reimbursement per day reflect reductions in beneficiary cost sharing mandated by the catastrophic coverage legislation.

Program experience with home health agency payments has shown a generally upward trend. The number of visits had increased sharply from year to year, but recent increases have been smaller. After 1990, when a generous increase in visits is expected due to the catastrophic coverage legislation, modest increases are projected. Reimbursement per visit is assumed to increase at about the same rate as increases in general earnings.

d. Administrative Expenses

The costs of administering the hospital insurance program have remained relatively small, in comparison with benefit amounts, throughout the history of the program. The ratio of administrative expenses to benefit payments has generally fallen within the range of 1 to 3 percent. The short-range projection of administrative cost is based on estimates of workloads and approved budgets for intermediaries and the Health care Financing Administration.

TABLE A1.—COMPONENTS OF HISTORICAL AND PROJECTED INCREASES IN HI INPATIENT HOSPITAL PAYMENTS [1]

(Percent)

Calendar year	Labor			Non-labor			Input price index	Unit input intensity allowance [2]	Units of service		Other Sources	HI inpatient hospital payments
	Average hourly earnings	Hospital hourly earnings level	Hospital hourly earnings	CPI	Hospital price input intensity	Non-labor hospital prices			HI enrollment	Admission incidence		
Historical Data:												
1975	8.2%	0.6%	8.8%	9.1%	3.5%	12.9%	10.5%	1.0%	3.4%	0.1%	6.1%	22.5%
1976	7.8	-0.2	7.6	5.7	1.7	7.5	7.6	1.0	2.9	1.5	5.1	19.2
1977	6.8	0.0	6.8	6.5	0.6	7.1	6.9	1.0	3.0	4.6	0.8	17.2
1978	8.0	-0.3	7.7	7.6	-0.8	6.7	7.3	1.0	2.7	-1.9	5.3	14.9
1979	8.5	-0.6	7.8	11.4	-1.1	10.2	8.8	1.0	2.7	3.1	0.2	16.5
1980	7.7	1.9	9.7	13.5	0.8	14.4	11.8	1.0	2.1	2.4	2.4	20.8
1981	9.0	1.2	10.3	10.3	-0.5	9.8	10.1	1.0	1.9	2.7	3.0	19.7
1982	5.9	2.8	8.9	6.0	0.3	6.3	7.7	1.0	1.8	0.0	4.6	15.7
1983	4.4	1.8	6.3	3.0	1.2	4.2	5.4	1.0	1.7	0.8	1.9	11.2
1984	5.8	-0.4	5.4	3.4	0.5	3.9	4.7	1.0	1.8	-3.8	7.4	11.2
1985	5.3	-0.9	4.4	3.5	-0.7	2.8	3.7	0.0	1.6	-7.4	8.6	6.0
1986	5.3	-1.5	3.7	1.5	0.3	1.8	2.9	-2.7	2.3	-4.9	6.1	3.4
1987	4.9	-0.8	4.1	3.6	-0.1	3.5	3.8	-2.7	1.7	-1.1	2.8	4.5
Projection:												
Alternative II-A												
1988	4.2	0.6	4.8	4.0	1.3	5.4	5.1	-2.7	2.3	-0.3	-0.1	4.3
1989	5.1	0.0	5.1	3.9	1.7	5.7	5.4	-1.9	2.0	1.9	3.8	11.7
1990	4.8	1.0	5.9	3.7	1.5	5.3	5.7	0.0	1.8	1.2	-0.2	8.7
1991	4.5	1.0	5.5	3.2	1.0	4.2	5.0	0.0	1.7	1.2	2.6	10.9
Alternative II-B												
1988	4.2	0.6	4.8	4.0	1.3	5.4	5.1	-2.7	2.3	-0.3	-0.1	4.3
1989	5.4	-0.3	5.1	4.8	0.9	5.7	5.4	-1.9	2.0	1.9	3.8	11.7
1990	4.7	1.1	5.9	4.5	0.8	5.3	5.7	0.0	1.8	1.2	0.0	8.9
1991	4.9	1.0	5.9	4.5	1.0	5.5	5.8	0.0	1.7	1.2	2.5	11.6

[1] Percent increase in year indicated over previous year, on an incurred basis.
[2] Reflects the allowances provided for in the prospective payment update factors.

