The ratios of the balance in the trust fund at the beginning of each calendar year to the total disbursements during that year are shown in table 7 for past years and as projected through 1976. The ratio of the fund to such disbursements grew gradually until it reached approximately the level of one half of a year's expenditures as of the beginning of 1971. The ratio fell during both of the following two years, but is expected to increase to 72% of 1974 expenditures at the beginning of that year, to reach 100% of 1977 expenditures by the beginning of that year, and to exceed 130% of 1980 expenditures by the beginning of that year.

TABLE 7.—*Ratio of assets at the beginning of the year to expenditures during the year for the hospital insurance trust fund*

	Ratio (percent)
Historical data (calendar year):	
1967	28
1968	25
1969	43
1970	47
1971	54
1972	47
1973	40
Projection:	
1974	72
1975	87
1976	97

ACTUARIAL STATUS OF THE TRUST FUND

The hospital insurance program, as a mature long-range social insurance program, is financed on a current-cost basis. The proportion of persons over age 65 who are currently eligible for benefits can be expected to increase at a relatively low rate in future years. Although the proportion of the population who have been disabled more than two years is gradually increasing, the impact of the increase on the expenditures of the program is relatively small. Similarly, the number of persons covered as a result of chronic kidney disease is projected to grow rapidly, but accounts for only a small proportion of total expenditures. It is appropriate to finance such a system on a pay-as-you-go basis, if modified to avoid abrupt changes in the tax rates and to maintain a suitable fund for adverse contingencies. The Board of Trustees, acting on the recommendation of the 1971 Advisory Council, has adopted these general financing principles.

The adequacy of the contribution rates specified by the current law to support the hospital insurance system is measured by comparison with the "current costs" for the program over the 25-year valuation period. The current cost for the program in any year is essentially the combined employer-employee contribution rate that would be just sufficient to (1) provide the benefit payments and administrative expenses for the year and (2) maintain the trust fund at the level of the following year's disbursements.

To finance the program over future years using these concepts, two further considerations must be taken into account. If the trust fund is not currently equal to the desired level of expected disbursements during the next year, the "current-costs" must be modified to adjust the growth (or decline) of the trust fund to a path that will lead to

the desired level in some future year. Further, in recommending a schedule of tax rates, it is desirable that the rates recommended be rounded to avoid frequent changes in rates charged.

The current-costs of the hospital insurance program over the next 25 years are summarized in table 8, along with that part of the current-cost required to actually pay disbursements in each year. For purposes of comparison, the latter are also shown for past years.

TABLE 8.—EXPENDITURES AND CURRENT COSTS OF THE HOSPITAL INSURANCE PROGRAM AS A PERCENT OF TAXABLE PAYROLL[1]

Calendar year	Expenditures[2]	Current cost[3]
Historical data:		
1967	0.95	
1968	1.03	
1969	1.09	
1970	1.17	
1971	1.30	
1972	1.26	
1973	1.37	
Projection:		
1974	1.50	1.63
1975	1.57	1.69
1980	1.97	2.07
1985	2.41	2.48
1990	2.86	2.94
1995	3.35	3.45
Average cost[4]		2.63

[1] Taxable payroll is adjusted to take into account the lower contribution rates on self-employed income, on tips, and on multiple employer "excess wages."
[2] Benefit payments and administrative expenses for insured beneficiaries.
[3] Includes provision for maintenance of fund equal to next year's expenditures.
[4] The average cost is the average of the "current costs" for the 25-year period 1974–98, adjusted to build the trust fund to 100 percent of the following year's expenditures.

Since the projected level of the hospital insurance trust fund at the beginning of calendar year 1974 is 72% of the projected disbursements during 1974, provision must be made for increasing the trust fund to the desired level. The average allowance required for this purpose over the 25-year projection period is added to the average of the current costs over this period to obtain the average cost of 2.63% of taxable payroll.

As can be seen from table 8, the ratio of expenditures to taxable payroll has increased from .95% in 1967 to an estimated 1.37% in 1973, reflecting the higher rate of increase in hospital costs than in earnings subject to hospital insurance taxes. This ratio is projected to increase to 1.50% in 1974 and 1.57% in 1975, reflecting both a continuation of this trend and the extension of hospital benefits to disabled beneficiaries and persons suffering from chronic kidney disease. A further increase in this ratio in the long run to 3.35% in 1995 results from the assumed continued increases in the cost of institutional health care at a higher rate than in taxable earnings.

