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 A1 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 0.4 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)

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).

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 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 1/

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.

1/ 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).

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.

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 1/

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

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1/ 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).

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 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 29, 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.

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