Note: Historical and projected data reflect a recalibration of the hospital input price index which occurred in 1986.

APPENDIX B

ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) INPATIENT HOSPITAL DEDUCTIBLE, FOR CALENDAR YEAR 1989[1]

SUMMARY: This notice announces that the inpatient hospital deductible for calendar year 1989 under Medicare's hospital insurance program (Part A) is $560. The Medicare statute specifies the formula to be used to determine this amount.

Effective Date: January 1, 1989.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) (42 U.S.C. 1395e) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished an individual. Section 1813(b)(2) of the Act requires the Secretary to determine and publish by September 15 of each year the amount of the inpatient hospital deductible applicable for the following calendar year.

Computing the Deductible

Section 9301 of Pub. L. 99-509 amended section 1813(b) of the Act to establish for years after 1987 the method for computing the amount of the inpatient hospital deductible. The deductible specified for 1987 was $520 and, under the formula specified in the law, the deductible for subsequent calendar years is the- deductible for the preceding year multiplied by the same percentage increase (that is, the update factor) used for updating the prospective payment rates for inpatient hospital services effective October 1 of the same preceding year and adjusted to reflect real case mix. The amount so determined is rounded to the nearest multiple of $4. The deductible for 1988 calculated in this manner is $540. Section 1813 of the Act was further amended by section 4002(f) of Pub. L.100-203, as amended by section 411(b)(1)(H)(ii) of Pub. L. 100-360, to require that, beginning January 1989, the deductible be changed each year by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates for hospitals (according to whether they are prospective payment system (PPS) hospitals in rural, large urban, or other urban areas or are hospitals excluded from PPS) and adjusted to

[1] Extracted from the notice entitled "Medicare Program; Inpatient Hospital Deductible for 1989," which was published in the Federal Register on September 30, 1988 (Vol. 53, No. 190, p. 38357), as corrected in the Federal Register on November 1, 1988 (Vol. 53, No. 211, p. 44144).

reflect real case mix. (Without this amendment, we would have been required to assess four different deductibles, according to the status or location of the hospital to which a beneficiary was admitted when a deductible is applicable.)

Section 1886(b)(3)(B) of the Act, as amended by section 4002 of Pub. L. 100-203, requires the applicable percentage increases for fiscal year 1989 for Medicare prospective payment rates to be the market basket percentage increase minus 1.5 percent for rural hospitals, minus 2.0 percent for large urban hospitals, and minus

2.5 percent for other urban hospitals. The market basket percentage increase that we are using for fiscal year 1989 is 5.4 percent. Therefore, the percentage increases for Medicare prospective payment rates are 3.9 percent for rural hospitals, 3.4 percent for large urban hospitals, and 2.9 percent for other urban hospitals; the payment percentage increase for hospitals excluded from PPS is 5.4 percent. Our best estimate of the payment-weighted average of these increases in the payment rates is 3.3 percent.

A case-mix index is calculated for each hospital reflecting the relative costliness of that hospital's mix of cases compared to a national average mix of cases. We computed the increase in average case mix for hospitals paid under PPS in fiscal year 1988 compared to fiscal year 1987. (Hospitals excluded from PPS were excluded from this calculation, since their payments are unaffected by increases in case mix.) We used PPS bills available to us as of the end of July 1988. This is a total of about 6.4 million discharges for fiscal year 1988. The increase in average case mix in fiscal year 1988 is computed to be 2.66 percent.