The additional allowance necessary to maintain the trust fund at the level of 100% of the next year's disbursements (provided the trust fund is already at the level of the current year's disbursements at the beginning of the year) is projected to be at a reasonably high level in the short run as a result of increases in disbursements due to the newly added coverage of disabled beneficiaries and persons with chronic kidney disease and due to relatively high rates of increase in hospital costs. In the long run, this factor is relatively less important.

The current cost is estimated to be 1.63% for 1974, rising to 1.69% for 1975 when the coverage of new beneficiaries has full effect, and is projected to increase to 3.45% by 1995.

The assumptions used in projecting these current cost rates are described in the actuarial appendix. The long run cost of the hospital insurance program depends primarily on the relationship between the aggregate cost of hospital services furnished to beneficiaries and the aggregate taxable payroll. In the long run, the average increase in the average earnings of hospital workers cannot be expected to differ substantially from that for other workers. Consequently, the rate of increase assumed for all workers will affect hospital costs and average earnings in approximately the same way over the long run and is thus a relatively minor parameter. Ultimately, the increase in quality, complexity, and extent of health services furnished in an institutional setting determine the major portion of the increase in the current cost of the hospital insurance program. Demographic aspects play only a secondary role over the 25-year period covered in the projections.

These projections assume that public pressure will keep hospital costs from increasing substantially faster than average earnings, in contrast to what has happened in the recent past. It is specifically assumed that in the long run such pressure will reduce the differential between the rate of increase in hospital costs and the rate of increase in taxable earnings to only 3.5% per year. The cost estimates will prove to be too low should there be a continuation of the rate of increase in the cost of hospital services that has been experienced since the beginning of the program. The 1972 Amendments included a number of provisions permitting administrative actions which when implemented could reduce the cost of the program. Projections of the cost of the program, assuming alternative rates of increase in hospital costs, are discussed in the actuarial appendix, along with a more detailed discussion of the assumptions used.

Table 9 compares the average cost from table 8 with the average combined contribution rate under current law for the same 25-year period. The slightly positive actuarial balance (+0.02% of taxable payroll) indicates that the system is approximately in overall balance, according to the assumptions used.

TABLE 9.—*Actuarial balance of the hospital insurance program, as a percent of taxable payroll**

	(*Percent*)
Average contribution rate in present schedule	2.65
Average current cost	2.63
Actuarial balance	+0.02

*For the 25-year period 1974–1998.

CONCLUSION

The hospital insurance trust fund balance at the beginning of 1974 is 72 percent of the projected expenditures for that year, below the level of one year's expenditures recommended by the Advisory Council. Under the present financing schedule, the ratio of fund to expenditures will increase, with the trust fund balance projected to reach 100% of the year's expenditures by the beginning of 1977 and to exceed 130% of the year's expenditures by the beginning of 1980. The relatively large trust fund balances projected for the late 1970's and early 1980's reflect contribution rates during these years that are slightly in excess of those required to meet the recommendations of the Advisory Council.

The present financing schedule is actuarially adequate over the twenty-five year period 1974–98 to provide the expenditures anticipated, including the benefits for newly eligible classes of beneficiaries, provided that the assumptions underlying the estimates prove to be realistic (among these is the assumption of future public influence toward reducing the rate of increase in hospital costs). Although the overall financing of the program is adequate, the year-by-year incidence of contribution rates is such that somewhat higher than necessary contribution rates during the early years of the 25-year period offset inadequate ones during the later years.

APPENDIXES

APPENDIX A.—ACTUARIAL METHODOLOGY AND PRINCIPAL ASSUMPTIONS FOR COST ESTIMATES [1]

The basic methodology and assumptions used in the estimates for the hospital insurance program are described in this appendix.

1. Methodology

The adequacy of financing for the hospital insurance program (the HI program) for the next 25 years is expressed as an actuarial balance. The actuarial balance is calculated as the difference between the average of the contribution rates specified in current law and the average of the current costs for the 25-year period, adjusted to build the trust fund to the level of a year's expenditures. The current-cost for any year is the ratio to the effective taxable payroll for that year of the cost of benefits and administration for insured persons plus an amount required to maintain the trust fund at the level of the next year's expenditures. In projecting the taxable payroll, it is assumed that the taxable wage base is adjusted periodically to keep pace with rising earnings.

