III. APPENDICES

A. ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) INPATIENT HOSPITAL DEDUCTIBLE AND HOSPITAL AND SKILLED NURSING FACILITY COINSURANCE AMOUNTS, FOR CALENDAR YEAR 1992 [1]

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and skilled nursing facility coinsurance amounts for services furnished in calendar year 1992 under Medicare's hospital insurance program (Part A). The Medicare statute specifies the formulae to be used to determine these amounts.

The inpatient hospital deductible will be $652. The daily coinsurance amounts will be: (a) $163 for the 61st through 90th days of hospitalization in a benefit period; (b) $326 for lifetime reserve days; and (c) $81.50 for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period.

Effective Date: January 1, 1992.

SUPPLEMENTARY INFORMATION:

1. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires the Secretary to determine and publish between September 1 and September 15 of each year the amount of the inpatient

[1] Extracted from the notice entitled "Medicare Program; Inpatient Hospital Deductible and Hospital and Skilled Nursing Facility Coinsurance Amounts for 1992," which was published in the Federal Register on November 15, 1991 (Vol. 56, no. 221, pp. 58061-58062).

hospital deductible and the hospital and skilled nursing facility (SNF) coinsurance amounts applicable for services furnished in the following calendar year.

2. Computing the Inpatient Hospital Deductible for 1992

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding calendar year, and adjusted to reflect real case mix. The adjustment to reflect real case mix is determined on the basis of the most recent case mix data available. The amount determined under the formula is rounded to the nearest multiple of $4 (or, if midway between two multiples of $4, to the next higher multiple of $4).

For FY 1992, section 1886(b)(3)(B) of the Act, as amended by section 4002 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508, enacted on November 5, 1990), provides that the applicable percentage increase for all urban prospective payment system (PPS) hospitals is the market basket percentage increase minus 1.6 percent; and for rural PPS hospitals, the applicable percentage increase is the market basket percentage increase minus 0.6 percent. The market basket percentage increase for FY 1992 is 4.4 percent, as announced in the **Federal Register** on August 30, 1991 (56 FR 43196). Therefore, the percentage increases for Medicare prospective payment rates are 2.8 percent for urban hospitals and 3.8 percent for rural hospitals; the payment percentage increase for hospitals excluded from the PPS is 4.7 percent. Thus, the Secretary's best estimate of the payment-weighted average of the increases in the payment rates for FY 1992 is 2.9859 percent. We recognize that Congress has frequently revised the payment rate increase provisions found in section 1886(b)(3)(B) of the Act during the budget reconciliation process, subsequent to the determination and promulgation of the deductible. Such revisions may occur this year as well and may affect the FY 1992 payment rate increase. However, at the time of this determination, we must use the payment rate increase specified in current law to determine the 1992 deductible.

To develop the adjustment for real case mix, an average case mix was first calculated for each hospital that reflects the relative costliness of that hospital's mix of cases compared to that of other hospitals. We then computed the increase in average case mix for hospitals paid under the Medicare PPS in FY 1991 compared to FY 1990. (Hospitals excluded from the PPS were excluded from this calculation since their payments are based on reasonable costs and are affected only by real increases in case mix.) We used bills from prospective payment hospitals received in HCFA as of the end of July 1991. These bills represent a total of about 7.3 million discharges for FY 1991 and provide the most recent case mix data available at this time. Based on these bills, the increase in average case mix in FY 1991 is 1.73 percent.

Although average case mix has increased by 1.73 percent in 1991, 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. We estimate that the increase in real case mix is about 1 percent. The increase in total case mix is about the same as the increase for FY 1990. We expect that the real case mix percentage would be about the same as it was for FY 1990. Consequently, we will continue to use our estimate of one percent for the real case mix increase.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 2.9859 percent, and the real case mix adjustment factor for the deductible is 1 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in calendar year 1992 is $652. This deductible amount is determined by multiplying $628 (the inpatient hospital deductible for 1991) by the payment rate increase of 1.029859 multiplied by the increase in average real case mix of 1.01, which equals $653.22 and is rounded to $652.