Although the case mix index has increased by 2.66 percent in fiscal year 1988, section 1813 of the Act requires that the inpatient hospital deductible be increased only by that portion of the case mix increase that is determined to be real. The long-term trend in real case mix increase was determined to be approximately 0.5 percent. During the first few years of the prospective payment system, estimated real case mix increases exceeded that level, primarily because of the shift of many lower-cost treatments out of the inpatient hospital setting. This shift out of the inpatient hospital setting resulted in declining Medicare hospital admissions. However, during 1988, hospital admission patterns have returned to levels consistent with long-term trends. Furthermore, we have observed that nearly 0.9 percent of the 2.66 percent case mix increase is associated with changes in the DRG classification and changes in the relative DRG weights. Therefore, there is no reason to believe that real case mix increase has not also returned to the long-term trend level of 0.5 percent. As a consequence, we believe that the case mix increase associated with coding changes totals 2.16 percent and, for purposes of determining the 1989 inpatient hospital deductible, we are estimating the real case mix increase at 0.5 percent.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.3 percent, and the case-mix adjustment factor for the deductible is 0.5 percent.

II. Inpatient Hospital Deductible for 1989

The inpatient hospital deductible for calendar year 1989 is $540 times the payment rate increase of 1.033 times the increase in average real case mix of 1.005, which equals $560.61 and is rounded to $560.

III. Costs to Beneficiaries

Section 102 of the Medicare Catastrophic Coverage Act of 1988 (Pub L. 100-360) amended section 1813 of the Act so that there is only one deductible for hospitalization per year and there are no longer any coinsurance amounts for days 61 through 90 of hospitalization or for lifetime reserve days.

The estimated cost to beneficiaries due to the deductible increase is $150 million. That amount is, for 1989, based on an estimated 7.3 million beneficiaries who will be admitted to a hospital and be subject to the deductible. The cost is offset by an estimated $800 million, which represents the savings to beneficiaries from multiple admissions being subject only to an annual deductible and no longer subject to a deductible for each spell of illness, and from removal of the requirement for coinsurance amounts for hospital services.

IV. Regulatory Impact Statement

This notice merely announces an amount required by legislation. This notice is not a proposed rule or a final rule issued after a proposal, and does not alter any regulation or policy. Therefore, we have determined, and the Secretary certifies, that no analyses are required under Executive Order 12291, the Regulatory Flexibility Act (5 U.S.C. 601 through 612) or section 1102(b) of the Act.

Dated: September 23, 1988.

William L. Roper,
Administrator,
Health Care Financing Administration

Approved: September 27, 1988.

Otis R. Bowen,
Secretary,
Department of Health and Human Services

APPENDIX C

ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) SKILLED NURSING FACILITY COINSURANCE AMOUNT, FOR CALENDAR YEAR 1989[2]

SUMMARY: This notice announces that the skilled nursing facility coinsurance amount for calendar year 1989 for the 1st through 8th days of extended care services in a skilled nursing facility under Medicare's hospital insurance program (Part A) is $25.50. The Medicare statute specifies the method to be used to determine this amount.

Effective Date: January 1, 1989.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813(a)(3) of the Act requires, until January 1, 1989, that the amount payable for extended care services in a skilled nursing facility during a spell of illness is to be reduced by an amount equal to one-eighth of the hospital deductible, per day, for the 21st through 100th day of covered extended care services. section 102 of Pub. L. 100-360 amended section 1813(a) and repealed section 1813(b)(3) of the Act to change the method of determining coinsurance for skilled nursing facility (SNF)care and to change the days subject to coinsurance.

Beginning January 1, 1989, beneficiaries are liable for coinsurance for days one through eight of covered days spent in a SNF in a calendar year rather than days 21 through 100 in a spell of illness. Notice of the coinsurance amount applicable to extended care services in the succeeding year must be published in September.

II. Skilled Nursing Facility Coinsurance Amount for 1989

The coinsurance is 20 percent of the national average per diem cost estimated for a year by HCFA before September 1 of the previous year. The amount is rounded to the nearest multiple of $.50. (If it is a multiple of $.25 but not of $.50, the amount is rounded to the next highest multiple of $.50.)

The SNF coinsurance amount for calendar year 1989 is $25.50.

---

[2] Extracted from the notice entitled "Medicare Program; SNF Coinsurance Amount for 1989," which was published in the Federal Register on October 20, 1988 (Vol. 53, No. 203, p. 41242).