The actuarial balance is +0.02% of payroll indicating that the program is in approximate actuarial balance according to the assumptions used.

2. Principal problems in forecasting the cost of the hospital insurance program

The principal problems involved in forecasting the future costs of the hospital insurance program are (1) establishing the present cost of the services provided by type of service, to serve as a base for projecting the future, (2) forecasting of the increase in the cost of hospital services (which account for approximately 95% of the cost of the program), and (3) estimating the cost for new beneficiaries covered as a result of the 1972 Amendments.

(*a*) Problems involved in establishing the present cost of services incurred as a base for forecasting future costs.—In order to establish a suitable base from which to forecast the future costs of the hospital insurance program, it is necessary to eliminate the effect of any transitory factors. Thus the initial problem is to find the incurred cost of services provided for the most recent year for which reliable estimates can be made. To do this, the non-recurring effects of any changes in regulations or administration of the program and of any irregularities in the system of payments to providers must be eliminated. As the result of the elimination of such transitory factors, the rates of increase in the cost of the health insurance program are different from the increases in cash disbursements shown in tables 5 and 6. This analysis concentrates on the longer run cost of the health insurance program in relation to the designated sources of income.

The hospital insurance program is obligated by the law to reimburse institutions for the actual reasonable cost of providing covered services to beneficiaries. Payment is initially made on an "interim" or temporary basis, with the remainder of reasonable costs paid in a series of subsequent cost settlements with the institutions.

On the average, interim payments have been set at rates lower than actual costs, as recovery of any overpayment is thought to pose a serious problem. Further, there is a delay between the date on which services are performed and the date on which interim payments based on bills are made. Such delay is due to the time required (1) for the institutions to bill intermediaries; (2) for the intermediaries to query the Social Security Administration to determine the benefit period status of the patient, determine that the services are covered, and draw checks for approved services; and (3) for the institutions to present these checks for payment. Current financing payments, not exceeding the program liability for services performed but for which no payment has been made, have in the past been advanced to institutions requesting them. Such payments have been discontinued, and amounts previously advanced are being recovered during fiscal year 1974. Another method

[1] Prepared by the Office of the Actuary, Social Security Administration.

of interim reimbursement, "periodic interim payments," makes fixed payments to the hospitals at regular intervals throughout the year. The payments are based on projections of estimated reasonable costs from past experience and may vary substantially from the actual bills submitted from month to month.

In order to adjust interim payments to the actual cost of providing services (as determined by cost reports which make the necessary allocations of all of an institution's costs on a functional basis), a series of settlements is made with each institution. The total cost settlements have averaged around 5.5% of the interim payments during the early years of the program; however, the incomplete data available do not permit an accurate estimate of the exact amount. Due to the time that has been required to obtain cost reports from institutions and to verify and, where appropriate, audit these reports, the settlements have lagged behind the liability for such payments by as much as several years for many institutions. The final cost of the program has not been completely determined even for the early years of the program, and more uncertainty exists as to the final cost of subsequent years. The overall incurred costs for any past year can be estimated, however, to within a few percent of the actual cost.

An additional complication stems from the reimbursement of the HI program from the supplementary medical insurance program (the SMI program) for the cost of certain salaried physicians. If a hospital has an agreement with salaried radiologists and pathologists under which the institution bills for the professional component of these services, interim payments are made from the HI trust fund and later reimbursed from the SMI trust fund on the basis of that hospital's cost report. Interim transfers are made from the SMI trust fund to the HI trust fund for the estimated difference between current incurred costs and cash settlements for these services. Reliable data as to the interim cost of these services is not available. Estimates are made on the basis of the final cost settlements, which as noted before are not available on a comprehensive basis for some time after the ends of hospital fiscal years.

Additional problems are posed by changes in administrative or reimbursement policy which have a substantial effect on either the amount or incidence of payment. The extent and incidence with which such changes are incorporated into interim payment rates cannot be determined precisely.