3. Computing the Inpatient Hospital and Skilled Nursing Facility Coinsurance Amounts for 1992

The coinsurance amounts provided for in section 1813 of the Act are defined as fixed percentages of the inpatient hospital deductible for services furnished in the same calendar year. Thus, the increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in 1992, in accordance with the fixed percentages

defined in the law, the daily coinsurance for the 61st through 90th days of hospitalization in a benefit period will be $163 (1/4 of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $326 (1/2 of the inpatient hospital deductible); and the daily coinsurance for the 21st through 100th days of extended care services in a SNF in a benefit period will be $81.50 (1/8 of the inpatient hospital deductible).

4. Cost to Beneficiaries

We estimate that in 1992 there will be about 8.3 million deductibles paid at $652 each, about 3.2 million days subject to coinsurance at $163 per day (for hospital days 61 through 90), about 1.3 million lifetime reserve days subject to coinsurance at $326 per day, and about 12.5 million extended care days subject to coinsurance at $81.50 per day. Similarly, we estimate that in 1991 there will be about 8.0 million deductibles paid at $628 each, about 3.1 million days subject to coinsurance at $157 per day (for hospital days 61 through 90), about 1.3 million lifetime reserve days subject to coinsurance at $314 per day, and about 12.2 million extended care days subject to coinsurance at $78.50 per day. Therefore, the estimated total increase in cost to beneficiaries is about $500 million (rounded to the nearest $10 million), due to (1) the increase in the deductible and coinsurance amounts and (2) the change in the number of deductibles and daily coinsurance amounts paid.

5. 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 16, 1991.

Gail R. Wilensky,
Administrator,
Health Care Financing Administration

Approved: October 30, 1991.

Louis W. Sullivan,
Secretary,
Department of Health and Human Services

B. ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) MONTHLY PREMIUM RATE FOR THE UNINSURED AGED, FOR CALENDAR YEAR 1992 [1]

SUMMARY: This notice announces the hospital insurance premium for the uninsured aged for calendar year 1992 under Medicare's hospital insurance program (Part A). The monthly Medicare Part A premium for the 12 months beginning January 1, 1992 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 $192. Section 1818(d) of the Social Security Act specifies the method to be used to determine this amount.

Effective Date: January 1, 1992.

SUPPLEMENTARY INFORMATION:

1. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare hospital insurance program (Medicare Part A), 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.)

The Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239, enacted on December 19, 1989) added section 1818A to the Act, which provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, of certain disabled individuals who have exhausted other entitlement. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act, continue to have the disabling impairment upon which their entitlement was based, and whose entitlement

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[1]Extracted from the notice entitled "Medicare Program; Part A Premium for the Uninsured Aged for 1992," which was published in the Federal Register on November 15, 1991 (Vol. 56, No. 221, pp. 58067-58068).

ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).

Section 1818(d)(2) of the Act, as amended by section 103 of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360, enacted on July 1, 1988), requires the Secretary to determine and publish, during September of each calendar year, the amount of the monthly premium for the following calendar year for persons who voluntarily enroll in Medicare Part A.

Section 1818(d) of the Act, as amended by section 103 of Pub. L. 100-360, requires the Secretary to estimate, on an average per capita basis, 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. The Secretary must then, during September of each year, determine the monthly actuarial rate (the per capita amount estimated above divided by 12) and publish the dollar amount to be applicable for the monthly premium in the succeeding year. If the premium is not a multiple of $1, the premium is rounded to the nearest multiple of $1 (or if it is a multiple of 50 cents but not of $1, it is rounded to the next highest $1). The 1991 premium under this method was $177 and was effective January 1991. (See 55 FR 41603; October 12, 1990.)

2. Premium Amount for 1992

Under the authority of section 1818(d)(2) of the Act (42 U.S.C. 1395i-2(d)(2)), the Secretary has determined that the monthly Medicare Part A hospital insurance premium for the uninsured aged for the 12 months beginning January 1, 1992 is $192.

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

As discussed in section 1 of this notice, the monthly premium for the uninsured aged for 1992 is equal to the estimated monthly actuarial rate for 1992 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 1992 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 Medicare 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 1992 on (a) current historical data and (b) projection assumptions under current law from the Midsession Review of the President's Fiscal Year 1992 Budget. It is estimated that in calendar year 1992, 30.935 million people age 65 and over will be entitled to Medicare Part A benefits (without premium payment), and that these individuals will, in 1992, incur $71.388 billion of benefits for services performed and related administrative costs. Thus, the estimated monthly average per capita amount is $192.31 and the monthly premium is $192.

