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**1994 ANNUAL REPORT OF
THE BOARD OF TRUSTEES OF THE
FEDERAL SUPPLEMENTARY MEDICAL
INSURANCE TRUST FUND**

COMMUNICATION

From

**THE BOARD OF TRUSTEES,
FEDERAL SUPPLEMENTARY MEDICAL
INSURANCE TRUST FUND**

Transmitting

**THE 1994 ANNUAL REPORT OF THE BOARD,
PURSUANT TO
SECTION 1841(b) OF THE SOCIAL SECURITY ACT,
AS AMENDED**

LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE TRUST FUND
Washington, D.C, April 11, 1994

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

HONORABLE ALBERT GORE, JR.
President of the Senate
Washington, D.C.

GENTLEMEN: We have the honor of transmitting to you the 1994 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the 29th such report), in compliance with the provisions of section 1841(b) of the Social Security Act.

Respectfully,

LLOYD M. BENTSEN,
*Secretary of the Treasury, and
Managing Trustee of the Trust Fund*

ROBERT B. REICH
Secretary of Labor, and Trustee

DONNA E. SHALALA,
*Secretary of Health and Human Services
and Trustee*

STANFORD G. ROSS
Trustee

DAVID M. WALKER
Trustee

BRUCE C. VLADECK,
*Administrator of the Health Care
Financing Administration, and
Secretary, Board of Trustees*

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I. OVERVIEW

A. SUMMARY

1. Operations of the Supplementary Medical Insurance Program

The supplementary medical insurance (SMI) program pays for physician services, outpatient hospital services, and other medical expenses for aged 65 and over and for the long-term disabled. In calendar year (CY) 1993, 34.6 million persons were covered under SMI. General revenue contributions during 1993 amounted to \$41.5 billion, accounting for 71.9 percent of all SMI income. About 24.6 percent of all income resulted from the premiums paid by the enrollees. Interest payments to the SMI fund accounted for the remaining 3.5 percent. Of the \$57.8 billion in SMI disbursements, \$54.0 billion was for benefit payments, \$1.8 billion was for the transfer of the SMI catastrophic coverage reserve fund to the hospital insurance (HI) trust fund, and the remaining was spent for administrative expenses. SMI administrative expenses were 3.6 percent of the total of benefit payments and administrative expenses.

The SMI program essentially is yearly renewable term insurance financed from premium income paid by the enrollees and from income contributed from general revenue by the federal government. This means that the SMI program is financed on an accrual basis with a contingency margin, and, therefore, the SMI trust fund should always be somewhat greater than the claims that have been incurred by enrollees but not yet paid by the program. The trust fund holds all of the income not currently needed to pay benefits and related expenses. The assets of the fund may not be used for any other purpose; however, they may be invested in certain interest-bearing obligations of the federal government.

Financing for the SMI program is established annually on the basis of standard monthly premium rates (paid by or on behalf of all participants) and monthly actuarial rates determined separately for aged and disabled beneficiaries on which general revenue contributions are based. Prior to the 6-month transition period (July 1, 1983 through December 31, 1983), these rates were applicable in the 12-month periods ending June 30. Beginning January 1, 1984, the annual basis was changed to calendar years. Monthly actuarial rates are equal to one-half the monthly amounts necessary to finance the SMI program. These rates determine the amount to be contributed from general revenues on behalf of each enrollee. Pursuant to the formula in the law, the Government contribution effectively makes up the difference between twice the monthly actuarial rates and the standard monthly premium rate.

Overview

The financial status of the program depends on both the total net assets and total liabilities. It is, therefore, necessary to examine the incurred experience of the program, since it is this experience that is used to determine the actuarial rates discussed above and which forms the basis of the concept of actuarial soundness as it relates to the SMI program.

The concept of actuarial soundness, as it applies to the SMI program, is closely related to the concept as it applies to many private group insurance plans. The SMI program is essentially yearly renewable term insurance financed from premium income paid by the enrollees, from income contributed from general revenue, and from interest payments on the trust fund assets.

In testing the actuarial soundness of the SMI program, it is appropriate to look only to the periods for which the enrollee premium rates and level of general revenue financing have been established. The primary tests of actuarial soundness, then, are that: (1) assets and income for years for which financing has been established be sufficient to meet the projected benefits and associated administrative expenses incurred for that period and (2) assets be sufficient to cover projected liabilities that will have been incurred by the end of that time but will not have been paid yet. Even if these tests of actuarial soundness are not met, the program can continue to operate if the trust fund remains at a level adequate to permit the payment of claims as presented. However, to protect against the possibility that cost increases under the program will be higher than assumed, assets should be sufficient to cover a reasonable degree of variation between actual and projected costs in case actual costs exceed projected.

The primary tests for actuarial soundness and trust fund adequacy can be viewed by direct examination of absolute dollar levels. In providing an appropriate contingency or margin for variation, however, there must also be some relative measure. The relative measure or ratio used for this purpose is the ratio of the assets less liabilities to the following year's incurred expenditures.

2. Conclusion of the Board of Trustees

The financing established through December 1994 is sufficient to cover projected benefits and administrative costs incurred through that time period. This financing is sufficient to maintain a level of trust fund assets which is adequate to cover a reasonable degree of variation between actual costs and projected costs in case actual costs exceed projected. On this basis, the SMI program can thus be said to be actuarially sound.

Summary

Although the SMI program is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. In spite of the evidence of slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 59 percent in aggregate and 45 percent per enrollee in the last 5 years. For the same time period, the program grew 23 percent faster than the economy despite recent efforts to control the cost of the program. As a result, the incurred disbursements of the program are projected to increase from 0.88 percent of the Gross Domestic Product (GDP) in CY 1993 to 4.37 percent of GDP in CY 2068. Initially, this rapid growth is attributable primarily to the inability to control (1) the growth in the volume of services billed per beneficiary and (2) the reported case mix intensity (the reporting of services which receive higher reimbursement). Later in the projection period, the changing demographic composition of the population will also have a major influence on the growth in program costs. Given the past and projected cost of the program, the Trustees urge the Congress to promptly take additional actions designed to control SMI costs through specific program legislation and as a part of enacting more comprehensive health care reform. The Trustees believe that prompt, effective, and decisive action is necessary.

B. THE BOARD OF TRUSTEES

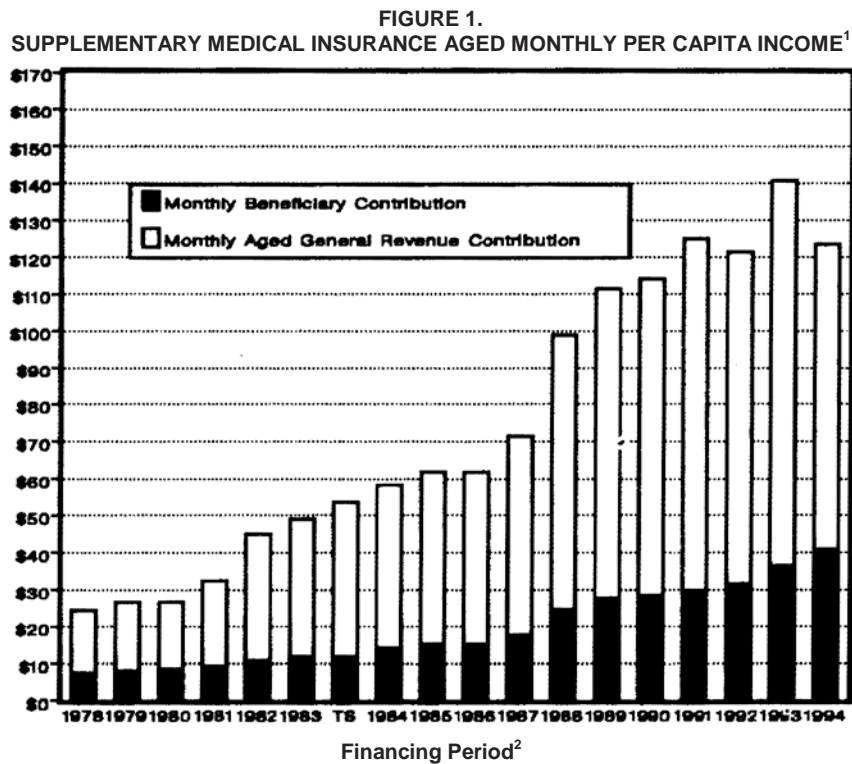
The Federal Supplementary Medical Insurance Trust Fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1841(b) of the Social Security Act, as amended. The Board is composed of five members, three of whom serve in an ex officio capacity: the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services. The President nominated and the Senate confirmed Stanford G. Ross and David M. Walker to be the other two members, who serve as representatives of the public. Mr. Ross and Mr. Walker are serving 4-year terms that began on October 2, 1990.

By law, the Secretary of the Treasury is designated as the Board Chairperson and the Managing Trustee, and the Administrator of the Health Care Financing Administration (HCFA) 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 1841(b)(2) of the Social Security Act. This annual report, for 1994, is the 29th such report.

Overview

C. EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND

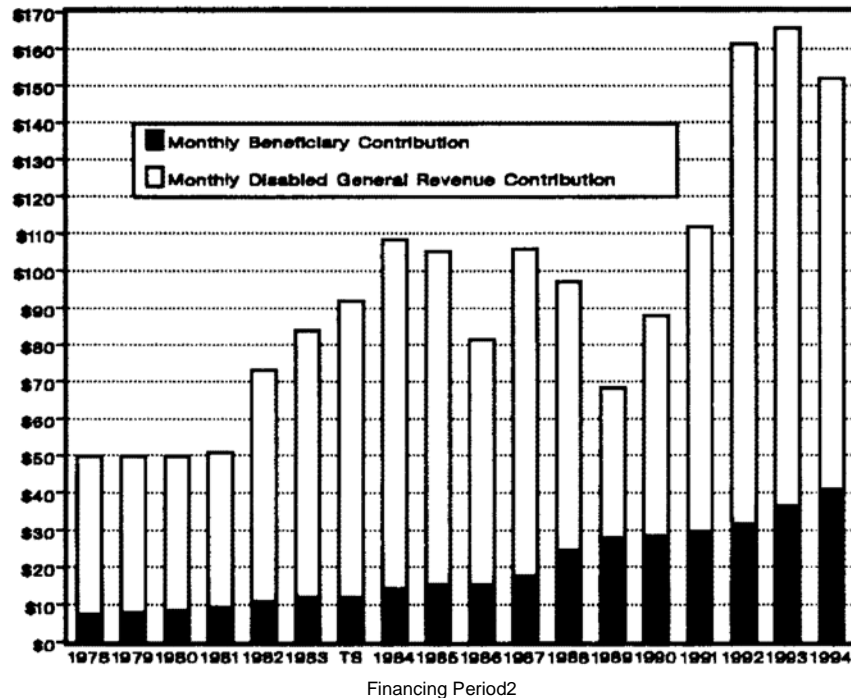
Financing for the SMI program is established annually on the basis of standard monthly premium rates (paid by or on behalf of the enrollees) and actuarial rates on which general revenue contributions are based. Beginning January 1, 1984, the annual basis has been the calendar year. For 1989, only, the financing was established also on the basis of the catastrophic coverage monthly premium rate. Figures 1 and 2 present these values for financing periods since 1978. These figures clearly indicate the extent to which general revenue financing is the major source of income for the program.



¹The amounts shown do not include the catastrophic coverage monthly premium rate for 1989.

²For periods 1983 and earlier, the financing period is July 1 through June 30. For the transitional semester (T.S.), the financing period is July 1, 1983 through December 31, 1983. For 1984 through 1994 the financing period is January 1 through December 31.

FIGURE 2.
SUPPLEMENTARY MEDICAL INSURANCE DISABLED MONTHLY PER CAPITA INCOME¹



¹The amounts shown do not include the catastrophic coverage monthly premium rate for 1989.

²For periods 1983 and earlier, the financing period is July 1 through June 30. For the transitional semester (T.S.), the financing period is July 1, 1983 through December 31, 1983. For 1984 through 1994 the financing period is January 1 through December 31.

Although standard monthly premium rates have been set for periods through December 31, 1995 and actuarial rates have been set for periods through December 31, 1994, estimates in the report are presented for periods beyond those times. It has been assumed in this report that financing for those periods will be established in accordance with the provisions described in the section II.B "Nature of the Trust Fund."

The estimates shown in Tables I.C1, I.C2, and I.C3 are based on the economic assumptions labeled "intermediate assumptions." The economic and demographic assumptions underlying the estimates under the intermediate assumptions are described in detail in the 1994 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. The section II.D "Actuarial Methodology and Principal Assumptions for Cost Estimates for the Supplementary Medical Insurance Program" presents an explanation of the effects of the intermediate assumptions on the estimates in this report.

The January 1, 1994 average update of the allowable fee for physician services is assumed to be 4.0 percent. The intermediate assumptions

Overview

assume the January 1, 1995 average update to be 5.9 percent. This average update is a weighted average of the updates of the allowed fees for various goods and services included in the “physician” category. Besides physician services, the “physician” category also includes some goods and services not considered to be purely physician services such as laboratory tests performed in a physician’s office, durable medical equipment (DME), ambulance services, and services performed in a free-standing ambulatory surgical center. The costs per enrollee for institutional and other services under the SMI program are projected to increase an average of 14.0 percent for CY 1994 and 14.1 percent for CY 1995. These increases are due to factors such as price, volume, and intensity.

Table I.C1 shows the estimated operations of the trust fund under the intermediate assumptions on a fiscal-year basis through FY 1996. Table I.C2 shows the corresponding development on a calendar-year basis. These tables show that the level of the trust fund increased in FY 1993 while it decreased in CY 1993. However, the display in Table I.C2 is misleading in assessing the impact that the operations of the trust fund had on the CY 1993 trust fund balance. There are two anomalies that occurred that effect the trust fund balance at the end of both CY 1992 and 1993, and, therefore, it would be better to first adjust these balances for the anomalies before making this assessment. The first anomaly is that the trust fund balance at the end of CY 1992 is higher than it ordinarily would be. Section 708 of Title VII of the Social Security Act modifies the delivery day of Social Security benefit checks when the regularly designated delivery day falls on a Saturday, Sunday or legal public holiday. As a result, the benefit checks were delivered on December 31, 1992 instead of January 3, 1993, a Sunday. Consequently, the SMI premiums withheld from the checks (\$1,089 million) and the general revenue contributions (\$3,175 million) were added to the SMI trust fund on December 31, 1992 instead of January 3, 1993. If the checks had been delivered in January 1993, the trust fund balance at the end of CY 1992 would have been \$19,972 million instead of \$24,235 million. The second anomaly is due to the passage of Public Law 102-394, after the financing for CY 1993 had been established, which authorized the transfer of the funds in the SMI catastrophic coverage reserve fund to the HI trust fund to compensate for the increased costs to that fund which occurred in 1989. This transfer of \$1,805 million occurred on March 31, 1993. Adjusting for this anomaly would raise the CY 1993 trust fund balance to \$25,936 million. With these adjustments in mind, the actuarial rates for CY 1993 were promulgated with specific margins to reduce aged assets and to increase disabled assets. However, actual expenditures were lower than those estimated at the time the financing was established for CY 1993. Therefore, after adjusting the trust fund balances for the anomalies, the fund increased in CY 1993.

Expected Operations

The actuarial rates for CY 1994 were promulgated with specific margins to reduce assets. Based on these actuarial rates and the above economic assumptions, the fund is estimated to decrease to a level of \$17.4 billion by the end of CY 1994 and then decrease to \$9.5 billion by the end of CY 1995.