Allocating the various payments to the proper incurred period, using incomplete data and estimates of the impact of administrative actions, presents very difficult problems, the solution of which can only be approximate. Under the circumstances, the best that can be expected is that the actual incurred cost of the program for a recent period can be estimated within a few percent. This situation has the dual effect of (1) increasing the error of forecast directly, by incorporating any error in estimating the base year into all future years and (2) lengthening the periods that must be forecast, since a projection of the most recent year is more accurate than an attempt to reconstruct the actual cost in that year.

Hospital insurance program data from 1972 indicate that aged patients used 3.89 days per capita of hospital services and 0.28 days per capita of skilled nursing facility services.

Program data for 1972, corrected for anticipated final settlements with providers, indicates that the average reimbursement for a day of hospital care for the aged was $77.31 per day. They paid 6.3% of their hospital costs in the form of the inpatient deductible and coinsurance. In 1972, the average reimbursement per day in skilled nursing facilities for services covered by the hospital insurance program was $26.12. The unit reimbursement for home health services was approximately $14.92 in 1972.

(*b*) Problems involved in forecasting the increase in hospital costs.—In order to evaluate the adequacy of a tax schedule to support the hospital insurance program, it is necessary to relate the increases in the cost of institutional care for beneficiaries to the increases in taxable earnings which support those costs. There are three principal factors to consider: (1) The aggregate increases in expenditures by institutions for producing services of the types covered by the hospital insurance program, (2) the changes in the share of these expenditures that are for beneficiaries and hence will be paid by the HI program (as affected by administrative policy), and (3) the resultant hospital insurance program expenditure increases, relative to the increases in taxable earnings. These factors, in addition to a factor indicating the differential between program costs and taxable earnings, are shown in table A1. The assumptions as to the overall rate of population increase and increases in average earnings affect income and outgo in a parallel way and are thus of secondary importance. Similarly, the number of days of hospitalization by beneficiaries is primarily important as an index of the

share of hospital costs borne by the program. Uniform decreases in the average days institutionalized for persons over and under age 65 do not immediately reduce program costs proportionately, but rather only eliminate certain direct costs (e.g. supplies purchased, overtime, etc.). If such a reduction persisted over a long enough period of time, greater reductions in cost would occur, especially if an expansion of facilities that might otherwise have occurred were not carried out.

TABLE A1.—COMPONENTS OF HISTORICAL AND PROJECTED LONG RANGE INCREASES IN HI HOSPITAL COSTS INCURRED, COMPARED TO THE INCREASE IN HI TAXABLE EARNINGS[1]

[In percent]

Calendar year	Aggregate inpatient hospital costs[2]	HI share of aggregate inpatient hospital costs[3]	Total HI hospital costs	HI taxable earnings	Cost-earnings differential
Historical data:					
1956–65	10.4				
1966	11.7				
1967	18.6				
1968	16.5	7.4	25.2		
1969	18.4	—3.1	14.8		
1970	16.8	—5.1	10.8		
1971	13.7	—1.2	15.0		
1972	13.5	—2.2	10.9		
Projection:					
1973	12.5	4.6	17.7	13.1	+4.1
1974	13.5	5.6	19.8	12.3	+6.7
1975	14.0	1.1	15.3	10.4	+4.4
1980	12.2	.8	13.1	6.8	+5.9
1985	9.4	.7	10.2	6.0	+4.0
1990	9.3	.5	9.8	5.7	+3.8
1995	9.3	.1	9.4	5.7	+3.5

[1] Increase in year indicated over previous year.
[2] See table A2.
[3] See table A5.

Of these factors, the increase in aggregate inpatient hospital costs has dominated all others, due to the very rapid rate (14% to 18% per year) and the irregular pattern of increases. The share of hospital costs allocated to beneficiaries by the reimbursement system has also fluctuated somewhat in recent years, but it is projected to stabilize for future years under the assumption that present administrative policy is retained. The changes in share for other institutional services have been substantial, as well as changes in aggregate expenditures, but these influence only 5% of the overall cost of the program. The primary assumption that determines the level of costs is thus the differential between the rates of increase in the hospital insurance program's share of aggregate hospital costs and in taxable earnings.

3. Principal assumptions used in projecting the future costs of the hospital insurance system

(*a*) Trends in covered hospital costs and the impact of the Economic Stabilization Program:

(1) Analysis of data concerning past trends

The increase in the aggregate cost of covered hospital services paid by the hospital insurance program may be analyzed into the following components:

(*a*) Increases in aggregate inpatient hospital costs, consisting of increases due to:

1. Factor prices: the increase in unit costs that would result if every function were performed in precisely the same way by the same people and only the salaries of the people employed or the cost of the equipment and other supplies used changed.
2. Services provided and their method of provision, consisting of:

Changes in the number and composition by relative expense of services furnished (including the increase in services required to keep pace with population growth).