4. Costs to Beneficiaries

The 1992 Part A premium is about 8.5 percent higher than the $177 monthly premium amount for the 12-month period beginning January 1, 1991.

We estimate that there will be, in calendar year 1992, approximately 220 thousand enrollees who are voluntarily enrolled in Medicare Part A by paying the premium, who do not otherwise meet the requirements for entitlement. The estimated cost of the increase in the premium to these enrollees will be about $40 million. As of January 1, 1991, there were approximately 130 thousand enrollees paying the premium. This is the latest complete data available to us on voluntary enrollment through payment of premium. However, as a result of section 6013 of the Pub. L. 101-239, "Buy-In Under Part A for Qualified Medicare Beneficiaries," we expect, based on preliminary data, that approximately 90 thousand individuals who do not otherwise meet the requirements for entitlement and who are not currently enrolled will be enrolling in Medicare Part A by premium payment (with payment of the premium being made by the States). The estimated Federal share of the increased Medicaid cost of covering the estimated 200,000 Qualified Medicare

Beneficiaries due to the increase in the premium is $20.5 million. The estimated State share is $15.5 million.

5. 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 20, 1991.

Gail R. Wilensky,
Administrator,
Health Care Financing Administration

Approved: October 10, 1991.

Louis W. Sullivan,
Secretary,
Department of Health and Human Services

C. GLOSSARY

Accrual basis. An incurred basis.

Actuarial balance. The difference between the summarized tax rate and the summarized cost rate over a given period.

Actuarial deficit. A negative actuarial balance.

Actuarial surplus. A positive actuarial balance.

Administrative expenses. Expenses incurred by the Department of HHS and the Department of the Treasury in administering the HI program and the provisions of the Internal Revenue Code relating to the collection of contributions. Such administrative expenses include expenditures for contractors to determine costs of and make payments to providers as well as salaries and expenses of the HCFA.

Advisory Council on Social Security. Under the Social Security Act, an Advisory Council is appointed every four years to study and review the financial status of the OASDI and Medicare programs. The most recent Advisory Council was appointed in 1989 and issued its reports in 1991.

Aged enrollee. An individual, age 65 or over, who has been enrolled in the Medicare program.

Alternative I, II, or III. See "Assumptions."

Amortization. Process of the gradual retirement of an outstanding debt by making periodic payments to the trust fund.

Annual balance. The difference between the income rate and the cost rate in a given year.

Assets. Treasury notes and bonds guaranteed by the Federal government and cash held by the trust funds for investment purposes.

Assumptions. Values relating to future trends in certain factors which affect growth of the trust funds. Demographic assumptions include fertility, mortality, net immigration, marriage, divorce, retirement patterns, disability

incidence and termination rates, and changes in the labor force. Economic assumptions include unemployment, average earnings, inflation, interest rates, and productivity. Three sets of economic assumptions are presented in the Trustees Report.

(1) Alternative I is characterized as an "optimistic" set--it assumes relatively rapid economic growth, low inflation, and favorable (from the standpoint of program financing) demographic conditions.

(2) Alternative II is the "intermediate" set of assumptions, with "best estimates" of future economic and demographic conditions.

(3) Alternative III is more "pessimistic," with slow economic growth, more rapid inflation, and financially disadvantageous demographic conditions.

Automatic adjustment. This refers to the increase in the maximum taxable amount of annual earnings. In 1992, it was $130,200, and it is indexed to increases in covered wages.

Average market yield. A computation which is made on all marketable interest-bearing obligations of the United States. It is computed on the basis of market quotations as of the end of the calendar month next preceding the date of such issue.

Baby boom. The period from the end of World War II through the mid-1960s marked by unusually high birth rates.

Base estimate. The updated estimate of the most recent historical year.

Beneficiary. A person enrolled in the HI program.

Benefit payments. The amounts disbursed for service covered after the deductible and coinsurance amounts have been deducted.

Board of Trustees. A Board established by the Social Security Act to oversee the financial operations of the Federal Hospital Insurance Trust Fund. The Board is composed of five members, three of whom serve automatically by virtue of their positions in the Federal government: the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services. The other two members are appointed by the President as public representatives: Stanford G. Ross and David M. Walker are currently serving four-year terms that began on October 2, 1990. The Administrator of the HCFA serves as Secretary of the Board of Trustees.