TABLE I.C1.—OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) DURING FISCAL YEARS 1967-1996

(In millions)

Fiscal Year ¹	Income				Disbursements			Balance at end of year ⁴
	Premium from enrollees	Government contribu- tions ²	Interest and Other Income ³	Total Income	Benefit payments	Adminis- trative expenses	Total disburse- ments	
Historical Data:								
1967	647	623	15	1,285	664	135 ⁵	799	486
1968	698	634	21	1,353	1,390	142	1,532	307
1969	903	984	24	1,911	1,645	195	1,840	378
1970	936	928	12	1,876	1,979	217	2,196	57
1971	1,253	1,245	18	2,516	2,035	248	2,283	290
1972	1,340	1,365	29	2,734	2,255	289	2,544	481
1973	1,427	1,430	45	2,902	2,391	246	2,637	746
1974	1,704	2,029	76	3,809	2,874	409	3,283	1,272
1975	1,887	2,330	105	4,322	3,765	405	4,170	1,424
1976	1,951	2,939	104	4,994	4,672	528	5,200	1,219
T.Q.	539	878	4	1,421	1,269	132	1,401	1,239
1977	2,193	5,053	137	7,383	5,867	475	6,342	2,279
1978	2,431	6,386	228	9,045	6,852	504	7,356	3,968
1979	2,635	6,841	363	9,839	8,259	555	8,814	4,994
1980	2,928	6,932	415	10,275	10,144	593	10,737	4,532
1981	3,320	8,747	372	12,439	12,345	863	13,228	3,743
1982	3,831	13,323	473	17,627	14,806	754	15,560	5,810
1983	4,227	14,238	682	19,147	17,487	824	18,311	6,646
1984	4,907	16,811	807	22,525	19,473	899	20,372	8,799
1985	5,524	17,898	1,155	24,577	21,008	922	22,730	10,646
1986	5,699	18,076	1,228	25,003	25,169	1,049	26,218	9,432
1987	6,480	20,299	1,018	27,797	29,937	900	30,837	6,392
1988	8,756	25,418	828	35,002	33,682	1,265	34,947	6,447
1989	11,548 ⁶	30,712	1,022 ⁶	43,282 ⁶	36,867	1,450 ⁶	38,317 ⁶	11,412 ⁶
1990	11,494 ⁶	33,210	1,434 ⁶	46,138 ⁶	41,498	1,524 ⁶	43,022 ⁶	14,527 ⁶
1991	11,807	34,730	1,629	48,166	45,514	1,505	47,019	15,675
1992	12,748	38,684	1,717	53,149	48,627	1,661	50,288	18,535
1993	14,683	44,227	1,889	60,799	54,214 ⁷	1,845	56,059	23,276
Estimates:								
1994	16,830	38,188	1,867	56,885	58,192	1,738	59,930	20,231
1995	19,228	39,755	1,113	60,096	65,644	1,812	67,456	12,871
1996	19,347	54,273	512	74,132	73,534	1,892	75,426	11,577

¹For 1967 through 1976, fiscal years cover the interval from July 1 through June 30; the 3-month interval from July 1, 1976, through September 30, 1976, is labeled "T.Q.", the transition quarter; FY 1977-96 cover the interval from October 1 through September 30.

²The payments shown as being from the general fund of the Treasury include certain interest-adjustment items.

³Other Income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and other miscellaneous income.

⁴The financial status of the program depends on both the total net assets and the liabilities of the program (See Table 1.02).

⁵Administrative expenses shown include those paid in FY 1966 and 1967.

⁶Includes the impact of the Medicare catastrophic coverage Act of 1988 (Public Law 100-360).

⁷Includes the impact of the transfer to the HI trust fund of the SMI catastrophic coverage reserve fund on March 31, 1993 as specified in Public Law 102-394. Actual benefit payments for FY 1993 are \$52,409 million and the amount transferred was \$1,005 million.

Overview

TABLE I.C2.—OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) DURING CALENDAR YEARS 1966-1996
(In millions)

Calendar Year	Income				Disbursements			Balance at end of year ³
	Premium from enrollees	Government contribu- tions ¹	Interest and Other Income ²	Total Income	Benefit payments	Adminis- trative expenses	Total disburse- ments	
Historical Data:								
1966	\$322	\$0	\$2	\$324	\$128	\$75	\$203	\$122
1967	640	933	24	1,597	1,197	110	1,307	412
1968	832	858	21	1,711	1,518	184	1,702	421
1969	914	907	18	1,839	1,865	196	2,061	199
1970	1,096	1,093	12	2,201	1,975	237	2,212	188
1971	1,302	1,313	24	2,639	2,117	260	2,377	450
1972	1,382	1,389	37	2,808	2,325	289	2,614	643
1973	1,550	1,705	57	3,312	2,526	318	2,844	1,111
1974	1,804	2,225	95	4,124	3,318	410	3,728	1,506
1975	1,918	2,648	107	4,673	4,273	462	4,735	1,444
1976	2,060	3,810	107	5,977	5,080	542	5,622	1,799
1977	2,247	5,386	172	7,805	6,038	467	6,505	3,099
1978	2,470	6,287	299	9,056	7,252	503	7,755	4,400
1979	2,719	6,645	404	9,768	8,708	557	9,265	4,902
1980	3,011	7,455	408	10,874	10,635	610	11,245	4,530
1981	3,722 ⁴	11,291 ⁴	361	15,374	13,113	915	14,028	5,877
1982	3,697 ⁴	12,284 ⁴	599	16,580	15,455	772	16,227	6,230
1983	4,236	14,861	727	19,824	18,106	878	18,984	7,070
1984	5,167	17,054	959	23,180	19,661	891	20,552	9,698
1985	5,613	18,250	1,243	25,106	22,947	933	23,880	10,924
1986	5,722	17,802	1,141	24,665	26,239	1,060	27,299	8,291
1987	7,409 ⁵	23,560 ⁵	875	31,844	30,820	920	31,740	8,394
1988	8,761 ⁵	26,203 ⁵	861	35,825	33,970	1,260	35,230	8,990
1989	12,263 ⁶	30,852	1,234 ⁶	44,349 ⁶	38,294	1,489 ⁶	39,783 ⁶	13,556 ⁶
1990	11,320	33,035	1,558	45,913	42,468	1,519	43,987	15,482
1991	11,934	37,602	1,688	51,224	47,336	1,541	48,877	17,828
1992	14,077 ⁷	41,359 ⁷	1,801	57,237	49,260	1,570	50,830	24,235
1993	14,193 ⁷	41,465 ⁷	2,021	57,679	55,784 ⁸	2,000	57,784	24,131
Estimates:								
1994	17,381	36,148	1,489	55,018	60,044	1,749	61,793	17,356
1995	19,844	40,957	765	61,566	67,577	1,833	69,410	9,512
1996	19,181	58,711	448	78,340	75,638	1,912	77,550	10,302

¹The payments shown as being from the general fund of the Treasury include certain Interest adjustment items.

²Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and other miscellaneous income.

³The financial status of the program depends on both the total net assets and the liabilities of the program (See Table 1.D2).

⁴Section 708 of Title VII of the Social Security Act modified the provisions for the delivery of Social Security benefit checks. When the regularly designated delivery day falls on a Saturday, Sunday, or legal public holiday, delivery of benefit checks normally due January, 1982 occurred on December 31, 1981. Consequently the SMI premiums withheld from the checks (\$264 million) and the general revenue contributions (\$883 million) were added to the SMI trust fund on December 31, 1981. These amounts are excluded from the premium income and general revenue income for CY 1982.

⁵Delivery of benefit checks normally due January, 1988 occurred on December 31, 1987. Consequently, the SMI premiums withheld from the checks (\$692 million) and the general revenue contributions (\$2,178 million) were added to the SMI trust fund on December 31, 1987. These amounts are excluded from the premium income and general revenue income for CY 1988 (Refer to footnote 4).

⁶Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

⁷Delivery of benefit checks normally due January, 1993 occurred on December 31, 1992. Consequently, the SMI premiums withheld from the checks (\$1,089 million) and the general revenue contributions (\$3,175 million) were added to the SMI trust fund on December 31, 1992. These amounts are excluded from the premium income and general revenue income for CY 1993 (Refer to footnote 4).

⁸Includes the impact of the transfer to the HI trust fund of the SMI catastrophic coverage reserve fund on March 31, 1993 as specified in Public Law 102-394. Actual benefit payments for CY1993 are \$53,979 million and the amount transferred was \$1,805 million.

Expected Operations

Table I.C3 shows the calendar-year average increase in aggregate and per capita benefit payments on a cash basis under the intermediate assumptions through CY 1996. To reflect the size of the program relative to the economy as a whole, Table I.C3 also shows SMI benefit expenditures on a cash basis as a percent of GDP. During CY 1993, the program grew 9.6 percent on an aggregate basis, grew 7.4 percent on a per capita basis, and increased from 0.82 to 0.85 percent of GDP. For CY 1994, the program is expected to grow 11.2 percent on an aggregate basis, to grow 9.1 percent on a per capita basis, and to increase from 0.85 to 0.89 percent of GDP.

TABLE I.C3.—GROWTH IN TOTAL CASH BENEFITS UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM THROUGH DECEMBER 31, 1996

Calendar year	Aggregate benefits (millions)	Percent change	Per capita benefits	Percent change	SMI benefits as a percent of GDP
Historical Data:					
1967	\$1,197		\$66.97		0.15
1968	1,518	26.8	82.27	22.8	0.17
1969	1,865	22.9	97.86	19.0	0.19
1970	1,975	5.9	101.30	3.5	0.20
1971	2,117	7.2	106.68	5.3	0.19
1972	2,325	9.8	114.91	7.7	0.19
1973	2,526	8.6	122.02	6.2	0.19
1974	3,318	31.4	144.47	18.4	0.23
1975	4,273	28.8	179.96	24.6	0.27
1976	5,080	18.9	207.39	15.2	0.29
1977	6,038	18.9	239.27	15.4	0.31
1978	7,252	20.1	279.58	16.8	0.32
1979	8,708	20.1	326.86	16.9	0.35
1980	10,635	22.1	389.87	19.3	0.39
1981	13,113	23.3	471.15	20.8	0.43
1982	15,455	17.9	545.55	15.8	0.49
1983	18,106	17.2	627.79	15.1	0.53
1984	19,661	8.6	670.77	6.8	0.52
1985	22,947	16.7	768.25	14.5	0.57
1986	26,239	14.3	861.37	12.1	0.61
1987	30,820	17.5	992.69	15.2	0.68
1988	33,970	10.2	1,076.64	8.5	0.69
1989	38,294	12.7	1,195.42	11.0	0.73
1990	42,468	10.9	1,305.14	9.2	0.77
1991	47,336	11.5	1,426.90	9.3	0.83
1992	49,260	4.1	1,455.16	2.0	0.82
1993	53,979	9.6	1,562.30	7.4	0.85
Estimates:					
1994	60,044	11.2	1,703.81	9.1	0.89
1995	67,577	12.5	1,883.89	10.6	0.95
1996	75,638	11.9	2,077.40	10.3	1.01

Table I.C4 shows the estimated incurred disbursements of the SMI program under the intermediate assumptions expressed as a percentage of GDP, for selected years over the period CY 1993-2068. These estimated incurred disbursements are for benefit payments and administrative expenses combined unlike the values in Table I.C3 which only express benefit payments on a cash basis as a percentage of GDP. The 75-year projection period fully allows for the presentation of future contingencies that reasonably may be expected to occur, such as the impact of a large increase in enrollees which occurs after the turn of the

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century. This large increase in enrollees occurs because the relatively large number of persons born during the period between the end of World War II and the early 1960's (known as the "baby boom") will reach retirement age and begin to receive benefits. Increases in the costs per enrollee during the initial 25-year period are assumed to gradually decline in the last 12 years to the same rate as GDP per capita and then continue at the same rate as GDP per capita in the last 50 years. Given the historical experience of SMI costs per enrollee increasing faster than GDP per capita, the assumption of the increases in costs per enrollee declining to the same rate as GDP per capita may be considered optimistic because changes in the last 50 years of the estimation period reflect only the impact of the changing demographic composition of the population. Based on these assumptions, incurred SMI disbursements as a percentage of GDP increase rapidly from 0.88 percent in CY 1993 to 4.19 percent in CY 2036, decrease slightly to 4.05 percent in CY 2051, and then increases to 4.37 percent in CY 2068.

TABLE I.C4.—SUPPLEMENTARY MEDICAL INSURANCE INCURRED DISBURSEMENTS AS A PERCENT OF THE GROSS DOMESTIC PRODUCT¹

Calendar year	SMI Disbursements as a percent of GDP
1993	0.88
1994	0.93
1995	0.99
2000	1.31
2005	1.77
2010	2.37
2015	2.91
2020	3.27
2025	3.67
2030	4.01
2035	4.17
2040	4.16
2045	4.10
2050	4.05
2055	4.09
2060	4.21
2065	4.33
2068	4.37

¹Disbursements are the sum of benefit payments and administrative expenses.

Since future health care usage and cost experience may vary considerably from the intermediate assumptions on which the cost estimates were based, estimates have also been prepared on the basis of two additional alternative sets of assumptions: low cost and high cost. The estimated operations of the SMI trust fund during CY 1993-2003 are summarized in Table I.C5 for all three alternatives. The assumptions underlying the intermediate assumptions are presented in substantial detail in the section II.D "Actuarial Methodology and Principal Assumptions for Cost Estimates for the Supplementary Medical Insurance Program." The assumptions used in preparing estimates under the low cost and high cost alternatives are also summarized in this section.

Expected Operations

TABLE I.C5.—ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) DURING CALENDAR YEARS 1993-2003

(In billions)

Calendar year	Premiums from enrollees	Other Income ¹	Total Income	Total disbursements	Balance in fund at end year
Intermediate:					
1993	14.2	43.5	57.7	56.0	24.1
1994	17.4	37.6	55.0	61.8	17.4
1995	19.8	41.7	61.6	69.4	9.5
1996	19.2	59.2	78.3	77.6	10.3
1997	21.4	65.8	87.2	86.4	11.1
1998	23.9	73.3	97.2	96.3	11.9
1999	25.1	83.6	108.6	107.6	12.9
2000	26.2	95.2	121.4	120.4	14.0
2001	27.5	108.6	136.1	134.9	15.2
2002	28.9	124.0	152.8	151.5	16.6
2003	30.4	141.6	171.9	170.4	18.1
Low Cost:					
1993	14.2	43.5	57.7	56.0	24.1
1994	17.4	37.7	55.0	61.4	17.8
1995	19.8	40.4	60.3	68.1	9.9
1996	18.6	57.4	76.0	75.2	10.7
1997	20.5	63.0	83.5	82.8	11.4
1998	22.6	69.2	91.8	91.0	12.2
1999	23.5	77.3	100.8	99.9	13.1
2000	24.5	85.9	110.4	109.4	14.1
2001	25.6	95.5	121.0	119.9	15.3
2002	26.6	106.1	132.6	131.5	16.4
2003	27.7	117.9	145.6	144.4	17.7
High Cost:					
1993	14.2	43.5	57.7	56.0	24.1
1994	17.4	37.6	55.0	61.9	17.2
1995	19.8	42.6	62.4	70.3	9.4
1996	20.0	61.6	81.5	80.8	10.1
1997	22.8	70.3	93.1	92.2	11.0
1998	26.0	79.4	105.4	104.4	12.0
1999	28.0	92.8	120.8	119.7	13.1
2000	29.6	109.9	139.6	138.3	14.4
2001	31.4	129.3	180.7	159.3	15.8
2002	33.4	151.5	184.9	183.2	17.4
2003	35.5	177.6	213.1	211.2	19.3

¹Other income contains government contributions and interest.

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

The three sets of assumptions were selected in order to indicate the general range in which the cost of the program reasonably might be expected to fall. The low and high cost alternatives provide for a fairly wide range of possible experience. Actual experience is expected to fall within the range, but no assurance can be given that this will be the case, particularly in light of the wide variations in experience that have occurred since the beginning of the program.