Changes in the method of providing the same services (including improvements to a given service, normally increasing the unit cost, and the effects of more efficient techniques or labor-saving equipment, normally decreasing the unit cost).

Incorporation of new services not previously provided (normally new, technically advanced services).

(*b*) Increases in the hospital insurance program's share of aggregate inpatient hospital costs, consisting of increases due to:

1. Proportion of the population covered: the increase in the proportion of the general population which receives reimbursement for its hospital care under the hospital insurance program.

2. Relative amount of care paid by the hospital insurance program, consisting of:

Changes in the proportion of hospital services used by beneficiaries (including the number of services and their relative values), independent of any population change.

Changes in administrative or reimbursement policy which have an effect on the amount or incidence of payment.

It has been possible to isolate some of these elements and identify their role in previous hospital cost increases. The increases due to changes in the services provided and the method of their provision, however, must be combined to use available data, and separated into (i) a portion due to hiring more employees and (ii) a residual due to all other causes. A large portion of the historical increases must thus be studied only as a residual element. Table A2 shows the values of the principal components of the increases for periods for which data is available, together with the projections used in the estimates.

TABLE A2.—COMPONENTS OF HISTORICAL AND PROJECTED LONG-RANGE INCREASE IN AGGREGATE INPATIENT HOSPITAL COSTS INCURRED [1]

[In percent]

Calendar year	Factor prices [2]	Services provided and method of provision [3]	Aggregate inpatient hospital costs
Historical data:			
1956–65	3.8	6.6	10.4
1966	1.8	9.9	11.7
1967	7.2	11.3	18.6
1968	8.1	8.4	16.5
1969	8.4	10.0	18.4
1970	9.2	7.6	16.8
1971	8.4	5.3	13.7
1972	6.5	7.0	13.5
Projection:			
1973	7.4	5.1	12.5
1974	8.4	5.2	13.5
1975	8.6	5.4	14.0
1980	6.8	5.4	12.2
1985	4.4	5.0	9.4
1990	4.4	4.9	9.3
1995	4.4	4.9	9.3

[1] Increase in year indicated over previous year.
[2] See table A3.
[3] See table A4.

Hospital factor prices can be divided into those for personnel and those for non-personnel expenditures. Table A3 shows the approximate increases that have occurred in these components and in overall factor costs.

TABLE A3.—HISTORICAL AND PROJECTED LONG-RANGE PRICE INCREASES FOR FACTORS USED BY HOSPITALS [1]

[In percent]

Calendar year	Average earnings in covered employment [2]	Average payroll per hospital employee [3]	Price index [4]	Factor prices
Historical data:				
1956–65	3.6	4.7	2.2	3.8
1966	4.4	.6	3.4	1.8
1967	6.3	9.3	3.6	7.2
1968	7.0	9.9	4.7	8.1
1969	6.0	9.4	6.2	8.4
1970	4.8	10.1	7.0	9.2
1971	5.0	10.3	4.9	8.4
1972	5.8	8.1	3.6	6.5
Projection:				
1973	7.5	8.5	5.3	7.4
1974	7.9	9.0	7.0	8.4
1975	8.5	10.0	6.0	8.6
1980	5.5	8.0	4.5	6.8
1985	5.0	5.0	3.3	4.4
1990	5.0	5.0	3.3	4.4
1995	5.0	5.0	3.3	4.4

[1] Increase in year indicated over previous year.
[2] Average earnings subject to OASDHI taxes in 1st quarter.
[3] Based on data from the American Hospital Association through 1972.
[4] See text for explanation.

Approximately 60% of hospital costs are for personnel. For several years preceding the beginning of the hospital insurance program, average hospital wages and salaries (as reported by the American Hospital Association) increased at a rate of about one percent per year more than the rate of increase in earnings in OASDI covered employment. Since the beginning of the hospital insurance program, this differential has been about 3% to 5% per year. Increases in the prices of the goods and services hospitals purchase are treated as a function of increases in the Consumer Price Index, weighted more heavily by services since hospitals purchase a large volume of services, as no index of hospital non-personnel factor prices is available.