Bond. A certificate of ownership of a specified portion of a debt due by the Federal government to individual holders, bearing a fixed rate of interest.

Callable. Subject to redemption upon notice, such as a bond.

Case mix index. The average DRG relative weight for all the Medicare admissions.

Cash basis. The costs of the service at the point payment was made rather than when the service was performed.

Certificate of indebtedness. A short-term certificate of ownership of 12 months or less of a specified portion of a debt due by the Federal government to individual holders, bearing a fixed rate of interest.

Consumer Price Index--(CPI). A measure of the average change in prices over time in a fixed market basket of goods and services.

Contribution rate. The percentage of taxable earnings that is paid for Medicare tax. In 1992 the percentages are 1.45 for employees and employers, each. The self-employed pay 2.9 percent. For 1992, $130,200 is the maximum taxable amount of annual earnings.

Cost rate. The cost rate for a year is the ratio of the cost (or outgo, expenditures, or disbursements) of the program to the taxable payroll for the year. In this context, the outgo is defined to include benefit payments, and exclude payments for certain uninsured persons whose payments are reimbursable from the general fund of the Treasury as well as payments for voluntary enrollees who pay a premium in order to be enrolled.

Covered employment. All employment and self-employment creditable for Social Security purposes. Almost every kind of employment and self-employment is covered under the program. In a few employment situations, for example, religious orders under a vow of poverty, foreign affiliates of American employers, or State and local governments, coverage must be elected by the employer. However, effective July 1991, coverage is mandatory for State and local employees who are not participating in a public employee retirement system. All new State and local employees have been covered since April 1986. In a few situations, for example, ministers or self-employed members of certain religious groups, workers can opt out of

coverage. Even though employment is covered, not all earnings may be taxable and creditable.

Covered services. For those expenses still reimbursed on a reasonable cost basis, medically necessary care as an inpatient in a hospital or a skilled nursing facility following a hospital stay, home health, and hospice care.

Current dollars. Amounts expressed in nominal dollars with no adjustment for inflationary changes in the value of a dollar over time.

Deductible. The amount payable by the beneficiary for covered services before Medicare makes reimbursement.

Deemed wage credit. See "Military Service wage credits."

Demographic assumptions. See "Assumptions."

Diagnosis-related groups (DRGs). A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the Prospective Payment System, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Disability. For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers age 55 or older whose disability is based on blindness.

The law generally requires that a person be disabled continuously for five months before he or she can qualify for a disabled-worker cash benefit. An additional 24 months is necessary to qualify for benefits under Medicare.

Disabled enrollee. An individual under age 65 who has been entitled to disability benefits under Title II of the Social Security Act or the railroad retirement system for at least two years and who are now enrolled under Medicare.

DRG Coding. The DRG categories used by hospitals on discharge billing.

Earnings. Unless otherwise qualified, all wages from employment and net earnings from self-employment, whether or not taxable or covered.

Economic assumptions. See "Assumptions."

End-stage renal disease (ESRD). A disease involving irreversible and permanent kidney failure.

Excess wages. Wages in excess of the wage base on which a worker initially pays taxes as a result of working for more than one employer. Employee taxes on excess wages are refunded to affected employees, while the employer taxes are not refunded.

Federal Insurance Contributions Act (FICA). Provision authorizing taxes on the wages of employed persons to provide for Retirement, Survivors, and Disability insurance, and for Hospital Insurance for persons over age 65 and for disabled persons. The tax is paid in equal amounts by workers and their employers.

Financial interchange. Provisions of the Railroad Retirement Act providing for transfers between the trust funds and the Social Security Equivalent Benefit Account of the Railroad Retirement program in order to place each trust fund in the same position as if railroad employment had always been covered under Social Security.

Fiscal year. The accounting year of the United States Government. Since 1976, each fiscal year has begun on October 1 of the prior calendar year and ended the following September 30. For example, fiscal year 1992 began October 1, 1991 and will end September 30, 1992.

Fixed capital assets. The net worth of facilities and other resources.

General fund of the Treasury. Funds held by the Treasury of the United States, other than revenue collected for a specific purpose (such as Medicare) and maintained in a separate account for that purpose. The majority of this income is from individual and business income tax.

General revenue. Income to the HI trust fund from the general fund of the Treasury.

Gramm-Rudman-Hollings Act. The Balanced Budget and Emergency Deficit Control Act of 1985.