SMI expenditures are estimated to grow faster than the GDP under all three alternatives, with the most rapid growth occurring under the high cost alternative and the least rapid under the low cost alternative. Table I.C5 indicates that by CY 2003 total disbursements for the low cost and for the high cost alternatives will be 15 percent lower and 24 percent higher, respectively, than for the intermediate assumptions. Similarly,

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for CY 2003 total income for the low cost and for the high cost alternatives will be 15 percent lower and 24 percent higher, respectively, than for the intermediate assumptions. However, the trust fund balances for the low cost and the high cost alternatives do not display this divergence. The CY 2003 trust fund balance under the low cost alternative is 2 percent lower than the trust fund balance for the intermediate assumptions, and the trust fund balance for the high cost alternative is 7 percent higher than under the intermediate assumptions. The reason the trust fund balances show much smaller variations under the three alternatives is that the financing has only been fully established through CY 1994. It is assumed that financing for years beyond 1994 will be established to adequately finance the expenditures, irrespective of the underlying economic assumptions.

D. ACTUARIAL STATUS OF THE TRUST FUND

1. Actuarial Soundness of the Supplementary Medical Insurance Program

The concept of actuarial soundness, as it applies to the SMI program, is closely related to the concept as it applies to many private group insurance plans. The SMI program essentially is yearly renewable term insurance financed from premium income paid by the enrollees and from income contributed from general revenue by the federal government. Consequently, the income to the program during a 12-month period for which financing is being established should be sufficient to maintain assets at a level to pay for services (including associated administrative costs) expected to be rendered during that period, even though payment for some of these services will not be made until after the close of the period. The portion of income required to cover those benefits not paid until after the close of the year is added to the trust fund. Thus, the assets in the trust fund at any time should be no less than the costs of the benefits and the administrative expenses incurred but not yet paid.

The law requires the Secretary of Health and Human Services (HHS) to establish income on the basis of incurred costs (including associated administrative costs) for the 12-month period for which financing is being established. Financing on an incurred basis means that income should be sufficient to cover the cost of services rendered during the period. However, since the income per enrollee (premium rate plus Government contribution) is established prospectively, it is subject to projection error. Additionally, legislation enacted after the financing has been established but effective for the period for which financing has been set may affect program costs. As a result, the income to the program may not be equal to incurred costs; therefore, trust fund assets should be maintained at a level which is adequate to cover a reasonable degree of variation between actual and projected costs, in case actual costs exceed

projected, as well as the value of incurred but unpaid expenses. In testing the actuarial soundness of the SMI program, it is appropriate to look only to the periods for which the enrollee premium rates and level of general revenue financing have been established. The primary tests of actuarial soundness, then, are that: (1) assets and income for years for which financing has been established be sufficient to meet the projected benefits and associated administrative expenses incurred for that period and (2) assets be sufficient to cover projected liabilities that will have been incurred by the end of that time but will not have been paid yet. Even if these tests of actuarial soundness are not met, the program can continue to operate if the trust fund remains at a level adequate to permit the payment of claims as presented. However, to protect against the possibility that costs under the program will be higher than assumed, assets should be sufficient to include contingency levels to cover a reasonable degree of variation between actual and projected costs, in case actual costs exceed projected.

Contingency levels to accommodate costs that may be higher than expected are measured by the excess of assets over liabilities. An appropriate target level for this excess depends on numerous factors. The most important of these factors are: (1) the difference from prior years in the actual performance of the program and the estimates made at the time financing was established and (2) the expected relationship between incurred and cash expenditures. Ongoing analysis is made of the former as trends in the differences vary over time.

2. Incurred Experience of the Supplementary Medical Insurance Program

The tests of actuarial soundness of the SMI program noted above rely on the incurred experience of the program. Cash disbursements for benefits and administrative expenses by themselves are misleading, due to the relatively large liabilities outstanding at any time for benefits and processing costs. Outstanding liabilities result from the lag between the time that services are performed and the time that payments for them are made.

The experience of the program is substantially more difficult to determine on an incurred basis than on a cash basis. Payment for some services is reported only on a cash basis, and the incurred experience must be inferred from the cash payment information. For recent time periods, the tabulations of bills are incomplete due to normal processing delays. Finally, since bills are tabulated only for a sample of beneficiaries, the data is subject to biases and random fluctuations inherent in the sampling process.

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Table I.D1 shows the estimated transactions of the trust fund on an incurred basis. For the reasons stated above, the incurred experience must be viewed as an estimate even for historical years. Various tests, such as the comparison to cash outlay data, assure that the estimates are reasonably close, however.

TABLE I.D1.—ESTIMATED INCOME AND DISBURSEMENTS INCURRED UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM FOR FINANCING PERIODS THROUGH DECEMBER 31, 1994

(In millions)

Financing period	Premiums from enrollees	Government Contributions	Interest and other Income	Benefit payments	Administrative expenses	Net operations in year
Historical Data:						
12-Month period ending June 30,						
1967	\$647	\$647	\$15	\$1,109	\$123 ¹	\$77
1968	698	698	21	1,443	155	-181
1969	903	903	24	1,765	198	-133
1970	936	936	12	1,929	213	-258
1971	1,253	1,253	18	2,090	259	175
1972	1,340	1,340	29	2,289	259	161
1973	1,427	1,426	45	2,500	302	96
1974	1,704	2,031	76	3,174	353	284
1975	1,887	2,396	105	3,957	438	-7
1976	1,951	2,972	109	4,852	485	-305
1977	2,156	4,697	157	5,861	515	634
1978	2,358	5,991	254	6,924	511	1,168
1979	2,601	6,570	365	8,140	649	747
1980	2,823	6,627	421	9,839	645	-613
1981	3,178	8,219	371	11,906	692	-830
1982	3,737	12,488	495	13,888	728	2,104
1983	4,202	13,951	686	16,906	708	1,225
T.S. ²	2,120	7,836	374	9,720	483	127
Calendar year						
1984	5,167	17,052	962	20,345	869	1,967
1985	5,613	18,243	1,248	22,894	986	1,224
1986	5,722	17,802	1,141	26,633	1,000	-2,968
1987	6,717	21,377	880	30,800	1,036	-2,862
1988	9,453	28,342	903	34,615	1,343	2,740
1989	12,263 ³	30,826	1,257 ³	38,192	1,386 ³	4,768 ³
1990	11,320	33,035	1,558	42,527	1,541	1,845
1991	11,934	37,558	1,732	46,583	1,572	3,069
1992	12,988	38,158	1,827	49,684	1,663	1,626
1993	15,282	44,640	2,021	55,921 ⁴	1,703	4,319
Estimates:						
1994	17,381	36,148	1,489	60,702	1,749	-7,433

¹Includes administrative expenses incurred prior to the beginning of the program.

²The transition semester (T.S.) is the 6-month period July 1, 1983 to December 31, 1983.

³Includes the Impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

⁴Includes the impact of the transfer to the HI trust fund of the SMI catastrophic coverage reserve fund on March 31, 1993 as specified in Public Law 102-394. Estimated incurred payments for CY 1993 are \$54,116 million and the amount transferred was \$1,805 million.

3. Accumulated Excess of Assets Over Liabilities

The liability outstanding at any time for the cost of services performed for which no payment has been made is referred to as "benefits incurred but unpaid." Estimates of the amount of benefits incurred but unpaid as of the end of each financing period, and of the administrative expenses related to processing these benefits, appear in Table I.D2. For some

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years of the program, assets have not been as large as liabilities. Nonetheless, the fund has remained positive, allowing claims to be paid.

**TABLE I.D2.—SUMMARY OF ESTIMATED ASSETS AND LIABILITIES OF THE
SUPPLEMENTARY MEDICAL INSURANCE PROGRAM AS OF THE END OF THE
FINANCING PERIOD, FOR PERIODS THROUGH DECEMBER 31, 1994**

(Dollar amounts in millions)

	Balance in trust fund	Government contributions due but unpaid	Total assets	Benefits incurred but unpaid	Administrative cost incurred but unpaid	Total liab- ilities	Excess of assets over liabilities	Ratio ¹
Historical Data								
As of June 30,								
1967	\$466	\$24	\$510	\$445	-\$12	\$433	\$77	0.05
1968	307	88	395	498	1	499	-104	-0.05
1969	378	7	385	618	4	622	-237	-0.11
1970	57	15	72	568	0	568	-496	-0.21
1971	290	22	312	623	11	634	-322	-0.13
1972	481	-3	478	657	-19	638	-160	-0.06
1973	746	-7	739	766	37	603	-64	-0.02
1974	1,272	-5	1,267	1,066	-19	1,047	220	0.05
1975	1,424	67	1,491	1,258	14	1,272	219	0.04
1976	1,219	106	1,325	1,438	-29	1,409	-84	-0.01
1977	2,170	91	2,261	1,710	3	1,713	548	0.07
1978	3,766	48	3,834	2,077	40	2,117	1,717	0.20
1979	4,880	2	4,882	2,297	123	2,420	2,462	0.24
1980	4,657	0	4,657	2,620	188	2,608	1,849	0.15
1981	3,801	0	3,801	2,768	13	2,781	1,020	0.07
1982	5,534	1	5,535	2,420	-9	2,411	3,124	0.18
1983	6,780	2	6,782	2,481	-48	2,443	4,349	0.21
As of December 31,								
1983	7,070	1	7,071	2,663	-69	2,594	4,477	0.21
1984	9,698	2	9,700	3,347	-91	3,256	6,444	0.27
1985	10,924	0	10,924	3,294	-38	3,256	7,668	0.28
1986	8,291	0	8,291	3,668	-98	3,590	4,701	0.15
1987	8,394 ²	0	8,394 ²	3,668	17	6,555 ²	1,839	0.05
1988	8,990	3	8,993	4,313	100	4,413	4,580	0.12
1989 ³	13,556	0	13,556	4,211	-3	4,208	9,348	0.21
1990	15,482	0	15,482	4,270	19	4,289	11,193	0.23
1991	17,828	0	17,828	3,517	50	3,567	14,261	0.28
1992	24,235 ⁴	0	24,235 ⁴	3,941	143	8,347 ⁴	15,888	0.29
1993	24,131	0	24,131	4,078	-154	3,924	20,207	0.32
Estimates:								
1994	17,356	0	17,356	4,736	-154	4,582	12,774	0.18

¹Ratio of the excess assets over liabilities to the following year's total incurred expenditures.

²Section 708 of Title VII of the Social Security Act modified the provisions for the delivery of Social Security benefit checks when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January, 1988 occurred on December 31, 1987. Consequently, the SMI premiums withheld from the checks (\$692 million) and the general revenue matching contributions (\$2,178 million) were added to the SMI trust fund on December 31, 1987 and were included in the liabilities.

³The 1989 transactions of Medicare Catastrophic Coverage Account are included in the assets and liabilities of the trust fund.

⁴Section 708 of Title VII of the Social Security Act modified the provisions for the delivery of Social Security benefit checks when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January, 1993 occurred on December 31, 1992. Consequently, the SMI premiums withheld from the checks (\$1,089 million) and the general revenue matching contributions (\$3,175 million) were added to the SMI trust fund on December 31, 1992 and were included in the liabilities.

Program financing has been established through December 31, 1994. The financing for CY 1994 was designed with specific margins to reduce the excess of assets over liabilities as a percent of incurred expenditures

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for the following year, as is explained in appendix III.B. As a result, the CY 1994 incurred disbursements are expected to exceed the incurred income by \$7,433 million, as shown in Table I.D1, and the excess of assets over liabilities is expected to decrease from \$20,207 million at the end of December 1993 to \$12,774 million at the end of December 1994 for the intermediate assumptions, as shown in Table I.D2. This excess as a percent of incurred expenditures for the following year is expected to decrease from 32 percent as of December 31, 1993 to 18 percent as of December 31, 1994.

4. Sensitivity Testing

Some of the assumptions underlying the estimates presented in this report are highly uncertain, and variations in these assumptions would have a substantial impact on estimated expenditures. Since the financing rates are set prospectively, the actuarial soundness depends on the variations in these assumptions. In order to test the actuarial soundness of the program under varying assumptions, a lower range projection and an upper range projection were prepared by varying these key assumptions through the period for which the financing has been set. The lower and upper range alternative sets of assumptions are intended to reflect growth rates for the various components of program costs which are more favorable and adverse, respectively, than those of the intermediate assumptions. These two alternative sets of assumptions are reasonable in light of the nature and historical experience of the program. As such, they provide a range of financial outcomes within which the actual experience of the program might reasonably be expected to fall. The values for the lower and upper range assumptions were determined from a study on the average historical variation in the respective increase factors.

This sensitivity analysis differs from the low cost and high cost analysis discussed in the section I.C “Expected Operations and Status of the Trust Fund.” This analysis examines the variation in the projection factors through the period for which the financing has been established (1994 for this report). The low cost and high cost analysis begins the variation in program growth within the year for which financing has been established (1994 for this report) and continues through the projection period.

Table I.D3 indicates that, under the lower range assumptions, trust fund assets would exceed liabilities by the end of December 1994 (the period through which financing has been established), reaching a level of 24.1 percent of the following year’s incurred expenditures. If these lower range assumptions were actually to materialize, then subsequent financing rates would be adjusted downward in order to lower the excess of assets over liabilities to an appropriate level to maintain the actuarial soundness of the trust fund. Under the upper range assumptions, trust

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fund assets would still exceed liabilities by the end of December 1994, dropping to a level of 8.1 percent of the following year's incurred expenditures. Therefore, even if these upper range growth rates were to occur, assets would still be sufficient to cover outstanding liabilities. Figure 3 shows this ratio for historical years and for projected years under the intermediate assumptions, as well as the lower range (optimistic) and the upper range (pessimistic) cost sensitivity scenarios.

Table I.D3.—ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND UNDER THREE SETS OF ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 1994

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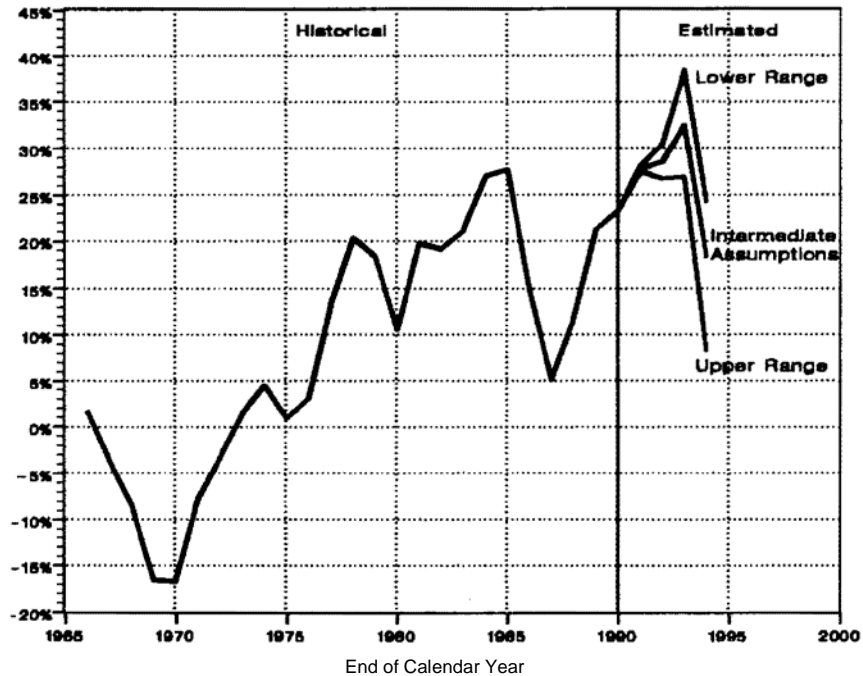
	Intermediate projection			Lower range projection			Upper range projection		
	12-Month period ending June 30,			12-Month period ending June 30,			12-Month period ending June 30,		
	1993	1994	1995	1993	1994	1995	1993	1994	1995
Projection factors (in percent):									
Physician fees ¹									
Aged	0.5	2.6	5.0	0.3	2.0	3.0	0.7	3.2	7.0
Disabled	0.5	2.6	5.0	0.3	2.0	3.0	0.7	3.2	7.0
Utilization of physician services ²									
Aged	-1.0	4.3	3.8	-2.6	2.6	1.4	0.6	5.9	6.2
Disabled	0.9	-4.7	2.4	-1.6	-7.5	-0.7	3.4	-1.8	5.5
Outpatient hospital services per enrollee									
Aged	12.0	11.2	11.7	8.0	6.3	6.2	16.1	16.1	17.2
Disabled	17.7	6.8	12.5	14.4	1.6	7.1	21.0	12.0	17.8
	As of December 31,			As of December 31,			As of December 31,		
	1992	1993	1994	1992	1993	1994	1992	1993	1994
Actuarial status (in millions):									
Assets	\$19,972	\$24,131	\$17,356	\$19,972	\$24,131	\$21,131	\$19,972	\$24,131	\$13,366
Liabilities	4,084	3,924	4,582	3,564	1,639	2,117	4,606	6,254	7,107
Assets less liabilities	\$15,888	\$20,207	\$12,774	\$16,408	\$22,492	\$19,014	\$15,366	\$17,877	\$6,259
Ratio of assets less liabilities to expenditures (In percent) ³	28.5	32.4	18.2	30.4	38.3	24.1	26.7	26.9	8.1

¹As recognized for payment under the program.