Increases in hospital costs due to changes in the services and how they are provided (exclusive of the effect of any change in factor costs) are analyzed on an aggregate basis. Due to lack of data, the increases are analyzed into a part due to adding more employees and a part due to all other causes, the latter being estimated as a residual.

TABLE A4.—CHANGES IN SERVICES PROVIDED AND THEIR METHOD OF PROVISION FOR INPATIENT HOSPITALS [1]

[In percent]

Calendar year	Number of hospital employees [2]	Nonemployee sources [3]	Services provided and method of provision
Historical data:			
1956–65	5.3	8.3	6.6
1966	10.5	8.8	9.9
1967	5.7	19.0	11.3
1968	6.1	11.3	8.4
1969	6.2	14.6	10.0
1970	5.8	9.7	7.6
1971	3.6	7.6	5.3
1972	2.9	12.8	7.0
Projection:			
1973	2.9	8.1	5.1
1974	3.0	8.2	5.2
1975	3.0	8.5	5.4
1980	3.0	8.7	5.4
1985	3.0	7.7	5.0
1990	3.0	7.5	4.9
1995	3.0	7.5	4.9

[1] Increase in year indicated over previous year.
[2] Based on data from the American Hospital Association through 1972.
[3] Actually a residual; i.e., the increase in hospital costs not explained by factor cost increases or the number of hospital employees.

During the early years of the hospital insurance program, the number of hospital workers in non-federal short-term general hospitals had been increasing about 6% per year (as reported by the American Hospital Association). The growth in the number of hospital employees has slowed somewhat during recent periods, especially during the period of wage-price controls.

The residual required to balance the historical increases in hospital costs allows for the effect of all changes in the services provided and how they are provided that cannot be attributed to an increase in the number of personnel (this item is stated so as to apply only to non-personnel costs). Before 1966, this residual averaged about 8.5% per year. After a surge in the early years of the hospital insurance program, the residual has declined to an average level of around 9% during recent years.

Changes in the program's share of aggregate hospital costs result primarily from changes in the proportion of the population covered (including changes due to legislation), changes in the relative number and value of services received by beneficiaries, and the effect of administrative actions defining the services eligible for reimbursement and the corresponding level of payment.

Ultimately, reimbursement by the program depends on the proportion of recognized costs that are allocated to beneficiaries in the final cost settlements with hospitals. In general, this allocation depends on the ratio of charges for services used by beneficiaries to charges for all services provided.

Unfortunately, due to the long delay experience in the filing of final cost settlements, no reliable data is available from which this ratio can be determined for any recent period. However, an approximation to the change in this share ratio from year to year is the combined effect of the change in the ratio of days of care provided for beneficiaries to days of care provided for all persons and any change in administrative or reimbursement policy. The change in program share appears in table A5, with the change in population covered netted from the other sources.

TABLE A5.—HISTORICAL AND PROJECTED LONG-RANGE INCREASES IN SHARE OF INCURRED HOSPITAL COSTS PAID BY HI[1]

[In percent]

Calendar year	Proportion of population covered	Relative amount of care paid by HI	HI share of aggregate inpatient hospital costs
Historical data:			
1968	0.3	7.1	7.4
1969	.3	−3.4	−3.1
1970	.3	−5.4	−5.1
1971	.3	.9	1.2
1972	.3	−1.9	−2.2
Projection:			
1973	[2] 5.1	−.5	4.6
1974	[2] 5.2	.4	5.6
1975	1.1	0	1.1
1980	.8	0	.8
1985	.7	0	.7
1990	.5	0	.5
1995	.1	0	.1

[1] Increase in year indicated over previous year.
[2] Reflects the extension of HI coverage to new classes of beneficiaries under the 1972 amendments.

A major change in administrative policy affecting the health insurance program's share of inpatient hospital costs was the termination in 1969 of the 2% allowance for costs not otherwise allocated and the institution of a new nursing differential based on cost accounting studies of the differential costs of furnishing hospital inpatient routine nursing services to persons over age 65. Payments for this differential cost of nursing in fiscal year 1970 and 1971 were delayed until after new regulations were promulgated in July 1971.