Gross Domestic Product (GDP). The total dollar value of all goods and services produced in a year in the United States, regardless of who supplies the labor or property.

Home health agency (HHA). A public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, occupational, or speech therapy, in the home.

Hospice. A program for the terminally ill to provide a variety of services and supplies, including nursing care, physician services, medical supplies, and short term inpatient hospital care.

Hospital assumptions. These include differentials between hospital labor and non-labor indices compared to general economy, rates of admission incidence, the trend toward treating less complicated cases in outpatient settings, and continued improvement in DRG coding, etc.

Hospital coinsurance. From the 61 - 90th day of a benefit period, a daily amount equal to one-fourth of the inpatient hospital deductible for which the enrollee is responsible.

Hospital input price index. An alternate name for the hospital market basket.

Hospital Insurance (HI). The Medicare program which covers specified hospital inpatient services, posthospital skilled nursing care, home health services, and hospice care.

Hospital market basket. The cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services.

Incurred costs. The costs based on when the service was performed rather than when the payment was made.

Inpatient hospital deductible. An amount of money which is deducted from the amount payable by Medicare for inpatient hospital services furnished to

a beneficiary during a spell of illness. In 1992 the inpatient hospital deductible is $652.

Inpatient hospital services. These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Interest. A payment for the use of money during a specified period.

Interfund borrowing. The borrowing of assets by a trust fund (OASI, DI, HI or SMI) from another of the trust funds when one of the funds is in danger of exhaustion.

Intermediary. A private or public organization, under contract to the Health Care Financing Administration, to administer the Part A benefits under Medicare. Also referred to as "contractors," these organizations make payments for providers.

Intermediate assumptions. See "Assumptions."

Lifetime reserve days. Under HI, there are 60 lifetime reserve days per beneficiary which are to be used when regular benefits are exhausted. Medicare does not pay for the entire day; the beneficiary pays for one half of the inpatient deductible for each day used.

Long-range. Actuarial estimates covered over the next seventy-five years.

Medicare. A nationwide, federally administered health insurance program authorized in 1965 to cover the cost of hospitalization, medical care, and some related services for most people over age 65. In 1972 coverage was extended to people receiving Social Security Disability Insurance payments for two years, and people with End-Stage Renal Disease. Medicare consists of two separate but coordinated programs -- Part A (Hospital Insurance, HI) and Part B (Supplementary Medical Insurance, SMI). Almost all persons aged 65 and over or disabled entitled to HI are eligible to enroll in the SMI program on a voluntary basis by paying a monthly premium. Health insurance protection is available to Medicare beneficiaries without regard to income.

Military service wage credits. Credits recognizing that military personnel receive other cash payments and wages in kind (such as food and shelter) in addition to their basic pay. Noncontributory wage credits of $160 are provided for each month of active military service from September 16, 1940,

through December 31, 1956. For years after 1956, the basic pay of military personnel is covered under the Social Security program on a contributory basis. Noncontributory wage credits of $300 for each calendar quarter in which a person receives pay for military service from January 1957 through December 1977 are granted in addition to contributory credits for basic pay. Deemed wage credits of $100 are granted for each $300 of military wages in years after 1977. (The maximum credits allowed in any calendar year are $1,200.)

Modified average-cost method. Under this system, the actuarial balance is defined as the difference between the arithmetic means of the annual cost rates and the annual tax rates.

Net contributions. The appropriation of employment taxes less refunds of employment taxes and deposits arising from State agreements.

Non-contributory or deemed wage credits. Prior to January 1, 1957, $160 per month wage credit given to members of the military for noncontributory quarters worked. To extend coverage for Medicare, for Civil Service annuitant employed during January 1983, credit was given for the period before 1983.

Optimistic assumptions. See "Assumptions."

Part A. This term refers to the Medicare Hospital Insurance program.

Part A premium. A monthly premium paid by individuals who wish for and are entitled to voluntary enrollment in the Medicare hospital insurance program. These individuals are those who are age 65 and older who are uninsured for social security or railroad retirement and do not otherwise meet the requirements for entitlement to Part A. In addition, disabled individuals who have exhausted other entitlement are qualified. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act, continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).

Participating hospitals. Those hospitals who participate in the Medicare program.

Pay-as-you-go financing. A financing scheme where taxes are scheduled to produce just as much income as required to pay current benefits, with trust fund assets built up only to the extent needed to prevent exhaustion of the fund by random economic fluctuations.