²Increase in the number of services received per enrollee and greater relative use of more expensive services.

³Ratio of assets less liabilities at the end of the year to the total Incurred expenditures during the following year, expressed as a percent.

FIGURE 3.
ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE
TRUST FUND THROUGH CALENDAR YEAR 1994



Note: The actuarial status of the SMI trust fund is measured by the ratio of the end of year surplus or deficit to the following year Incurred expenditures.

E. CONCLUSION

The financing for the SMI program has been established through December 1994 by the setting of the standard monthly premium rate (paid by or on behalf of each enrollee) of \$41.10 for CY 1994 and of actuarial rates that determine the amount to be contributed from general revenue on behalf of each enrollee. General revenue contributions are expected to account for 65.7 percent of all SMI income during CY 1994.

Under the intermediate assumptions used in this report, disbursements are estimated to exceed income during CY 1994 by \$6,775 million. Income is composed of premiums paid by the enrollees, general revenue contributions, and interest earned by the trust fund. As a result, the assets in the trust fund on a cash basis are estimated to decrease from \$24.1 billion at the end of CY 1993 to \$17.4 billion at the end of CY 1994.

The main reason for the decrease in assets during CY 1994 is that the financing for CY 1994 was established specifically to reduce assets. As a result, the excess of assets over liabilities is expected to decrease from \$20,207 million at the end of December 1993 to \$12,774 million by the

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end of December 1994 representing 18.2 percent of the following year's projected incurred expenditures. Under more pessimistic assumptions as to cost increases, assets based on financing already established will still be sufficient to cover outstanding liabilities. Hence, the financing established through December 1994 is sufficient to cover projected benefit and administrative costs incurred through that time period, and to maintain a level of trust fund assets adequate to cover the impact of a reasonable degree of variation between actual and projected costs.

Although the SMI program is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. In spite of the evidence of slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 59 percent in aggregate and 45 percent per enrollee in the last 5 years. For the same time period, the program grew 23 percent faster than the economy despite recent efforts to control the cost of the program. As a result, the incurred disbursements of the program are projected to increase from 0.88 percent of the GDP in CY 1993 to 4.37 percent of GDP in CY 2068. Initially, this rapid growth is attributable primarily to the inability to control (1) the growth in the volume of services billed per beneficiary and (2) the reported case mix intensity (the reporting of services which receive higher reimbursement). Later in the projection period, the changing demographic composition of the population will also have a major influence on the growth in program costs. Given the past and projected cost of the program, the Trustees urge the Congress to promptly take additional actions designed to control SMI costs through specific program legislation and as a part of enacting more comprehensive health care reform. The Trustees believe that prompt, effective, and decisive action is necessary.

II. TECHNICAL

A. SOCIAL SECURITY AMENDMENTS SINCE THE 1993 REPORT

Since the 1993 Annual Report was transmitted to Congress, the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66) was enacted on August 10, 1993. A section of this legislation affected the SMI program. The more important changes, from a financial standpoint, are briefly described below:

- (1) In both CY 1994 and 1995, the default update for the conversion factor is reduced for all services except primary care services. In 1994, the reduction is 3.6 percentage points for surgical services and 2.6 percentage points for all other services, excluding primary care services. In 1995, the reduction is 2.7 percentage points for all services except for primary care services.
- (2) For CY 1995 and thereafter, the performance standard factor reduction is increased to 4 percentage points. Further, the restriction in the downward adjustment to the default update has been increased to 5 percentage points.
- (3) Practice expense relative value units are reduced by 25 percent of the difference between practice expense relative value units and work relative value units in 1994. They are reduced an additional 25 percent in 1995 and an additional 25 percent in 1996. Services with no work component and services performed at least 75 percent of the time in an office setting, are excluded.
- (4) There is no longer a phase-in of payments to new physicians. The relative value units (RVUs) of the physician fee schedule were reduced in a budget neutral manner to pay for it.
- (5) Separate payments for EKG interpretations are restored. The RVUs of the physician fee schedule for visits and consultations were adjusted in a budget neutral manner to pay for it.
- (6) There is a limit on Medicare payment for anesthesia teams which is set at 100 percent of the Medicare payment if the anesthesia is furnished only by a physician. This limit is phased in over 4 years: 120 percent for services furnished in 1994; 115 percent in 1995; 110 percent in 1996; 105 percent in 1997; and 100 percent thereafter.
- (7) The 10 percent reduction for payments for capital-related costs is extended for 3 years, through 1998. The 5.8 percent reduction for payments for reasonable costs of outpatient hospital services (other than capital related costs) is extended for 3 years, through 1998.

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- (8) The annual adjustment to fee schedules for clinical diagnostic tests will be 0 percent for 1994 and 1995. The payment limits for tests is reduced from 88 percent of the median of fee amounts to 84 percent in 1994; 80 percent in 1995; and 76 percent in 1996 and thereafter.
- (9) Oral, self-administered, anti-cancer chemotherapeutic drugs are now covered if they are FDA-approved and if they contain the same active ingredient as the non-self-administered form. Off-label uses are acceptable unless the Secretary of Health and Human Services has determined that the use is not medically appropriate.
- (10) The period of time that Medicare is secondary payer for the disabled has been extended from October 1, 1995 to October 1, 1998. Effective with OBRA 90, Medicare's secondary payer provision for end-stage renal disease (ESRD) beneficiaries, increased from 12 months to 18 months through January 1, 1996. This has been extended to October 1, 1998. Under prior law, Medicare was secondary payer for beneficiaries with ESRD only if the beneficiary was entitled to Medicare solely on the basis of ESRD. Under this legislation, Medicare is now secondary payer for all beneficiaries with ESRD.
- (11) The period of coverage for immunosuppressive drugs after a covered transplant is lengthened to 18 months in 1995, 24 months in 1996, 30 months in 1997, and 36 months thereafter.
- (12) The Part B premium is established as 50 percent of the aged actuarial rate for 3 years: 1996-1998.

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

B. NATURE OF THE TRUST FUND

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

The major sources of revenue of the trust fund are: (1) contributions of the Federal Government that are authorized to be appropriated and transferred from the general fund of the Treasury and (2) premiums paid by eligible persons who are voluntarily enrolled in the program. The premiums paid by eligible persons in 1989 include both those specified by the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) and those needed to finance the non-catastrophic benefits. With the enactment of the Medicare Catastrophic Coverage Repeal Act of 1989

Nature of the Trust Fund

(Public Law 101-234), there are no catastrophic premiums after 1989. Therefore, the discussion in the remainder of this section will deal only with non-catastrophic coverage. Eligible persons aged 65 and over have been able to enroll in the program since its inception in July 1966. Since July 1973, disabled persons under age 65, who have met certain eligibility requirements, have also been able to enroll in the program.

The premiums paid by enrollees are based on the standard monthly premium rate, which is the same for enrollees aged 65 and over and for disabled enrollees under age 65. Premiums paid for FY 1967 through 1973 were matched by an equal amount of Government contributions. Beginning July 1973, the amount of Government contributions corresponding to premiums paid by each of the two groups of enrollees is determined by applying a ratio (known as the matching ratio), prescribed in the law for each group, to the amount of premiums received from that group of enrollees. The ratio is equal to: (1) twice the amount of the monthly actuarial rate applicable to the particular group of enrollees, minus the amount of the standard monthly premium rate, divided by (2) the amount of the standard monthly premium rate.

Standard monthly premium rates and actuarial rates are promulgated each year by the Secretary of HHS. The standard monthly premium rates in effect from July 1966 through June 1983, the rate for July 1983 through December 1983, and the rates for CY 1984 through 1994 are shown in Table II.B1. Actuarial rates and the corresponding matching ratios in effect from July 1973 through June 1983, the rates and ratios applicable for July 1983 through December 1983, and the rates and ratios for CY 1984 through 1994 are also shown. For a detailed discussion of the determination of the actuarial and premium rates, see appendix III.B.

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TABLE II.B1.—STANDARD MONTHLY PREMIUM RATES, ACTUARIAL RATES, AND MATCHING RATIOS

	Standard monthly premium rate	Monthly actuarial rate		Matching ratio	
		Enrollees aged 65 and over	Disabled enrollees under age 65	Enrollees aged 65 and over	Disabled enrollees under age 65
July 1966 - March 1968	\$3.00	—	—	—	—
April 1968 - June 1970	4.00	—	—	—	—
12-month period ending June 30 of -					
1971	5.30	—	—	—	—
1972	5.60	—	—	—	—
1973	5.80	—	—	—	—
1974 ¹	6.30	\$6.30	\$14.50	1.0000	3.6032
1975	6.70	6.70	18.00	1.0000	4.3731
1976	6.70	7.50	18.50	1.2388	4.5224
1977	7.20	10.70	19.00	1.9722	4.2778
1978	7.70	12.30	25.00	2.1948	5.4935
1979	8.20	13.40	25.00	2.2683	5.0976
1980	8.70	13.40	25.00	2.0805	4.7471
1981	9.60	16.30	25.50	2.3958	4.3125
1982	11.00	22.60	36.60	3.1091	5.6545
1983	12.20	24.60	42.10	3.0328	5.9016
July 1983 - December 1983	12.20	27.00	46.10	3.4262	6.5574
Calendar year					
1984	14.60	29.20	54.30	3.0000	6.4384
1985	15.50	31.00	52.70	3.0000	5.8000
1986	15.50	31.00	40.80	3.0000	4.2645
1987	17.90	35.80	53.00	3.0000	4.9218
1988	24.80	49.60	48.60	3.0000	2.9194
1989	31.90 ²	55.80	34.30	3.0000 ³	1.4588 ³
1990	28.60	57.20	44.10	3.0000	2.0839
1991	29.90	62.60	56.00	3.1873	2.7458
1992	31.80	60.80	80.80	2.8239	4.0618
1993	36.60	70.50	82.90	2.8525	3.5301
1994	41.10	61.80	76.10	2.0073	2.7032

¹In accordance with limitations on the costs of health care imposed under phase III of the Economic Stabilization program, the standard premium rate for July and August 1973 was set at \$5.80 and \$6.10, respectively. Effective September 1973, the rate increased to \$6.30.

²This is the premium paid by most groups. This rate includes the \$4.00 catastrophic coverage monthly premium which was paid by most enrollees.

³The matching ratios for CY 1989 apply to the non-catastrophic portion of the standard monthly premium rate.

Another source from which revenue of the trust fund is derived is interest received on investments held by the fund. The investment procedures of the fund are described later in this section. Section 201(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 for any activity financed through the fund.

Expenditures for benefit payments and administrative expenses under the program are paid out of the trust fund. All expenses incurred by the Department of HHS and by the Department of the Treasury in carrying out the SMI provisions of Title XVIII of the Social Security Act are charged to the trust fund. The Secretary of HHS certifies benefit payments to the Managing Trustee, who makes the payments from the trust fund in accordance therewith.

Nature of the Trust Fund

The Social Security Amendments of 1967 and 1972 authorize the Secretary of HHS 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 HI and SMI programs. A sizeable portion of the costs of such experiments and demonstration projects are paid out of the HI and SMI trust funds, with the remainder funded through general revenues.

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 SMI program. Both the capital costs of construction financed directly from the trust fund 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 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. Obligations of these types 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 calendar month.

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**C. SUMMARY OF THE OPERATIONS OF THE TRUST FUND,
FISCAL YEAR 1993**

A statement of the revenue and disbursements of the Federal SMI Trust Fund in FY 1993 and of the assets of the fund at the beginning and end of the fiscal year is presented in Table II.C1.

**TABLE II.C1.—STATEMENT OF OPERATIONS OF THE SUPPLEMENTARY MEDICAL
INSURANCE TRUST FUND DURING FISCAL YEAR 1993**

(in thousands)

Total assets of the trust fund, beginning of period		\$18,535,465
Revenue:		
Premiums from enrollees:		
Enrollees aged 65 and over	\$13,255,439	
Disabled enrollees under age 65	1,427,583	
Total premiums		14,683,021
Transfers from general fund of the Treasury:		
Government contributions:		
Supplementary premiums of enrollees aged 65 and over . . .	38,824,951	
Supplementary premiums of disabled enrollees under age 65	5,401,570	
Total Government contributions		44,226,521
Other		1,428
Interest:		
Interest on Investments	1,906,431	
Interest on amounts of interfund transfers ¹	-18,837	
Total Interest		1,887,594
Total revenue		60,798,566
Disbursements:		
Benefit payments		52,409,026
Transfer to the HI trust fund of the SMI catastrophic coverage reserve fund on March 31, 1993		1,804,517
Administrative expenses:		
Treasury administrative expenses	6,730	
Salaries and expenses – SSA	295,381	
Salaries and expenses – HCFA	1,521,248	
Salaries and expenses Office of Secretary	14,034	
Policy and Research	2,314	
Pay Assessment Commission	192	
Office of Personnel Management expenses	131	
Physicians Payment Review	4,880	
Total administrative expenses		1,844,910
Total disbursements		56,058,453
Net addition to the trust fund		4,740,113
Total assets of the trust fund, end of period		23,275,577

¹A positive figure represents a transfer of interest to the SMI trust fund from the other trust funds. A negative figure represents a transfer of interest from the SMI trust fund to the other trust funds.

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

The total assets of the trust fund amounted to \$18,535 million on September 30, 1992. During FY 1993, total revenue amounted to \$60,799 million, and total disbursements were \$56,058 million. Total assets thus increased \$4,740 million during the year to a total of \$23,276 million on September 30, 1993.

Of the total revenue, \$13,255 million represented premium payments by (or on behalf of) enrollees aged 65 and over and \$1,428 million represented premium payments by (or on behalf of) disabled enrollees

Summary of FY 1993 Operations

under age 65. Total premium payments amounted to \$14,683 million, an increase of 15.2 percent over the amount of \$12,748 million for the preceding year. This increase in premiums from enrollees resulted primarily from: (1) the increase from \$31.80 to \$36.60 per month in the standard premium rate that became effective on January 1, 1993 and (2) the growth of the number of persons enrolled in the SMI program.

Contributions received from the general fund of the treasury amounted to \$44,227 million, which accounted for 72.7 percent of total revenue. This amount consisted of \$38,825 million representing contributions relating to premiums paid by enrollees aged 65 and over, and \$5,402 million representing contributions relating to the premiums paid by disabled enrollees under age 65. The remaining \$1,889 million of revenue consisted almost entirely of interest on the investments of the trust fund.