The 1972 Amendments authorize payment for non-covered services for which payment was disallowed and the beneficiary was judged not to be at fault. This provision increases the share of services paid by a small amount.

The 1972 Amendments also contain a number of specific provisions which authorize administrative action which could reduce the share of hospital costs paid through the program. Included were provisions intended to reduce payments

to certain providers of services who have abused the program or who furnish services which are determined to be unduly expensive or unnecessary for efficient delivery of health services, the requirement of reasonable institutional planning, limitations on reimbursement for disapproved capital expenditures, and the limitation of reimbursement to charges when these are less than reasonable cost. The cost estimates assume that these provisions are implemented gradually over several years as part of the public effort to restrain the increase in cost of institutional care generally assumed in the estimates.

(2) Effect of Phase II of implementing the economic stabilization program

Regulations promulgated by the Price Commission in December 1971 restricted several of these components of the increase in hospital costs. Costs as recognized for third party reimbursements were treated as prices, and as such were limited by:

(*a*) Increases in wages and salaries (as recognized for cost based reimbursement) were limited to 5.5% per year.

(*b*) Increases in prices paid for goods and services were limited to 2.5% per year.

(*c*) Increases due to changes in the method of providing the same services were limited to 1.7% per year.

The Social Security Administration adopted the policy of withholding reimbursements which reflected increases in costs of more than 9% per year (adjusted for volume) for accounting periods beginning after the announcement of controls in August 1971, unless the hospital obtained certification of compliance from the Internal Revenue Service (the Cost of Living Council assumed this responsibility beginning in late 1973). This reimbursement policy establishing presumptive compliance levels appears to have had a substantial impact on aggregate reimbursable hospital cost increases. During 1972 and 1973, program cost increases (excluding the effects of new beneficiary groups) have been at a lower rate than in previous years and than the rate for aggregate inpatient hospital costs.

(3) Projection of future increases in hospital costs

To project the future rate of increase in hospital costs it is necessary to estimate the increase that has occurred since 1972, and then to project future increases (many of the principal components of the estimate of 1972 costs are, however, projected from previous years). In order to do this, the causes of past increases are analyzed into components which can be predicted, have been stable, or are affected in a predictable way by administrative policy or other influences.

The average earnings of hospital employees have been increasing more rapidly than the average earnings of other workers over the past decade. Historically, hospital employees earned less than similarly skilled workers in other industries. With the growth in third party reimbursement of hospitals, hospital workers began to receive higher increases in earnings than other workers. The differential has been particularly pronounced since the beginning of the hospital insurance and medicaid programs, which brought the level of third party payments up to the point that most of the financing for hospital care in the U.S. is provided through such payments. As a result hospital managements have tended to assume that any costs incurred would be reimbursed, and resistance to expensive increases in the quality of services and wage demands of personnel has been lessened. Under these conditions, average wages of hospital workers have been increasing from 8% to 10.5% per year since 1966. Part of this increase in average wages has been due to a change in composition of the hospital work force so as to include relatively more higher paid personnel.

The cost estimates assume that the average increase in payroll per hospital employee will be 9% to 10% per year during 1974–75, slightly higher than the rates for all workers. Eventually this difference should disappear entirely, when hospital workers' wages are comparable to those for similarly skilled personnel in other industries and the proportion of highly trained personnel grows very large. This has been assumed to occur by 1985 as a result of public pressure on hospitals to reduce the rate of increase in their costs.

The index used to measure the rate of increase in prices paid by hospitals for factors other than personnel rose from a rate of 3.4% per year in 1966 to a level of 7.0% in 1970. Apparently as a result of the economic stabilization program, the increase dropped to 4.9% in 1971, 3.6% in 1972, and 5.3% in 1973. The increases beyond 1973 are projected by the rate of increase in the CPI assumed in projecting the experience of the OASDI program, with an adjustment to reflect the greater proportion of services purchased by hospitals.

No data is available beyond 1972 pertaining to increases in costs due to changes in services and how provided. The overall rate of increase in hospital costs appears to have declined moderately from 13.5% in 1972 to around 12.5% in 1973. This slightly lower rate of increase is attributable primarily to change in services.

(*b*) Assumptions as to increases in the cost per capita of skilled nursing facility benefits.