Payroll taxes. A tax levied on the gross wages of workers.

Per capita. By individuals.

Peer Review Organization (PRO). A group of practicing physicians and other health care professionals, paid by the federal government, to review the care given to Medicare patients.

Pessimistic assumptions. See "Assumptions."

Present value. The present value of a future stream of payments is the lump-sum amount that, if invested today, together with interest earnings would be just enough to meet each of the payments as they fell due. At the time of the last payment, the invested fund would be exactly zero.

Professional Standards Review Organization. The predecessor of the Peer Review Organization.

Projection error. Degree of variation between estimated and actual costs.

Prospective Payment Assessment Commission. This is a commission established by the Social Security Amendments of 1983. It reviews and recommends the appropriate percentage changes which should be effected for hospital inpatient discharges each fiscal year beginning with fiscal year 1986. Furthermore, it is expected to study and make recommendations regarding existing reimbursement policy for each fiscal year.

Prospective payment system (PPS). A method of reimbursement for hospitals which was implemented effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs).

Provider. Any organization or individual who is involved in providing health care services to the Medicare population. The provider list includes hospitals, physicians, ambulatory surgical centers, outpatient clinics, etc.

Proxy. The stand-in for estimating the labor and non-labor pieces of the hospital input price index.

Public Health Service. An agency within the Department of Health and Human Services dealing with health care research, medical research, food and drug analysis, and Indian health care.

Quinquennial military service determinations and adjustments. The Social Security Amendments of 1983 provided that the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund should be reimbursed in lump sums for the past and future benefits based on military service credits. This amount is adjusted every five years on the basis of benefits and administrative benefits actually paid from the trust funds.

Railroad retirement. A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Real-wage differential. The difference between the percentage increases, before rounding, in (1) the average annual wage in covered employment, and (2) the average annual Consumer Price Index.

Reasonable cost basis. The calculation to determine the reasonable cost incurred by the individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by the health insurance program.

Recession. A temporary decline in business occurring during a period of generally increasing economic prosperity.

Self-Employed Contributions Act (SECA). Provision authorizing taxes on the income of self employed persons to provide for Retirement, Survivors, and Disability insurance, and for Hospital Insurance for persons over age 65 and for disabled persons.

Self-employment. Operation of a trade or business by an individual or by a partnership in which an individual is a member.

Sequester. The reduction of funds to be used for benefits or administrative costs from a Federal account based on the requirements specified in the Gramm-Rudmann-Hollings Act.

Skilled nursing facility (SNF). An institution which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or engage in rehabilitation of injured, disabled, or sick persons.

SNF coinsurance. This is an amount for the 21st day through the 100th day of extended care services in a benefit period which is to be deducted from the amount payable by Medicare for SNF services furnished to a beneficiary. It is 1/8 of the inpatient hospital deductible. In 1992, this amount is $81.50.

Social Security Act. Public Law 74-271, enacted August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, of which four have been repealed. The Hospital Insurance and Supplementary Medical Insurance Trust Funds are authorized by Title XVIII of the Social Security Act.

Special public-debt obligation. Securities of the United States Government issued exclusively to the OASI, DI, HI, and SMI Trust Funds. Section 1817(c) of the Social Security Act provides that the public-debt obligations issued for purchase by the HI Trust Fund shall have maturities fixed with due regard for the needs of the funds. The usual practice in the past has been to spread the holdings of special issues, as of each June 30, so that the amounts maturing in each of the next 15 years are approximately equal. Special public-debt obligations are redeemable at par at any time.

Summarized balance. The difference between the summarized cost rate and the summarized tax rate, expressed as a percentage of taxable payroll.

Summarized cost rate. The ratio of the present value of expenditures to the present value of the taxable payroll for the years in a given period. The summarized cost rate includes the cost of reaching and maintaining a "target" trust fund level, or contingency fund ratio. Because a trust fund level of about one year's expenditures is considered to be an adequate reserve for unforeseen contingencies, the targeted contingency fund ratio used in

determining summarized cost rates is 100 percent of annual expenditures. Accordingly, the summarized cost rate is equal to the ratio of (a) the sum of the present value of the outgo during the period plus the present value of the targeted ending trust fund level plus the beginning trust fund level, to (b) the present value of the taxable payroll during the projection period.