Of the \$56,058 million in total disbursements, \$52,409 million represented: (1) benefits paid directly from the trust fund for health services covered under Title XVIII of the Social Security Act and (2) costs of experiments and demonstration projects in providing health care services. The transfer to the HI trust fund of the SMI catastrophic coverage reserve fund represented \$1,805 million of disbursements. The remaining \$1,845 million of disbursements was for administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds-old age and survivors insurance (OASI), disability insurance (DI), HI, and SMI-on the basis of provisional estimates. Similarly, the expenses of administering other programs of HCFA 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, the allocations of administrative expenses and costs of construction for prior periods are adjusted by interfund transfers. This adjustment includes transfers between the HI and SMI trust funds and the program management general fund account, with appropriate interest allowances.

In Table II.C2, the experience with respect to actual amounts of enrollee premiums, Government contributions, and benefit payments in FY 1993 is compared with the estimates for FY 1993 which appeared in the 1992 and 1993 annual reports.

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TABLE II.C2.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1993

(Dollar amounts in millions)

Item	Actual amount	Comparison of actual experience with estimates for FY 1993 published in -			
		1993 report ¹		1992 report ¹	
		Estimated amount	Actual as percentage of estimate	Estimated amount	Actual as percentage of estimate
Premiums from enrollees	\$14,683	\$14,568	101	\$14,523	101
Government Contributions	44,227	43,898	101	45,964	96
Benefit Payments	52,409	53,421 ²	98	59,958	87

¹Alternative II, which were the intermediate assumptions in those reports.

²Does not include the impact of the transfer to the HI trust fund of the SMI catastrophic coverage reserve fund on March 31, 1993 as specified in Public Law 102-394 which was included in the 1993 report.

Table II.C3 shows a comparison of the total assets of the fund and their distribution at the end of FY 1992 and at the end of FY 1993. The assets of the trust fund at the end of FY 1992 totaled \$18,535 million, consisting of \$18,534 million in the form of obligations of the U.S. Government, and an undisbursed balance of almost \$2 million. The assets of the trust fund at the end of FY 1993 totaled \$23,276 million, consisting of \$23,268 million in the form of obligations of the U.S. Government and an undisbursed balance of almost \$8 million. A comparison of assets of the trust fund with liabilities for incurred but unpaid benefits (and related administrative expenses) is shown in the section I.D “Actuarial Status of the Trust Fund.”

TABLE II.C3.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND AT THE END OF FISCAL YEARS 1992 AND 1993¹

	September 30, 1992	September 30, 1993
Investments in public-debt obligations sold only to this fund (special issues):		
Certificates of Indebtedness:	\$0.00	\$1,318,676,000.00
Bonds:		
6 1/4-percent, 1994-2008	0.00	4,516,692,000.00
7 3/8-percent, 1994-2007	3,171,661,000.00	2,184,637,000.00
8 1/8-percent, 1995-2006	3,719,999,000.00	3,719,999,000.00
8 3/8-percent, 2001	444,270,000.00	444,270,000.00
8 3/4-percent, 1994-2005	6,460,697,000.00	6,346,364,000.00
9 3/4-percent, 1995	115,003,000.00	115,003,000.00
10 3/8-percent, 1994-2000	1,661,292,000.00	1,661,292,000.00
10 3/4-percent, 1994-98	809,231,000.00	809,231,000.00
13 1/4-percent, 1994-97	1,033,983,000.00	1,033,983,000.00
13 1/4-percent, 1994-99	1,117,677,000.00	1,117,677,000.00
Total investments in public-debt obligations	18,533,813,000.00	23,267,824,000.00
Undisbursed balance	1,652,046.00	7,753,475.79
Total assets	18,535,465,046.00	23,275,577,475.79

¹The assets are carried at par value, which is the same as book value.

The net increase in the par value of the investments held by the fund during FY 1993 amounted to \$4,734 million. New securities at a total par value of \$394,990 million were acquired during the fiscal year

Summary of FY 1993 Operations

through the investment of revenue and reinvestment of funds made available from the redemption of securities. The par value of securities redeemed during the year was \$390,256 million. Included in these amounts is \$389,729 million in certificates of indebtedness that were acquired, and \$388,410 million in certificates of indebtedness that were redeemed, within the fiscal year.

The effective annual rate of interest earned by the assets of the SMI trust fund for the 12 months ending on June 30, 1993 was 8.76 percent. This period is used because interest on special issues is paid semiannually on June 30 and December 31. The interest rate on special issues purchased by the trust fund in June 1993 was 6 1/4 percent, payable semiannually.

***D. ACTUARIAL METHODOLOGY AND PRINCIPAL
ASSUMPTIONS FOR COST ESTIMATES FOR THE
SUPPLEMENTARY MEDICAL INSURANCE PROGRAM***

**1. Estimates under the Intermediate Assumptions for Aged
and Disabled (Excluding End-Stage Renal Disease)
Enrollees**

a. Introduction

Estimates under the intermediate assumptions for aged and disabled enrollees excluding disabled persons with ESRD—are prepared by calculating allowed charges incurred per enrollee in a recent year (the 12-month period ending June 30, 1992, for this report) and projecting these charges through the estimating period. The per enrollee charges are then converted to reimbursement amounts by subtracting the per enrollee values of the deductible and coinsurance. Aggregate reimbursement amounts are calculated by multiplying the per enrollee reimbursement amounts by the projected enrollment. In order to estimate cash disbursements, an allowance is made for the delay between receipt of service and payment therefor.

Disabled persons with ESRD have per enrollee costs which are higher and quite different in nature from those of most other disabled persons. Hence, program costs for them have been excluded from the analysis in this section and are included in a later section.

b. Establishing a Projection Base

(1) Physician Services

Reimbursement amounts for physician services (and smaller amounts for other services such as laboratory tests, DME and supplies) are paid through organizations acting for HCFA, referred to as “carriers.” The carriers determine whether billed services are covered under the program and determine the allowed charges for the services. A record of the amount reimbursed after reduction for coinsurance and the deductible is transmitted to the central office.

These records for 0.1 percent of aged beneficiaries and 5.0 percent of disabled beneficiaries are tabulated by date of service, thus providing a data base which is constructed on an incurred basis. Certain minor adjustments are made to the tabulated sample data to correct for biases and random fluctuations inherent in the sampling process. Having the data on an incurred basis is necessary to meet the statutory requirement that the program be financed on this basis.

As a check on the validity of the projection base, incurred reimbursement amounts are compared with cash expenditures reported by the carriers through an independent reporting system. In a program with continuously increasing incurred reimbursement amounts, cash payments are expected to be slightly lower than incurred expenses (except in the first year of coverage of a service or group of beneficiaries, when the difference should be substantial). These differences between cash and incurred reimbursement amounts occur because of the lag between receipt of services and payment therefor.

(2) Institutional and Other Services

Reimbursement amounts for institutional services under the SMI program are paid by the same fiscal intermediaries that pay for HI services. The principal institutional services covered under the SMI program are outpatient hospital care services.

Reimbursements for institutional services occur in two stages. Provider bills are submitted to the intermediaries, and interim payments are made on the basis of these bills. The bills are then submitted to the central office, and tabulations for a sample of beneficiaries are prepared in a manner parallel to those records sent in by carriers.

At the close of a provider's accounting period, a cost report is submitted, and lump-sum payments or recoveries are made to correct for the difference between interim payments and final settlement amounts for providing covered services (net of coinsurance and deductible amounts). The difference is reported on a cash basis, and approximations are necessary to adjust to the time of service.

Group practice prepayment plans, which are not reimbursed through carriers, are reimbursed directly by HCFA on a reasonable cost or on a capitation basis. Comprehensive data on such direct reimbursements are available on a cash basis. Certain approximations must be made to allocate expenses to the period when services were rendered.

(3) Summary of Historical Data

Table II.D1 summarizes the incurred reimbursement amounts per enrollee for the various services for each of the 12-month periods ending June 30, through 1992. Also shown are average enrollment figures for these years. In order to analyze the historical trends in prices and use of services, these reimbursement amounts are converted to the allowed charges or reasonable costs on which reimbursement was based. This process is necessary largely because the fixed deductible becomes a smaller percentage of charges each year and thus causes reimbursement to rise faster than charges or costs. Table II.D2 shows the incurred charges or costs per enrollee corresponding to the reimbursement values shown in Table II.D1.

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**TABLE II.D1.—INCURRED REIMBURSEMENT AMOUNTS PER ENROLLEE:
HISTORICAL DATA**

Year ending June 30,	Average enrollment (millions)	All services	Physician	Out-patient hospital	Home health Agency ¹	GPPP ²	Independent lab
Aged:							
1967	17.750	\$62.51	\$59.12	\$1.41	\$0.79	\$0.89	\$0.30
1968	18.038	80.06	74.47	2.40	1.49	1.35	0.35
1969	18.833	93.74	85.67	4.21	1.92	1.54	0.40
1970	19.312	99.91	90.03	5.91	1.99	1.50	0.48
1971	19.664	106.25	95.05	7.53	1.67	1.40	0.60
1972	20.043	114.22	101.63	8.55	1.60	1.66	0.78
1973	20.428	122.39	107.96	9.43	2.17	1.87	0.94
1974	20.988	135.44	117.48	12.38	2.03	2.35	1.20
1975	21.504	161.29	136.28	16.47	3.83	3.07	1.64
1976	22.089	189.65	156.27	22.29	5.20	3.86	2.03
1977	22.605	222.36	179.30	29.65	6.53	4.41	2.47
1978	23.133	255.19	207.05	34.39	6.81	4.02	2.92
1979	23.693	290.16	233.99	41.15	6.84	4.87	3.31
1980	24.287	343.51	277.23	47.59	7.58	7.05	4.06
1981	24.827	407.74	328.14	57.04	8.04	9.13	5.39
1982	25.363	465.27	381.02	66.34	0.52	10.92	6.47
1963	25.873	558.57	456.25	80.69	0.77	13.52	7.34
1984	26.433	636.23	512.94	96.14	0.99	16.85	9.31
1985	26.914	686.36	538.90	111.76	1.05	19.52	15.13
1966	27.453	782.15	594.10	133.93	1.19	31.70	21.23
1967	28.013	905.31	671.19	164.69	0.98	42.88	25.57
1968	28.497	1,021.61	741.17	187.10	1.54	61.74	30.06
1989	28.936	1,115.37	797.91	207.60	1.53	73.37	34.96
1990	29.380	1,209.49	862.97	214.60	2.91	86.97	42.04
1991	29.865	1,336.46	933.28	247.62	2.45	103.64	49.47
1992	30.383	1,397.24	952.06	270.88	2.10	118.74	53.46
Disabled (excluding ESRD):							
1974	1.638	118.34	97.59	15.55	3.45	1.09	0.66
1975	1.817	150.98	125.63	18.84	3.58	1.87	1.06
1976	2.019	180.29	148.31	23.19	5.12	2.20	1.47
1977	2.231	222.31	174.82	38.28	4.79	2.42	2.00
1978	2.423	258.28	202.91	44.75	5.54	2.48	2.60
1979	2.563	303.50	240.64	51.67	5.95	2.06	3.18
1980	2.646	363.87	288.09	61.58	6.07	4.30	3.83
1981	2.692	435.05	340.15	77.77	7.21	5.23	4.69
1982	2.690	514.04	394.87	107.04	0.00	6.26	5.87
1983	2.633	625.92	485.07	126.02	0.00	7.53	7.30
1984	2.599	672.89	529.01	126.59	0.00	8.32	8.97
1985	2.598	706.15	552.84	130.39	0.00	9.25	13.67
1986	2.634	774.19	593.50	148.87	0.00	12.78	19.04
1987	2.682	859.66	657.01	164.12	0.00	16.30	22.23
1988	2.729	927.12	684.93	195.78	0.00	22.02	24.39
1989	2.763	979.19	724.42	201.83	0.00	25.79	27.15
1990	2.805	1,046.13	767.40	220.10	0.00	26.77	31.88
1991	2.869	1,154.54	835.15	251.24	0.00	30.85	37.30
1992	3.015	1,190.74	827.99	287.17	0.00	33.80	41.78

¹Since July 1, 1981, home health agency services have been almost exclusively provided by the Medicare HI program. However, for those SMI enrollees not entitled to HI the coverage of these services is provided by the SMI program. Since all SMI disabled enrollees are entitled to HI, their coverage of these services is provided by the HI program.

²Group practice prepayment plan

TABLE II.D2.—INCURRED CHARGES OR COSTS PER ENROLLEE: HISTORICAL DATA

Year ending June 30,	Average enrollment (millions)	All services	Physician	Out-patient hospital	Home health Agency ¹	GPPP ²	Independent lab
Aged:							
1967	17.750	\$108.58	\$102.70	\$2.45	\$1.37	\$1.54	\$0.52
1968	18.038	128.08	119.02	3.89	2.42	2.18	0.57
1969	18.833	145.18	132.22	6.77	3.08	2.47	0.64
1970	19.312	153.63	137.86	9.43	3.17	2.40	0.77
1971	19.664	162.10	144.41	11.89	2.64	2.21	0.95
1972	20.043	172.75	153.15	13.32	2.49	2.58	1.21
1973	20.428	186.21	163.99	14.79	3.02	2.94	1.47
1974	20.988	205.52	178.04	19.38	2.54	3.68	1.88
1975	21.504	237.88	201.04	25.03	4.66	4.66	2.49
1976	22.089	273.30	225.26	33.12	6.18	5.73	3.01
1977	22.605	314.45	253.67	43.16	7.60	6.42	3.60
1978	23.133	355.53	288.50	49.28	7.81	5.76	4.18
1979	23.693	399.57	322.11	58.18	7.74	6.88	4.68
1980	24.287	466.37	376.29	66.20	8.43	9.80	5.65
1981	24.827	545.68	438.82	78.15	8.81	12.51	7.39
1982	25.363	628.91	513.49	91.03	0.52	14.99	8.88
1963	25.873	753.70	615.07	109.55	0.77	18.35	9.96
1984	26.433	852.65	687.12	129.34	0.99	22.67	12.53
1985	26.914	911.81	718.53	150.23	1.05	26.24	15.76
1966	27.453	1,031.83	787.36	178.85	1.19	42.33	22.10
1967	28.013	1,185.89	883.26	218.24	0.98	56.82	26.59
1968	28.497	1,340.44	977.05	248.42	1.55	81.98	31.44
1989	28.936	1,445.67	1,039.01	272.40	1.53	96.27	36.46
1990	29.380	1,580.41	1,134.57	284.43	2.95	114.26	44.20
1991	29.865	1,744.04	1,225.63	328.06	2.47	136.36	51.32
1992	30.383	1,810.66	1,240.95	356.45	2.10	156.25	55.11
Disabled (excluding ESRD):							
1974	1.638	173.15	142.91	23.44	4.16	1.65	0.99
1975	1.817	214.01	178.14	27.44	4.17	2.72	1.54
1976	2.019	252.06	207.53	33.36	5.89	3.17	2.11
1977	2.231	305.80	240.20	53.97	5.40	3.41	2.82
1978	2.423	352.08	276.27	62.53	6.19	3.46	3.63
1979	2.563	408.90	323.85	71.27	6.56	2.84	4.38
1980	2.646	484.89	363.36	83.85	6.61	5.86	5.21
1981	2.692	573.38	447.56	104.70	7.16	7.04	6.32
1982	2.690	683.25	522.78	144.13	0.00	8.43	7.91
1983	2.633	831.28	643.25	168.23	0.00	10.05	9.75
1984	2.599	892.49	701.05	168.44	0.00	11.07	11.93
1985	2.598	931.81	731.37	173.87	0.00	12.34	14.23
1986	2.634	1,016.43	782.04	197.63	0.00	16.96	19.80
1987	2.682	1,122.57	861.32	216.64	0.00	21.51	23.10
1988	2.729	1,215.96	901.68	259.58	0.00	29.19	25.51
1989	2.763	1,272.41	944.90	265.29	0.00	33.90	28.32
1990	2.805	1,372.20	1,011.06	292.36	0.00	35.25	33.51
1991	2.869	1,513.22	1,099.99	333.81	0.00	40.71	38.71
1992	3.015	1,552.17	1,084.56	379.81	0.00	44.71	43.09

¹Since July 1, 1981, home health agency services have been almost exclusively provided by the Medicare HI program. However, for those SMI enrollees not entitled to HI the coverage of these services is provided by the SMI program. Since all SMI disabled enrollees are entitled to HI, their coverage of these services is provided by the HI program.