III. Statement of Actuarial Assumptions and Bases Employed in Determining the SNF Coinsurance Rate

As discussed in Section II of this notice, the SNF coinsurance rate for 1989 is equal to 20 percent of the national average per diem cost for Medicare extended care services for 1989. The national average per diem cost is determined on a reasonable cost basis and includes any cost sharing costs paid by the beneficiary.

The principal steps involved in projecting the future cost per day of skilled nursing care are: (a) determining the present cost per day to serve as a projection base, using a 100 percent sample of SNF bills, actual beneficiary billing experience (to identify coinsurance), and a review of SNF cost reports; and (b)projecting increases in cost per day amounts.

We have completed the above steps, basing our projections for 1989 on (a) current historical data from 1987 and (b) projection assumptions from the 1988 Annual Report of the Board of Trustees Alternative II-B (Intermediate) assumptions. It is estimated that in calendar year 1989 the national average per diem cost for Medicare extended care services is $127.43. Thus, 20 percent of this cost is $25.49, and the coinsurance rate is $25.50.

IV. Costs to Beneficiaries

The coinsurance amount for 1989 represents a $42 decrease from coinsurance for 1988. In addition, the coinsurance amount applies to the first eight days only in 1989. That is, we estimate that in 1989 there will be 2.3 million days subject to coinsurance at $25.50 per day versus 3.7 million days subject to coinsurance at $67.50 per day in 1988. The total savings to beneficiaries is about $190 million.

V. Regulatory Impact Statement

This notice merely announces an amount required by legislation. This notice is not a proposed rule or a final rule issued after a proposal, and does not alter any regulation or policy. Therefore, we have determined, and the Secretary certifies, that no analyses are required under Executive Order 12291, the Regulatory Flexibility Act (5 U.S.C. 601 through 612) or section 1102(b) of the Act.

Dated: September 30, 1988.

William L. Roper,
Administrator,
Health Care Financing Administration

Approved: October 5, 1988.

Otis R. Bowen,
Secretary,
Department of Health and Human Services

APPENDIX D

ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) MONTHLY PREMIUM RATE FOR THE UNINSURED AGED, FOR CALENDAR YEAR 1989[3]

SUMMARY: This notice announces the hospital insurance premium for the uninsured aged for calendar year 1989 under Medicare's hospital insurance program (Part A). The monthly Medicare Part A premium for the 12 months beginning January 1, 1989 (for individuals who are not insured under the Social Security or Railroad Retirement Acts and do not otherwise meet the requirements for entitlement to Part A) is $156. The Medicare statute specifies the method to be used to determine this amount.

Effective Date: January 1, 1989.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the social security Act (the Act) provides for voluntary enrollment in the hospital insurance program (Part A of Medicare), subject to payment of a monthly premium, of certain persons age 65 and older who are uninsured for social security or railroad retirement benefits and do not otherwise meet the requirements for entitlement to Part A. (Persons insured under the Social Security or Railroad Retirement Acts need not pay premiums for hospital insurance.)

Section 1818(d)(2) of the Act, as amended by section 103 of Pub. L. 100-360, requires the Secretary to determine and publish, during September of each calendar year, the amount of the monthly Part A premium for voluntary enrollment for the following calendar year.

Section 1818(d) of the Act, as amended by section 103 of Pub. L. 100-360, requires the Secretary to estimate the amount to be paid from the Federal Hospital Insurance Trust Fund for services performed and for related administrative costs incurred in the following year with respect to individuals age 65 and over who will be entitled to benefits under Part A, and to estimate the average per capita cost. He must then, during September, determine the monthly actuarial rate (the per capita amount estimated above divided by 12) and promulgate the dollar amount to be applicable for premiums in the succeeding year. If the premium is not a multiple of $1.00, the premium is rounded to the

[3] Extracted from the notice entitled "Medicare Program; Part A Premium for the Uninsured Aged for 1989," which was published in the Federal Register on November 8, 1988 (Vol. 53, No. 216, p. 45161).

nearest multiple of $1.00 (or if it is a multiple of 50 cents but not of $1.00, it is rounded to the next highest $1.00). The first premium under this new method is effective January 1989.