Summarized tax rate. The ratio of (a) the present value of the total income (excluding interest earnings) during a given period, to (b) the present value of the taxable payroll for the years in a given period.

Supplementary Medical Insurance (SMI). The trust fund used for paying a portion of the costs of physician's services, outpatient hospital services, and other related medical and health services for voluntarily insured aged and disabled individuals.

Taxable earnings. Taxable wages and/or self-employment income under the prevailing annual maximum taxable limit.

Taxable payroll. A weighted average of taxable earnings and taxable self-employment income. When multiplied by the combined employee-employer tax rate, it yields the total amount of taxes incurred by employees, employers, and the self-employed for work during the period.

Taxable self-employment income. Net earnings from self-employment, generally above $400 and below the annual taxable and creditable maximum amount for a calendar or other taxable year, less any taxable wages in the same taxable year.

Taxable wages. Wages paid for services rendered in covered employment up to the annual taxable maximum. In some cases, wages must also be above a specified amount to be taxed and credited (for example, $50 or more in a calendar quarter from one employer for domestic employment, $100 or more in a calendar year for employment in a nonprofit organization or for services not in the course of an employer's trade or business).

Taxes. See "Contributions."

Test of Actuarial Status. The overall test of actuarial status for the HI program, which includes a test of Short-Range Financial Adequacy, and a test of Long-Range Close Actuarial Balance.

Test of Long-Range Close Actuarial Balance. Summarized tax rates and cost rates are calculated for each of the 65 valuation periods in the full 75 year long-range projection period. The first of these periods consists of the next 11 years. Each succeeding period becomes longer by one year, culminating with the period consisting of the next 75 years. The long-range test is met if, for each of the 65 time periods, the actuarial balance is not less than zero or is negative by, at most, a specified percentage of the summarized cost rate for the same time period. The percentage allowed for a negative actuarial balance is five percent for the full 75-year period and is reduced uniformly for shorter periods, approaching zero as the duration of the time periods approaches the first 10 years. The criterion for meeting the test is less stringent for the longer periods in recognition of the greater uncertainty associated with estimates for more distant years.

Test of Short-Range Financial Adequacy. The conditions required to meet this test are as follows: If the trust fund ratio for a fund exceeds 100 percent at the beginning of the projection period, then it must be projected to remain at or above 100 percent throughout the 10 year projection period. Alternatively, if the fund ratio is initially less than 100 percent, it must be projected to reach a level of at least 100 percent within five years (and not be depleted at any time during this period) and then remain at or above 100 percent throughout the remainder of the 10 year period.

Trust fund. Separate accounts in the United States Treasury mandated by Congress whose assets may only be used for a specified purpose. Funds not withdrawn for current monthly or service benefits, the financial interchange, and administrative expenses are invested in interest-bearing Federal securities, as required by law; the interest earned is also deposited in the trust funds.

Trust fund ratio. A short range measure of the adequacy of the trust fund level, the "trust or contingency fund ratio," is defined to be the assets at the beginning of the year expressed as a percentage of the outgo during the year.

Unit input intensity allowance. The amount added to or subtracted from the hospital input price index to yield the PPS update factor.

Valuation period. A period of years which is considered as a unit for purposes of calculating the status of a trust fund.

Voluntary enrollee. Any individual aged 65 or older not otherwise entitled to Medicare may obtain coverage under Part A by paying a monthly premium.

Worker. A person who has earnings creditable for Social Security purposes on the basis of services for wages in covered employment and/or on the basis of income from covered self-employment. Data on covered self-employment exclude self-employed persons who had no self-employment income taxable or creditable under Social Security because they had wages or salaries reaching the annual taxable maximum reported for the same year.

Year of exhaustion. The year in which a trust fund would be unable to pay benefits when due because the assets of the fund were exhausted.

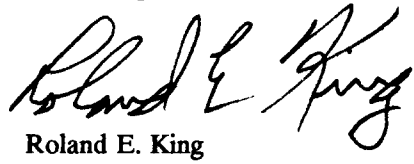
D. STATEMENT OF ACTUARIAL OPINION

Subject to the reservations noted below, it is my opinion that (1) the methodology used herein is based upon sound principles of actuarial practice and (2) 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.