²Group practice prepayment plan

c. Per Enrollee Increases

(1) Physician Services

Per enrollee charges for physician services are affected by a variety of factors. One factor, increase in average charge per service, can be

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identified explicitly. Others can be recognized only by the fact that the increase in the average charge per service does not explain all of the increase in per enrollee charges year-to-year.

The increase in the average charge per service is one of the most important factors creating the increase in charges per enrollee. The physician fee component of the Consumer Price Index (CPI) provides an approximation of the historical increases in submitted charge per service. Increases in this index are shown in the first column of Table II.D3.

TABLE II.D3.—COMPONENTS OF INCREASES IN TOTAL ALLOWED CHARGES PER ENROLLEE FOR PHYSICIAN SERVICES: HISTORICAL DATA

(in percent)

Year ending June 30,	Increase due to price changes		Residual factors ¹	Total increase in allowed charges per enrollee
	Increase in physician fee component of CPI	Net increase in allowed fees		
Aged:				
1967	7.6	—	—	—
1968	5.9	4.8	10.6	15.9
1969	6.2	4.7	6.2	11.2
1970	6.7	3.9	0.4	4.3
1971	7.5	4.5	0.3	4.8
1972	5.2	3.9	2.0	6.0
1973	2.6	2.0	5.0	7.1
1974	5.0	3.2	5.2	8.6
1975	12.8	8.9	3.7	12.9
1976	11.4	8.2	3.6	12.1
1977	10.2	9.0	3.3	12.6
1978	8.9	9.0	4.3	13.7
1979	8.6	7.8	3.6	11.7
1980	11.5	8.6	7.6	16.8
1981	11.1	7.7	8.3	16.6
1982	9.9	10.8	5.6	17.0
1983	8.2	8.9	10.0	19.8
1984	7.5	7.2	4.2	11.7
1985	6.0	0.8	3.7	4.5
1986	6.7	0.3	9.3	9.6
1987	7.5	5.4	6.4	12.1
1988	7.2	3.1	7.3	10.6
1989	7.4	1.4	4.9	6.4
1990	7.1	1.0	8.1	9.2
1991	6.9	-1.5	9.7	8.1
1992	5.9	-0.3	1.5	1.2
Disabled (excluding ESRD):				
1974	5.0	—	—	—
1975	12.8	8.9	14.5	24.7
1976	11.4	8.2	7.7	16.5
1977	10.2	9.0	6.2	15.7
1978	8.9	9.0	5.5	15.0
1979	8.6	7.8	8.7	17.2
1980	11.5	8.6	9.0	18.3
1981	11.1	7.7	8.4	16.7
1982	9.9	10.8	5.4	16.8
1983	8.2	8.9	13.0	23.1
1984	7.5	7.2	1.6	8.9
1985	6.0	0.8	3.5	4.3
1986	6.7	0.3	6.6	6.9
1987	7.5	5.4	4.5	10.1
1988	7.2	3.1	1.5	4.6
1989	7.4	1.4	3.4	4.8
1990	7.1	1.0	5.9	7.0
1991	6.9	-1.5	10.5	8.8
1992	5.9	-0.3	-1.1	-1.4

¹The physician conversion factor includes a baseline adjustment for the volume and intensity of services (or residual factors). Due to the transition rules, these adjustments affect price changes in calendar years 1992 through 1996. These adjustments are included in the Medicare Volume Performance Standards (MVPS). The adjustments for the years ending June 30 in the above tables are: -1.3% in 1992, -1.6% in 1993, -0.7% in 1994, -0.7% in 1995, -0.7% in 1996, and -0.4% in 1997.

Bills submitted to the carriers during a specified period, the fee-screen year, are subject by statute to certain limitations on the level of fees to be allowed by the program for reimbursement purposes. The fee-screen-year period has changed over the history of the program. For 1984 and

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earlier, the fee-screen year was the 12-month period ending June 30. Beginning with 1987, the fee- screen year is on the calendar-year basis. Fee-screen years 1985 and 1986 were each 15-month periods allowing for the transition of the fee-screen years from the 12-month periods ending June 30 to the 12-month periods ending December 31. The fee level allowed for a particular service by a physician is subject to reduction if it exceeds the median charge that the physician assessed for the same service in the base period, the 12-month period ending 6 months prior to the beginning of the fee-screen year. This median charge is called the “customary charge.” Fees are subject to further reduction if they exceed the prevailing charges for the locality. The prevailing charge is defined as the 75th percentile of customary charges for a particular service in a particular locality. Since July 1, 1975, the rate of increase in prevailing charges has been limited further by the application of the Medicare Economic Index. The customary and prevailing charge limits maintained by the carriers are called “fee screens.” Allowed charges are charges after they have been reduced by the fee screens and are the charges on which reimbursement is based.

Public Law 101-239 provides for the replacement of customary and prevailing charges with fee schedules for physician services starting in CY 1992. The fee schedules will be based on a resource-based relative value scale. The fee schedule amount will be equal to the product of the procedure’s relative value, a conversion factor and a geographic adjustment factor. Payments will be based on the lower of the actual charge and the fee schedule amount. For the 4-year period from 1992 to 1995, the fee schedule amounts will be adjusted to reflect the prevailing charges in each fee screen area.

Certain services included with the physician services are not subject to the same fee-screen reduction process as described above. Beginning July 1, 1984 a unique fee schedule was established for laboratory tests performed in physician offices and independent laboratories. Since that time other unique fee schedules or reimbursement mechanisms have been established for other services. The list of the services includes anesthesiology, certified registered nurse anesthetists, and DME.

Since legislation has twice changed the time span of the fee-screen year, and since the two transitional fee-screen years (1985 and 1986) cover 15-month periods, data presented in Tables II.D1 through II.D9 will be displayed for the same 12-month basis for all years. This basis will be the 12-month periods ending June 30.

The average reduction in submitted fees has increased almost every year. The result is that the net increase in allowed fees due to price changes (i.e., the increase in fee levels allowed for reimbursement purposes) has been less than the increase in submitted fees for most

years. The second column of Table II.D3 shows this increase in allowed fees due to price changes.

Per capita charges also have increased each year as a result of a number of possible factors including more physician visits per enrollee, the aging of the Medicare enrollment, greater use of specialists and more expensive techniques, and certain administrative actions. The third column of Table II.D3 shows the increases in charges per enrollee resulting from these residual causes. Because the measurement of increased allowed charges per service is subject to error, this error is included implicitly under residual causes.

The last column of Table II.D3 shows the total increases in charges per enrollee for physician services. It includes the effects of all the items discussed above.

Projected increases in total allowed charges per enrollee are shown in Table II.D4. It compares with the corresponding historical data shown in Table II.D3. Column 1 of Table II.D4 shows the projected increases in the physician fee component of the CPI in each of the years ending June 30, 1993 through June 30, 2004. It represents an estimate of projected increases in the charges for all physician services (not only Medicare services). Column 2 shows the projected net increases in allowed charges, and column 3 shows the increases due to residual causes.

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TABLE II.D4.—COMPONENTS OF INCREASES IN TOTAL ALLOWED CHARGES PER ENROLLEE FOR PHYSICIAN SERVICES: ESTIMATES

(in percent)

Year ending June 30,	Increase due to price changes		Residual factors ¹	Total increase in allowed charges per enrollee
	Increase in physician fee component of CPI	Net increase in allowed fees		
Aged:				
1993	6.1	0.5	-1.0	-0.5
1994	4.9	2.6	4.3	7.0
1995	5.1	5.0	3.8	9.0
1996	5.5	2.1	4.9	7.1
1997	5.8	-0.6	7.7	7.1
1998	4.7	-0.2	7.1	6.9
1999	5.7	-0.7	7.1	6.4
2000	5.4	-0.6	7.3	6.7
2001	5.4	-0.7	7.6	6.8
2002	5.4	-0.7	7.6	6.8
2003	5.5	-0.7	7.6	6.8
2004	5.5	-0.8	7.6	6.7
Disabled (excluding ESRD):				
1993	6.1	0.5	0.9	1.4
1994	4.9	2.6	-4.7	-2.2
1995	5.1	5.0	2.4	7.5
1996	5.5	2.1	8.1	10.4
1997	5.8	-0.6	7.3	6.7
1998	4.7	-0.2	4.6	4.4
1999	5.7	-0.7	3.3	2.6
2000	5.4	-0.6	4.7	4.1
2001	5.4	-0.7	8.4	7.6
2002	5.4	-0.7	8.4	7.6
2003	5.5	-0.7	8.4	7.6
2004	5.5	-0.8	8.4	7.5

¹The physician conversion factor includes a baseline adjustment for the volume and intensity of services (or residual factors). Due to the transition rules, these adjustments affect price changes in calendar years 1992 through 1996. These adjustments are included in the MVPS. The adjustments for the years ending June 30 in the above tables are: -1.3% in 1992, -1.6% in 1993, -0.7% in 1994, -0.7% in 1995, -0.7% in 1996, and -0.4% in 1997.

(2) Institutional and Other Services

The historical increases in charges and costs per enrollee for institutional and other services are shown in Table II.D5, and the projected increases are shown in Table II.D6. The year-to-year changes in some services have been quite erratic. At best, these series provide only a rough indication of future trends in costs.

TABLE II.D5.—INCREASES IN RECOGNIZED CHARGES AND COSTS PER ENROLLEE FOR INSTITUTIONAL AND OTHER SERVICES: HISTORICAL DATA

(in percent)

Year ending June 30,	Outpatient hospital	Home health agency ¹	Group practice Prepayment plan	Independent lab
Aged:				
1968	58.8	76.6	41.6	9.6
1969	74.0	27.3	13.3	12.3
1970	39.3	2.9	-2.8	20.3
1971	26.1	-16.7	-7.9	23.4
1972	12.0	-5.7	16.7	27.4
1973	11.0	21.3	14.0	21.5
1974	31.0	-15.9	25.2	27.9
1975	29.2	83.5	26.6	32.4
1976	32.3	32.6	23.0	20.9
1977	30.3	23.0	12.0	19.6
1978	14.2	2.8	-10.3	16.1
1979	18.0	-0.9	19.4	12.0
1980	13.8	8.9	42.4	20.7
1981	18.1	4.5	27.7	30.8
1982	16.5	-94.1	19.8	20.2
1983	20.3	48.1	22.4	12.2
1984	18.1	28.6	23.5	25.8
1985	16.2	6.1	15.7	25.8
1986	19.1	13.3	61.3	40.2
1987	22.0	-17.6	34.2	20.3
1988	13.8	58.2	44.3	18.2
1989	9.7	-1.3	17.4	16.0
1990	4.4	92.8	18.7	21.2
1991	15.3	-16.3	19.3	16.1
1992	8.7	-15.0	14.6	7.4
Disabled (excluding ESRD):				
1975	17.1	0.2	64.8	55.6
1976	21.6	41.2	16.5	37.0
1977	61.8	-8.3	7.6	33.6
1978	15.9	14.6	1.5	28.7
1979	14.0	6.0	-17.9	20.7
1980	17.7	0.8	106.3	18.9
1981	24.9	17.4	20.1	21.3
1982	37.7	-100.0	19.7	25.2
1983	16.7	0.0	19.2	23.3
1984	0.1	0.0	10.1	22.4
1985	3.2	0.0	11.5	19.3
1986	13.7	0.0	37.4	39.1
1987	9.6	0.0	26.8	16.7
1988	19.8	0.0	35.7	10.4
1989	2.2	0.0	16.1	11.0
1990	10.2	0.0	4.0	18.3
1991	14.2	0.0	15.5	15.5
1992	13.8	0.0	9.8	11.3

¹Since July 1, 1981, home health agency services have been almost exclusively provided by the Medicare HI program. However, for those SMI enrollees not entitled to HI the coverage of these services is provided by the SMI program. Since all SMI disabled enrollees are entitled to HI, their coverage of these services is provided by the HI program.

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TABLE II.D6.—INCREASES IN RECOGNIZED CHARGES AND COSTS PER ENROLLEE FOR INSTITUTIONAL AND OTHER SERVICES: ESTIMATES

(in percent)

Year ending June 30,	Outpatient hospital	Home health agency ¹	Group practice Prepayment plan	Independent lab
Aged:				
1993	12.0	55.5	16.7	8.6
1994	11.2	14.4	23.3	15.0
1995	11.7	14.9	18.4	14.6
1996	11.8	14.3	18.4	15.6
1997	12.1	15.0	18.4	17.3
1998	12.0	14.7	18.3	18.1
1999	15.6	14.7	18.3	18.1
2000	13.2	14.7	18.3	18.3
2001	12.1	14.4	18.3	19.2
2002	12.1	14.4	18.3	19.5
2003	12.1	14.4	18.3	19.6
2004	12.1	14.4	18.3	19.6
Disabled (excluding ESRD):				
1993	17.7	0.0	10.7	11.3
1994	6.8	0.0	1.0	18.0
1995	12.5	0.0	14.3	12.0
1996	16.4	0.0	25.8	11.6
1997	13.9	0.0	16.4	15.4
1998	12.1	0.0	13.3	17.1
1999	15.7	0.0	13.1	15.6
2000	13.5	0.0	13.0	17.7
2001	15.1	0.0	12.8	21.3
2002	15.1	0.0	12.8	21.5
2003	15.1	0.0	12.8	21.6
2004	15.1	0.0	12.8	21.6

¹Since July 1, 1981, home health agency services have been almost exclusively provided by the Medicare HI program. However, for those SMI enrollees not entitled to HI the coverage of these services is provided by the SMI program. Since all SMI disabled enrollees are entitled to HI, their coverage of these services is provided by the HI program.

d. Projected Charges and Costs

Table II.D7 shows projections of per enrollee incurred charges and costs based on the assumptions in Tables II.D4 and II.D6. Table II.D8 shows the total reimbursement amounts per enrollee that result from subtracting the average amounts of copayment per enrollee from the total covered charges in Table II.D7. The aggregate reimbursement amounts shown are derived by multiplying average enrollment by average reimbursement per enrollee.