II. Premium Amount for 1989

Under the authority in section 1818(d)(2) of the Act (42 U.S.C. 1395i-2(d)(2)), I have determined that the monthly Medicare hospital insurance premium for the uninsured aged for the 12 months beginning January 1, 1989 is $156, which is a decrease from the 1988 premium. This premium represents a decrease from previous premiums as the law now requires that the premium be based on the cost of services. Until now, the premium was, as required by statute, $33 multiplied by the ratio of the inpatient hospital deductible for the same calendar year to the deductible for 1973.

III. Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Premium Rate

As discussed in section I of this notice, the monthly premium for the uninsured aged for 1989 is equal to the monthly actuarial rate for 1989 rounded to the nearest multiple of $1; the monthly actuarial rate is defined to be one-twelfth of the average per capita amount that the Secretary estimates will be paid from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in 1989 for individuals age 65 and over who will be entitled to benefits under the hospital insurance program. Thus, the number of individuals age 65 and over who will be entitled to hospital insurance benefits and the costs incurred on behalf of these beneficiaries must be projected to determine the premium rate.

The principal steps involved in projecting the future costs of the hospital insurance program are (a) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base; (b) projecting increases in payment amounts for each of the various service types; and (c) projecting increases in administrative costs. Establishing historical Part A enrollment and projecting future enrollment, by type of beneficiary, is part of this process.

We have completed all of the above steps, basing our projections for 1989 on (a) current historical data and (b) projection assumptions from the Midsession Review of the President's Fiscal Year 1989 Budget. It is estimated that in calendar year 1989, 29.543 million people age 65 and over will be entitled to Part A benefits (without premium payment), and that these individuals will, in 1989, incur $55.425 billion of benefits for services performed and related administrative costs. Thus, the estimated monthly average per capita amount is $156.34, and the monthly premium is $156.

IV. Savings to Beneficiaries

The 1989 Part A premium is 33 percent lower than the $234 monthly premium amount for the 12-month period beginning January 1, 1988.

The estimated savings of this decrease to the approximately 19 thousand enrollees who do not otherwise meet the requirements for entitlement to hospital insurance will be about $1.5 million.

V. Regulatory Impact Statement

This notice merely announces amounts required by legislation. This notice is not a proposed rule or a final rule issued after a proposal, and does not alter any regulation or policy. Therefore, we have determined, and the Secretary certifies, that no analyses are required under Executive Order 12291, the Regulatory Flexibility Act (5 U.S.C. 601 through 612) or section 1102(b) of the Act.

Dated: September 9, 1988.

William L. Roper,
Administrator,
Health Care Financing Administration

Approved: October 4, 1988.

Otis R. Bowen,
Secretary,
Department of Health and Human Services

APPENDIX E

STATEMENT OF ACTUARIAL OPINION

It is my opinion that, subject to the qualification described below, (1) the methodology used herein is based upon sound principles of actuarial practice and (2) all the assumptions used and the resulting cost estimates are in the aggregate reasonable for the purpose of evaluating the actuarial and financial status of the Federal Hospital Insurance Trust Fund, taking into account the experience and expectations of the program.

Although the projections in this report do not extend beyond December 31, 1991, the Board of Trustees has adopted assumptions which underlie projections of the operations of the Federal Hospital Insurance Trust Fund 75 years into the future. During the first ten years of the projection period, the Trustees have assumed that real earnings in covered employment will increase at the rate of nearly 1.5 percent per year. This assumption is significantly different from actual experience during the ten-year period ending in 1987, when real earnings in the U.S. economy actually declined. During the 30-year period ending with 1987, real earnings increases averaged less than 0.9 percent annually, but the Trustees' long-range intermediate assumption (Alternative II-B) is 1.25 percent, over 40 percent higher than the experience of the last 30 years. Because of these large discrepancies between past experience and projection assumptions, with no plausible explanation for the significant improvement in future experience, I recommend that in future reports the Trustees reduce substantially the real earnings assumption to make it more consistent with reasonable expectations regarding future experience.

Roland E. King
Fellow of the Society of Actuaries
Member of the American Academy of Actuaries
Chief Actuary,
Health Care Financing Administration