The Board of Trustees has assumed that real earnings increases during the next quarter century, and each quarter century thereafter, will greatly exceed the rates of the last quarter century. My opinion is that the real earnings assumption is substantially inconsistent with appropriate projections based on past experience.

The present-value method used to summarize the long-range actuarial status of the HI program is inappropriate because (1) it produces a summary actuarial balance that is inconsistent with the trust fund projections it is intended to summarize and (2) it understates the long-range cost and the long-range deficit of the program by assuming significant amounts of hypothetical interest income.

The combined effect of the two concerns noted above is substantial. The actuarial deficit of the HI program using an earnings assumption similar to real earnings of the most recent 25-year period and using the modified average-cost method for summarizing the long-range actuarial status of the program is significantly greater than the actuarial deficit presented under the intermediate assumptions in this report.



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

E. STATEMENT OF THE PUBLIC TRUSTEES

The Social Security Act requires that the annual report of the Board of Trustees on the Federal Hospital Insurance (HI) Trust Fund include "an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration [HCFA] certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable."

The HCFA Chief Actuary has issued a qualified and confusing actuarial opinion on the 1992 HI report based on his concerns about the actuarial methodology and real-wage assumptions made by the Board. In particular, the fourth paragraph of his actuarial opinion appears to contradict the first paragraph and could be read as, in substance, an adverse opinion on the 1992 HI report. Last year, the HCFA Chief Actuary qualified his opinion on the 1991 HI report for essentially the same reasons, and we included a statement in that report regarding his opinion.

We fully support the requirement in the Social Security Act for an independent actuarial opinion and recognize the value that this provision adds to the HI report. In fact, we have strongly supported the right of the HCFA Chief Actuary to express his professional opinion regarding the actuarial methods and assumptions adopted by the Trustees. In an effort to provide for full and fair disclosure of differences of opinion, we encouraged the HCFA Chief Actuary to include a section in the 1991 report and in the 1992 report to fully set forth his opinions, and both reports include sections that discuss his preferred actuarial methods and present alternative actuarial projections based on those methods. The only issue is whether the opinion qualification of the HCFA Chief Actuary is consistent with the statutory provisions of the Social Security Act and generally accepted standards of the actuarial profession.

As Trustees of the HI Trust Fund, we have a statutory requirement to determine the actuarial methods and assumptions to be adopted; and in discharging our statutory duty, we believe that the opinion qualification of the HCFA Chief Actuary exceeds the bounds of the statutory requirements for the

HI actuarial opinion and is inconsistent with prevailing standards of actuarial practice. Furthermore, we believe that the methodology, assumptions, data, estimates, and all other information contained in the HI report clearly, fully, and fairly present the current and projected financial condition of the HI fund.

The HCFA Chief Actuary asserts that the method used to measure the financial condition of the HI trust fund is inappropriate. After extensive examination and consultation, we have determined that the present-value method used in the HI report is generally accepted within the actuarial profession and, in our opinion, meets the statutory test for actuarial certification.

The HCFA Chief Actuary also asserts that the real wage assumptions chosen by the Trustees are unreasonable, based on his analysis of certain historical data. After extensive review, we believe that the assumptions used in the HI report meet the statutory test of reasonableness.

In reaching those conclusions, we relied on, among other things, the unqualified opinion of the Chief Actuary of the Social Security Administration on this year's Old-Age, Survivors, and Disability Insurance report, based on the same underlying actuarial methodology and economic and demographic assumptions that are used in the HI report.

It is perplexing and disconcerting that an actuarial opinion with unjustifiable qualifications has been allowed to be repeated for several years in the HI reports. It seems to us that the public would be better served by having what are technical, professional issues resolved as promptly as possible. The continuation of this controversy is confusing to the public and serves to distract attention from the essential issue that is of public concern. By any measure, the HI Trust Fund is severely out of financial balance, and it is projected to run out of funds in about 10 years. The Trustees have urged the Congress to take prompt legislative action to control the alarming growth in costs of the Medicare program and to restore the financial integrity of the HI Trust Fund by enacting specific program legislation or as a part of more comprehensive health care reform.

For the reasons stated above, we have adopted the 1992 HI report with the ex officio Trustees who, this year as last year, have indicated that they agree

with our conclusion that the methods and assumptions in the report are both generally accepted and reasonable, and we have signed the 1992 HI report for transmission to the Congress and the public.

Stanford G. Ross
Trustee

David M. Walker
Trustee