TABLE II.D7.—INCURRED CHARGES OR COSTS PER ENROLLEE: ESTIMATES

Year ending June 30,	All services	Physician	outpatient hospital	Home health agency ¹	Group practice prepayment plan	Independent lab
Aged:						
1993	\$1,878.97	\$1,234.21	\$399.37	\$3.27	\$182.29	\$59.83
1994	2,061.64	1,320.14	444.14	3.74	224.81	68.81
1995	2,284.12	1,438.78	495.91	4.30	266.26	78.87
1996	2,506.44	1,540.74	554.51	4.91	315.13	91.15
1997	2,757.04	1,649.76	621.59	5.65	373.09	106.95
1998	3,033.57	1,763.26	696.10	6.48	441.43	126.30
1999	3,358.81	1,875.56	804.52	7.43	522.10	149.20
2000	3,714.13	2,000.87	910.60	8.52	617.61	176.53
2001	4,109.86	2,138.72	1,020.35	9.75	730.58	210.46
2002	4,556.15	2,286.07	1,143.32	11.15	864.21	251.40
2003	5,060.30	2,443.57	1,281.11	12.75	1,022.28	300.59
2004	5,628.04	2,609.29	1,435.51	14.58	1,209.26	359.40
Disabled (excluding ESRD):						
1993	1,644.79	1,100.30	447.04	0.00	49.49	47.96
1994	1,660.36	1,076.27	477.50	0.00	50.00	56.59
1995	1,814.53	1,157.01	537.02	0.00	57.13	63.37
1996	2,044.61	1,276.92	625.09	0.00	71.89	70.71
1997	2,239.69	1,362.27	712.15	0.00	83.64	81.63
1998	2,410.70	1,421.79	798.58	0.00	94.73	95.60
1999	2,599.62	1,457.99	924.05	0.00	107.11	110.47
2000	2,816.33	1,516.94	1,048.37	0.00	121.03	129.99
2001	3,133.50	1,632.57	1,206.76	0.00	136.55	157.62
2002	3,491.64	1,757.01	1,389.08	0.00	154.06	191.49
2003	3,896.56	1,890.94	1,598.94	0.00	173.82	232.86
2004	4,352.81	2,033.02	1,840.51	0.00	196.11	283.17

¹Since July 1, 1981, home health agency services have been almost exclusively provided by the Medicare HI program. However, for those SMI enrollees not entitled to HI the coverage of these services is provided by the SMI program. Since all SMI disabled enrollees are entitled to HI, their coverage of these services is provided by the HI program.

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TABLE II.D8.—INCURRED REIMBURSEMENT AMOUNTS: ESTIMATES

		Reimbursement amounts	
Year ending June 30,	Average enrollment (millions)	Per enrollee	Aggregate (millions)
Aged:			
1993	30.887	1,453.49	44,894
1994	31.354	1,601.04	50,199
1995	31.785	1,780.97	56,608
1996	32.096	1,961.02	62,941
1997	32.347	2,164.62	70,019
1998	32.559	2,389.57	77,802
1999	32.768	2,654.14	86,971
2000	32.972	2,943.74	97,061
2001	33.177	3,266.93	108,387
2002	33.361	3,632.15	121,172
2003	33.592	4,045.19	135,886
2004	33.859	4,511.21	152,745
Disabled (excluding ESRD):			
1993	3.200	1,264.69	4,047
1994	3.419	1,277.86	4,369
1995	3.666	1,402.35	5,141
1996	3.921	1,587.35	6,224
1997	4.166	1,745.56	7,272
1998	4.407	1,884.50	8,305
1999	4.641	2,037.92	9,458
2000	4.866	2,214.34	10,775
2001	5.085	2,473.16	12,576
2002	5.298	2,766.33	14,656
2003	5.485	3,097.90	16,992
2004	5.671	3,472.40	19,692

2. Estimates under the Intermediate Assumptions for Persons Suffering From End-Stage Renal Disease

Certain persons suffering from ESRD have been eligible to enroll for SMI coverage since July 1973 (under Section 2991 of Public Law 92-603). For analytical purposes, those enrollees suffering from ESRD who are also eligible as disability insurance beneficiaries are included in this section because their per enrollee costs are both higher and different in nature from those of most other disabled persons.

The estimates under the intermediate assumptions reflect the unique payment mechanism through which ESRD services are reimbursed under Medicare. Also, the estimates assume a continued increase in enrollment. The historical and projected enrollment and costs for SMI benefits are shown in Table II.D9.

TABLE II.D9.—ENROLLMENT AND INCURRED REIMBURSEMENT FOR END-STAGE RENAL DISEASE

Year ending June 30,	Average enrollment (thousands)		Reimbursement (millions)	
	Disabled ESRD	ESRD only	Disabled ESRD	ESRD only
1974	4	8	\$46	\$91
1975	7	11	84	131
1976	11	13	137	163
1977	14	15	145	194
1978	16	16	163	231
1979	18	20	206	283
1980	18	22	235	299
1981	20	24	275	336
1982	22	27	317	387
1983	24	30	358	447
1984	27	32	388	476
1985	29	35	430	522
1986	32	38	455	562
1987	34	42	480	592
1988	36	45	546	673
1989	38	50	601	787
1990	40	55	640	908
1991	42	61	726	1087
1992	45	66	843	1243
1993	47	70	942	1356
1994	50	74	1010	1415
1995	54	79	1112	1522
1996	57	83	1265	1686
1997	61	88	1436	1866
1998	65	92	1608	2041
1999	69	97	1793	2227
2000	74	102	2001	2435
2001	78	107	2254	2694
2002	82	112	2559	3006
2003	86	116	2892	3354
2004	89	121	3271	3744

3. Summary of Aggregate Reimbursement Amounts on a Cash Basis Under the Intermediate Assumptions

Table II.D10 shows aggregate historical and projected reimbursement amounts on a cash basis under the intermediate assumptions, by type of beneficiary. The difference between reimbursement amounts on a cash basis and incurred reimbursement amounts results from the lag between the time of service and the time of payment.

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TABLE II.D10.—AGGREGATE REIMBURSEMENT AMOUNTS ON A CASH BASIS

(In millions)

Fiscal Year ¹	Aged	Disabled (excluding ESRD)	Disabled ESRD and ESRD only	Total
Historical Data:				
1967	\$664	—	—	\$664
1968	1,390	—	—	1,390
1969	1,645	—	—	1,645
1970	1,979	—	—	1,979
1971	2,035	—	—	2,035
1972	2,255	—	—	2,255
1973	2,391	—	—	2,391
1974	2,541	\$191	\$142	2,874
1975	3,289	259	217	3,765
1976	4,042	343	287	4,672
T.Q.	1,079	109	82	1,270
1977	5,013	494	360	5,867
1978	5,795	621	436	6,852
1979	6,940	787	532	8,259
1980	8,497	1,026	621	10,144
1981	10,370	1,281	694	12,345
1982	12,418	1,605	783	14,806
1983	14,783	1,817	887	17,487
1984	16,804	1,771	898	19,473
1985	19,077	1,793	938	21,808
1986	22,067	2,091	1,011	25,169
1987	26,350	2,456	1,131	29,937
1988	29,796	2,610	1,276	33,682
1989	32,748	2,679	1,440	36,867
1990	36,837	3,063	1,598	41,498
1991	40,198	3,485	1,831	45,514
1992	42,784	3,781	2,062	48,627
1993	45,664	4,386	2,359	52,409
Estimates:				
1994	51,316	4,524	2,352	58,192
1995	57,719	5,345	2,580	65,644
1996	64,235	6,402	2,897	73,534
1997	71,451	7,452	3,229	82,132
1998	79,528	8,520	3,564	91,612
1999	88,869	9,710	3,932	102,511
2000	99,214	11,129	4,346	114,689
2001	110,808	12,966	4,866	128,640
2002	123,978	15,092	5,474	144,544
2003	139,120	17,503	6,143	162,766

¹For 1967 through 1976, fiscal years cover the interval from July 1 through June 30; the 3-month interval from July 1, 1976, through September 30, 1976, is labeled "T.Q." the transition quarter; fiscal years 1977-2003 cover the interval from October 1 through September 30.

4. Administrative Expenses

The ratio of administrative expenses to benefit payments has been under 5 percent in recent years and is projected to decline in future years. Projections of administrative costs are based on estimates of changes in average annual wages.

5. Cash Disbursements as a Percent of the Gross Domestic Product

Cash disbursements (benefit payments and administrative expenses) for the high cost and low cost alternatives were developed by examining the cash disbursements under the intermediate assumptions as a percentage

of GDP. Beginning in the middle of CY 1994, the rate of growth of cash benefits under the low cost alternative as a percentage of the GDP is assumed to be 2 percent less than the rate of growth of the benefits under the intermediate assumptions as a percentage of the GDP. Similarly, the rate of growth of the cash benefits under the high cost alternative as a percentage of the GDP is assumed to be 2 percent more than the rate of growth of the cash benefits under the intermediate assumptions as a percentage of the GDP. Administrative expenses under the low cost and the high cost alternatives are projected based on their respective wage series growth. Based on the above methodology, cash disbursements as a percentage of the GDP were calculated for all three sets of assumptions and are displayed in Table II.D11.

**TABLE II.D11.—SUPPLEMENTARY MEDICAL INSURANCE CASH DISBURSEMENTS
AS A PERCENT OF THE GROSS DOMESTIC PRODUCT FOR CALENDAR YEARS
1993-2003¹**

Calendar year	Intermediate Assumptions	Alternatives	
		Low Cost	High Cost
1993	0.88	0.88	0.88
1994	0.92	0.90	0.92
1995	0.98	0.94	1.02
1996	1.03	0.98	1.09
1997	1.09	1.01	1.16
1998	1.16	1.05	1.28
1999	1.23	1.09	1.37
2000	1.30	1.13	1.47
2001	1.37	1.18	1.59
2002	1.46	1.22	1.72
2003	1.55	1.27	1.87

¹Disbursements are the sum of benefit payments and administrative expenses.

III. APPENDICES

A. MEDICARE INCURRED DISBURSEMENTS AS A PERCENT OF GROSS DOMESTIC PRODUCT FROM CALENDAR YEAR 1993 TO 2068

Medicare incurred disbursements as a percentage of GDP gives a relative measure of the size of the Medicare program to the general economy. For these purposes, incurred disbursements are the sum of the incurred benefit and administrative expenses. The projection of this relative measure of disbursements affords the public an idea of the relative financial resources that will be necessary to pay for Medicare services.

Table III.A1 shows estimated incurred disbursements for the HI and SMI programs under the intermediate assumptions expressed as a percentage of GDP, for selected years over the period CY 1993-2068. (The percentages for SMI are identical to the values in Table I.C4.) These incurred disbursements assume no change in current law for any specific program legislation or for any comprehensive health care reform. The 75-year projection period fully allows for the presentation of future contingencies that reasonably may be expected to occur, such as the impact of a large increase in enrollees which occurs after the turn of the century. This large increase in enrollees occurs because the relatively large number of persons born during the period between the end of World War II and the early 1960's (known as the "baby boom") will reach retirement age and begin to receive benefits.

Table III.A1.-HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE INCURRED DISBURSEMENTS AS A PERCENT OF GROSS DOMESTIC PRODUCT¹

Calendar year	Disbursements as a percent of GDP		
	HI	SMI	Total
1993	1.52	0.88	2.40
1994	1.60	0.93	2.53
1995	1.66	0.99	2.65
2000	1.95	1.31	3.26
2005	2.24	1.77	4.01
2010	2.48	2.37	4.85
2015	2.84	2.91	5.75
2020	3.22	3.27	6.49
2025	3.64	3.67	7.31
2030	4.04	4.01	8.05
2035	4.33	4.17	8.50
2040	4.47	4.16	8.63
2045	4.55	4.10	8.65
2050	4.59	4.05	8.64
2055	4.66	4.09	8.75
2060	4.77	4.21	8.98
2065	4.90	4.33	9.23
2088	4.98	4.37	9.35

¹Disbursements are the sum of benefit payments and administrative expenses.

For HI, program costs beyond the first 25-year projection period are based on the assumption that costs per unit of service will increase at

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the same rate as average hourly earnings increase. The associated aggregate disbursements are then represented as a percentage of GDP. For SMI, increases in the costs per enrollee during the initial 25-year period are assumed to gradually decline in the last 12 years to the same rate as GDP per capita and then continue at the same rate as GDP per capita in the last 50 years. Given the historical experience of SMI costs per enrollee increasing faster than GDP per capita, the assumption of the increases in costs per enrollee declining to the same rate as GDP per capita may be considered optimistic because changes in the last 50 years of the estimation period reflect only the impact of the changing demographic composition of the population.

Based on these assumptions, incurred Medicare disbursements as a percent of GDP are assumed to increase rapidly from 2.40 percent in CY 1993 to 8.56 percent in CY 2036 and then increase gradually to 9.35 percent in CY 2068. After CY 2036, while Medicare disbursements as a percent of GDP increase more slowly, the HI percentage grows steadily while the SMI percentage decreases slightly to CY 2051 and then increases again to CY 2068.

**B. STATEMENT OF ACTUARIAL ASSUMPTIONS AND BASES
EMPLOYED IN DETERMINING THE MONTHLY ACTUARIAL
RATES AND THE MONTHLY PREMIUM RATE FOR THE
SUPPLEMENTARY MEDICAL INSURANCE PROGRAM
BEGINNING JANUARY 1994 ¹**

**1. Actuarial Status of the Supplementary Medical Insurance
Trust Fund**

Under the law, the starting point for determining the monthly premium is the amount that would be necessary to finance the SMI program on an incurred basis; that is, the amount of income that would be sufficient to pay for services furnished during that year (including associated administrative costs) even though payment for some of these services will not be made until after the close of the year. The portion of income required to cover benefits not paid until after the close of the calendar year is added to the trust fund and used when needed.

The rates are established prospectively and are therefore subject to projection error. Additionally, legislation enacted after the financing has been established, but effective for the period for which the financing has been set, may affect program costs. As a result, the income to the program may not equal incurred costs. Therefore, trust fund assets should be maintained at a level that is adequate to cover a moderate degree of variation between actual and projected costs in addition to the amount of incurred but unpaid expenses. Table III.B1 summarizes the estimated actuarial status of the trust fund as of the end of the financing period for 1992 through 1993.

**TABLE III.B1.—ESTIMATED ACTUARIAL STATUS OF THE SUPPLEMENTARY
MEDICAL INSURANCE TRUST FUND AS OF THE END OF THE FINANCING
PERIODS, JAN. 1, 1992 --DEC. 31, 1993**

(In millions of dollars)

Financing Period Ending	Assets	Liabilities	Assets less liabilities
Dec. 31, 1992	\$24,235	\$6,658	\$17,577
Dec. 31, 1993	\$23,293	\$2,626	\$20,667

Before establishing the actuarial rates for calendar year 1994, the assets of the trust fund as of December 31, 1993 (as displayed in Table Ili.B1) were adjusted to take into account calculations required by the United States District Court for the Southern District of New York in the case of *Cosgrove v. Sullivan*, No.85 Civ. 4472 (GLG) (S.D.N.Y. August 26, 1993). In that case, the court ordered the Secretary, in determining the actuarial rates for calendar year 1994, to assume that the amount of

¹ This statement appeared in the Federal Register on November 8, 1993. Projections shown in this statement differ from the projections shown in the rest of the report because of changes in assumptions since the preparation of this statement.

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assets in the Part B trust fund was approximately \$9 million less than the amount that would otherwise have been assumed for purposes of determining the actuarial rates.

2. Monthly Actuarial Rate for Enrollees Age 65 and Older

The monthly actuarial rate is one-half of the monthly projected cost of benefits and administrative expenses for each enrollee age 65 and older, adjusted to allow for interest earnings on assets in the trust fund and a contingency margin. The contingency margin is an amount appropriate to provide for a moderate degree of variation between actual and projected costs and to amortize unfunded liabilities.

The monthly actuarial rate for enrollees age 65 and older for CY 1994 was determined by projecting per-enrollee cost for the 12-month periods ending June 30, 1994 and June 30, 1995, by type of service. Although the actuarial rates are now applicable for calendar years, projections of per-enrollee costs were determined on a July to June period, consistent with the July annual fee screen update used for benefits prior to the passage of section 2306(b) of Pub. L. 98-369. The values for the 12-month period ending June 30, 1991, were established from program data. Subsequent periods were projected using a combination of program data and data from external sources. The projection factors used are shown in Table III.B2. Those per-enrollee values are then adjusted to apply to a calendar year period. The projected values for financing periods from January 1, 1991, through December 31, 1994, are shown in Table III.B3.

TABLE III.B2.—PROJECTION FACTORS¹
12-MONTH PERIODS ENDING JUNE 30 OF 1991-1995

(In percent)

	Physicians' services		Outpatient hospital services	Home health agency services ⁴	Group practice prepayment plans	Independent lab services
12-month period ending June 30,	Fees ²	Residual ³				
Aged:						
1991	-1.5	7.5	15.5	-16.3	19.6	12.2
1992	-1.6	2.2	8.9	-14.7	14.4	5.7
1993	0.4	4.0	12.6	15.3	18.6	9.0
1994	2.4	5.6	12.2	14.6	18.7	18.4
1995	2.1	5.8	12.3	15.9	18.7	18.2
Disabled:						
1991	-1.5	8.8	16.4	0.0	18.5	11.7
1992	-1.6	-0.1	16.1	0.0	6.8	12.3
1993	0.4	2.2	12.5	0.0	16.5	4.7
1994	2.4	-0.3	12.3	0.0	18.2	18.4
1995	2.1	3.8	12.1	0.0	17.0	12.4

¹All values are per enrollee.

²As recognized for payment under the program.

³Increase in the number of services received per enrollee and greater relative use of more expensive services.

⁴Since July 1, 1981, home health agency services have been almost exclusively provided by the Medicare HI program. However, for those SMI enrollees not entitled to HI, the coverage of these services is provided by the SMI program. Since all SMI disabled enrollees are entitled to HI, their coverage of these services is provided by the HI program.

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TABLE III.B3.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR ENROLLEES AGE 65 AND OVER FINANCING PERIODS ENDING DECEMBER 31, 1991 THROUGH DECEMBER 31, 1994

	Financing Periods			
	CY 1991	CY 1992	CY 1993	CY 1994
Covered services (at level recognized):				
Physicians' reasonable charges	\$50.06	\$51.32	\$54.58	\$59.00
Outpatient hospital and other institutions	14.28	15.83	17.79	19.96
Home health agencies	0.10	0.09	0.11	0.13
Group practice prepayment plans	6.08	7.09	8.42	9.99
Independent lab	2.10	2.26	2.58	3.05
Total services	\$72.62	\$76.59	\$83.48	\$92.13
Cost-sharing:				
Deductible	-3.53	-3.60	-3.61	-3.63
Coinsurance	-13.32	-13.87	-15.16	-16.77
Total benefits	\$55.77	\$59.12	\$64.71	\$71.73
Administrative expenses	1.88	1.92	1.95	2.00
Incurred expenditures	\$57.65	\$61.04	\$66.66	\$73.73
Value of Interest	-1.97	-2.20	-2.40	-1.85
Contingency margin for projection error and to amortize the surplus or deficit	6.92	1.96	6.24	-10.08
Monthly actuarial rate	\$62.60	\$60.80	\$70.50	\$61.80

The projected monthly rate required to pay for one-half of the total of benefits and administrative costs for enrollees age 65 and over for CY 1994 is \$73.73. The monthly actuarial rate of \$61.80 provides an adjustment of -\$1.85 for interest earnings and -\$10.08 for a contingency margin. Based on current estimates, it appears that the assets are more than sufficient to cover the amount of incurred but unpaid expenses and to provide for a moderate degree of projection error. Thus, a negative contingency margin is needed to reduce assets toward a more appropriate level.

An appropriate level for assets depends on numerous factors. The most important of these factors are: (1) the difference from prior years in the actual performance of the program and estimates made at the time financing was established and (2) the expected relationship between incurred and cash expenditures. Ongoing analysis is made of the former as the trends in the differences vary over time.

3. Monthly Actuarial Rate for Disabled Enrollees

Disabled enrollees are those persons enrolled in SMI because of entitlement (before age 65) to disability benefits for more than 24 months or because of entitlement to Medicare under the end-stage renal disease program. Projected monthly costs for disabled enrollees (other than those suffering from end-stage renal disease) are prepared in a fashion exactly parallel to projection for the aged, using appropriate actuarial assumptions (see Table III.B2). Costs for the end-stage renal disease program are projected differently because of the different nature

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of services offered by the program. The combined results for all disabled enrollees are shown in Table III.B4.

TABLE III.B4.—DERIVATION OF MONTHLY ACTUARIAL RATE FOR DISABLED ENROLLEES FINANCING PERIODS ENDING DECEMBER 31, 1991 THROUGH DECEMBER 31, 1994

	Financing Periods			
	CY 1991	CY 1992	CY 1993	CY 1994
Covered services (at level recognized):				
Physicians' reasonable charges	\$55.72	\$56.62	\$57.83	\$59.88
Outpatient hospital and other institutions	34.37	36.89	39.11	41.44
Home health agencies	0.00	0.00	0.00	0.00
Group practice prepayment plans	1.95	2.18	2.56	3.01
Independent lab	2.26	2.43	2.64	2.94
Total services	\$94.30	\$98.12	\$102.14	\$107.27
Cost-sharing:				
Deductible	-3.31	-3.42	-3.43	-3.44
Coinsurance	-17.83	-18.38	-19.13	-20.09
Total benefits	\$73.16	\$76.32	\$79.58	\$83.74
Administrative expenses	2.47	2.48	2.40	2.33
Incurred expenditures	\$75.63	\$78.80	\$81.98	\$86.07
Value of Interest	-3.60	-2.41	-2.27	-1.68
Contingency margin for projection error and to amortize the surplus or deficit	-16.03	4.41	3.19	-8.29
Monthly actuarial rate	\$56.00	\$80.80	\$82.90	\$76.10

The projected monthly rate required to pay for one-half of the total of benefits and administrative costs for disabled enrollees for CY 1994 is \$86.07. The monthly actuarial rate of \$76.10 provides an adjustment of -\$1.68 for interest earnings and a -\$8.29 for a contingency margin. Based on current estimates, it appears that assets are more than sufficient to cover the amount of incurred but unpaid expenses and to provide for a moderate degree of variation between actual and projected costs. Thus, a negative contingency margin is needed to reduce assets to more appropriate levels.

4. Sensitivity Testing

Several factors contribute to uncertainty about future trends in medical care costs. In view of this, it seems appropriate to test the adequacy of the rates announced here using alternative assumptions. The most unpredictable factors that contribute significantly to future costs are outpatient hospital costs, physician residual (as defined in Table III.B2), and increases in physician fees as constrained by the program's physician fee schedule that began implementation January 1, 1992. Two alternative sets of assumptions and the results of those assumptions are shown in Table III.B5. One set represents increases that are lower and is, therefore, more optimistic than the current estimate. The other set represents increases that are higher and is, therefore, more pessimistic than the current version. The values for the alternative assumptions were determined from a study on the average historical variation

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between actual and projected increases in the respective increase factors. All assumptions not shown in Table III.B5 are the same as in Table III.B2.

Table III.B5 indicates that, under the assumptions used in preparing this report, the monthly actuarial rates will result in an excess of assets over liabilities of \$12,319 million by the end of December 1994. This amounts to 17.3 percent of the estimated total incurred expenditures for the following year. Assumptions which are somewhat more pessimistic (and, therefore, test the adequacy of the assets to accommodate projection errors) produce a surplus of -\$1,054 million by the end of December 1994, which amounts to -1.3 percent of the estimated total incurred expenditures for the following year. Under fairly optimistic assumptions, the monthly actuarial rates will result in a surplus of \$24,656 million by the end of December, 1994, which amounts to 39.1 percent of the estimated total incurred expenditures for the following year.

Table III.B5.—ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND UNDER THREE SETS OF ALTERNATIVE ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 1994

	Intermediate projection			Lower range projection			Upper range projection		
	12-Month period ending June 30,			12-Month period ending June 30,			12-Month period ending June 30,		
	1993	1994	1995	1993	1994	1995	1993	1994	1995
Projection factors (in percent):									
Physician fees ¹									
Aged	0.4	2.4	2.1	-0.4	1.0	-0.4	1.2	3.8	4.6
Disabled	0.4	2.4	2.1	-0.4	1.0	-0.4	1.2	3.8	4.6
Utilization of physician services ²									
Aged	4.0	5.6	5.8	2.2	3.1	3.0	5.8	8.2	8.6
Disabled	2.2	-0.3	3.8	-1.9	-4.4	0.1	6.3	3.9	7.5
Outpatient hospital services per enrollee									
Aged	12.6	12.2	12.3	9.2	6.6	5.7	16.0	17.7	18.8
Disabled	12.5	12.3	12.1	7.3	7.0	6.5	17.7	17.6	17.8
	As of December 31,			As of December 31,			As of December 31,		
	1992	1993	1994	1992	1993	1994	1992	1993	1994
Actuarial status (in millions):									
Assets	\$24,235	\$23,293	\$15,218	\$24,235	\$26,661	\$25,074	\$24,235	\$19,696	\$4,416
Liabilities	6,658	2,626	2,899	4,487	331	418	8,873	4,977	5,470
Assets less liabilities	\$17,577	\$20,667	\$12,319	\$19,748	\$26,330	\$24,656	\$15,362	\$14,719	-\$1,054
Ratio of assets less liabilities to expenditures (In percent) ³	31.2	32.7	17.3	37.3	46.1	39.1	25.6	21.0	-1.3

¹As recognized for payment under the program.

²Increase in the number of services received per enrollee and greater relative use of more expensive services.

³Ratio of assets less liabilities at the end of the year to the total incurred expenditures during the following year, expressed as a percent.

5. Premium Rate

Section 4301 of OBRA '90 added section 1839(e)(1)(B)(iv) to the Act, which provides that the monthly premium rate for 1994, for both aged and disabled enrollees, is \$41.10.

C. GLOSSARY

Actuarial rates. One half the expected monthly cost of the SMI program for each aged enrollee (for the aged actuarial rate) and one half of the expected monthly cost for each disabled enrollee (for the disabled actuarial rate) for the duration the rate is in effect.

Actuarial soundness. A measure of the adequacy of the financing as determined by the actuarial status at the end of the periods for which financing was established.

Actuarial status. The difference between the assets and the liabilities. Administrative expenses. Expenses incurred by the Department of HHS and the Department of the Treasury in administering the SMI program and the provisions of the Internal Revenue Code relating to the collection of contributions. Such administrative expenses, which are paid from the SMI trust fund, include expenditures for contractors to determine costs of and make payments to providers as well as salaries and expenses of HCFA.

Advisory Council on Social Security. Under the Social Security Act, an Advisory Council is appointed every 4 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. The next Advisory Council is scheduled to be named in 1994.

Aged enrollee. An individual, age 65 or over, who is enrolled in the SMI program.

Allowed charge. Individual charge determined by a carrier for a covered SMI medical service or supply.

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

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) The low cost alternative with relatively rapid economic growth, low inflation, and favorable (from the standpoint of program financing) demographic conditions.

- (2) The intermediate assumptions represent the Trustees best estimates of likely future economic and demographic conditions.
- (3) The high cost alternative with slow economic growth, more rapid inflation, and financially disadvantageous demographic conditions.

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.

Beneficiary. A person enrolled in the SMI program. See also “Aged enrollee” and “Disabled enrollee.”

Benefit payments. The amounts disbursed for covered services 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 SMI 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 HHS. The other two members are appointed by the President as public representatives: Stanford G. Ross and David M. Walker are currently serving 4-year terms that began on October 2, 1990. The Administrator of 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.

Carrier. A private or public organization, under contract to HCFA, to administer the SMI benefits under Medicare. Also referred to as “contractors,” these organizations determine coverage and benefit amounts payable and make payments to physicians, suppliers, and beneficiaries.

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.

Coinsurance. Portion of the SMI costs paid by the beneficiary after meeting the annual deductible.

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Consumer Price Index (CPI). A measure of the average change in prices over time in a fixed group of goods and services. In this report, all references to the CPI relate to the CPI for Urban Wage Earners and Clerical Workers (CPI-W).

Contingency. Funds included in the trust fund to serve as a cushion in case actual expenditures are higher than those projected at the time financing was established. Since the financing is set prospectively, actual experience may be different than the estimates used in setting the financing.

Contingency margin. An amount included in the actuarial rates to provide for changes in the contingency level in the trust fund. Positive margins increase the contingency level and negative margins decrease it.

Covered services. Services for which SMI pays, as defined and limited by statute. Covered services are provided for most physician services, care in outpatient departments of hospitals, diagnostic tests, DME, ambulance services, and other health services which are not covered by the HI program.

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

Demographic assumptions. See “Assumptions.”

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 5 months before he or she can qualify for a disabled-worker cash benefit. An additional 24 months is necessary to qualify 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 2 years and who is enrolled in the SMI program.

Durable medical equipment (DME). Items such as iron lungs, oxygen tents, hospital beds, wheelchairs, and seat lift mechanisms which are used in the patient’s home and are either purchased or rented.

Economic assumptions. See “Assumptions.”

Economic stabilization program. A legislative program during the early 1970s that limited price increases.

End-stage renal disease (ESRD). Permanent kidney failure.

Fee-screen year. A specified period of time in which SMI recognized fees pertain. The fee-screen year period has changed over the history of the program.

Fiscal year (FY). 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 1994 began October 1, 1993 and will end September 30, 1994.

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

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

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.

Group practice prepayment plan (GPPP). An organization which has a formal arrangement with three or more full-time physicians to provide certain health services to the plan's members who, through the advance payment of premiums, have contributed toward the cost of services. The most prevalent arrangement is a Health Maintenance Organization (HMO).

High cost alternative. See "Assumptions."

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

Hospital Insurance (HI). The Medicare program which covers specified inpatient hospital services, posthospital skilled nursing, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.

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

Independent laboratories. A free-standing clinical laboratory meeting conditions for participation in the Medicare program and billing through a carrier.

Appendices

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

Intermediary. A private or public organization, under contract to HCFA, to determine costs of and make payments to providers for HI and certain SMI services.

Intermediate assumptions. See “Assumptions.”

Low cost alternative. See “Assumptions.”

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 2 years, and people with ESRD. 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 or 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.

Medicare Economic Index (MEI). An index which is often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index will be considered in connection with the update factor for the physician fee schedule.

Medicare Volume Performance Standard (MVPS). A system for establishing goals for the rate of growth in expenditures for physicians' services.

Old-Age, Survivors, and Disability Insurance (OASDI). The Social Security programs which pay for (1) monthly cash benefits to retired-worker (old-age) beneficiaries and their spouses and children and to survivors of deceased insured workers (OASI) and (2) monthly cash benefits to disabled-worker beneficiaries and their spouses and children and for providing rehabilitation services to the disabled (DI).

Outpatient hospital. Part of the hospital providing services covered by SMI including services in an emergency room or outpatient clinic, ambulatory surgical procedures, medical supplies, such as splints, laboratory tests billed by the hospital, etc.

Part A. The Medicare Hospital Insurance program.

Part B. The Medicare Supplementary Medical Insurance program.

Performance standard factor. A legislated reduction to the volume and intensity factor of the MVPS.

Provider. Any organization, institution, or individual who provides health care services to the Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

Residual factors. Factors other than price which include volume of services, intensity of services, and age/sex changes.

Resource-based relative value scale. A scale of national uniform relative values for all physicians' services. The relative value of each service must be the sum of relative value units representing physician work, practice expenses net of malpractice expenses, and the cost of professional liability insurance.

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 HI and SMI 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 and other Federal trusts funds. Section 1841(a) of the Social Security Act provides that the public-debt obligations issued for purchase by the SMI 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.

Supplementary Medical Insurance (SMI). The Medicare program which pays for 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. Also known as Part B.

SMI premium. Monthly premium paid by those individuals who have enrolled in the voluntary SMI program.

Term insurance. A type of insurance which is in force for a specified period of time.

Trust fund. Separate accounts in the United States Treasury mandated by Congress whose assets may only be used for a specified purpose. For the SMI trust fund, monies not withdrawn for current benefit payments and administrative expenses are invested in interest-bearing Federal securities, as required by law; the interest earned is also deposited in the trust fund.

Appendices

D. STATEMENT OF ACTUARIAL OPINION

It is my opinion that (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 Supplementary Medical Insurance Trust Fund, taking into account the experience and expectations of the program.

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