The number of days of care per capita in skilled nursing facilities covered by the program dropped very sharply in 1970 and continued to decline through 1972. This is the result of strict enforcement of regulations separating skilled nursing from custodial care. The 1972 amendments extended benefits to persons who require skilled rehabilitative services regardless of their need for skilled nursing services (the former prerequisite for benefits). This change has resulted in a significant increase in services rendered in 1973 (the first effective year of the provision), with more gradual increases anticipated thereafter.

Increases in the average cost per day in skilled nursing facilities under the program are caused principally by (i) the higher cost of nurses and other skilled labor required and (ii) the addition to covered facilities of new, better equipped, and more expensive facilities. Nurses have been in particularly short supply since the beginning of the hospital insurance program, and consequently their wages have been increasing more rapidly than earnings in general. This trend may be expected to continue for the foreseeable future due to (i) the continued rapid increase in demand for nursing services and (ii) the opening of a wide variety of occupations to women, forcing employers of nurses to be more competitive in wages and working conditions.

The average cost per day of skilled nursing facility services covered by the program increased by approximately 5% in 1972 over 1971, the lowest rate since the beginning of the program and less than half of the 12.8% increase for 1971 over 1970. It is assumed that the rate of increase will stabilize at a level of about 7% in the near future and then will decrease to a level slightly higher than the annual rate of increase in general wages by 1985. The resulting increases in the cost per capita of skilled nursing facility services are shown in table A6.

The long run assumption that increases in the cost per day of care in skilled nursing facilities will be only slightly higher than the increases in average earnings after 1985 requires increases in productivity to offset the higher than average increases in earnings anticipated for nurses and any tendency to upgrade the quality of services. As in the case of hospitals, public pressure to contain these costs will be required.

(*c*) Assumptions as to home health service benefits.

Reconstruction of the historical cost per capita of home health services is complicated by the substantial delay in bill processing. There have also been changes in administrative policy affecting the amount of interim reimbursement allowed on bills although the program has always ultimately paid the lower of the agencies' charges or reasonable cost. A modest increase in days per capita is projected for the next several years. It is anticipated that cost per service will increase at a rate close to the rate of increase in general wages. The assumptions used in the cost estimates are shown in table A6.

TABLE A6.—PROJECTED INCREASES IN HI COST PER CAPITA FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES[1]

[In percent]

Calendar year	Skilled nursing facilities	Home health agencies
1974	16.8	7.1
1975	8.3	7.1
1980	8.1	7.1
1985	6.0	6.0
1990	6.0	6.0
1995	6.0	6.0

[1] Increase in year indicated over previous year.

(*d*) Cost estimates by type of beneficiary.

Estimates for the new groups of beneficiaries eligible beginning in fiscal year 1974 are necessarily less reliable than those for the aged. The methodology used to estimate the costs was improvised to make the best use of such information as was available in proportion to judgments as to its reliability. Estimates of the

short range expenditures by type of beneficiary are summarized in table A7, and the long range estimates as a percent of payroll are shown in table A8.

(e) Administrative expenses.

The short range projections of administrative expenses are based on estimates of workloads and approved budgets for carriers and the Social Security Administration. The long range administrative expenses per capita are assumed to increase at 4% each year—that is, 1% less than the increase in average earnings. Historical data showing the relationship between administrative expenses and benefits is shown in table A9 together with projections through 1976.

(f) Interest rate.

It has been assumed that trust fund investments will earn an average of 6% interest per annum. The actual rate earned on the hospital insurance trust fund during fiscal 1973 was 6.4%.

TABLE A7.—PROJECTION OF HOSPITAL INSURANCE BENEFIT OUTLAYS, BY TYPE OF BENEFICIARY, CALENDER YEARS 1974–76

[In millions]

Calendar year	Aged beneficiaries	Disabled beneficiaries	Chronic kidney disease beneficiaries
1974	$7,555	$1,085	$46
1975	8,867	1,332	51
1976	10,092	1,562	55

TABLE A8.—PROJECTION OF EXPENDITURES[1] OF THE HOSPITAL INSURANCE PROGRAM, BY TYPE OF BENEFICIARY, AS A PERCENT OF TAXABLE PAYROLL

Calendar year	Aged beneficiaries[2]	Disabled beneficiaries	Chronic kidney disease beneficiaries
1974	1.29	0.20	0.01
1975	1.35	.21	.01
1980	1.68	.28	.01
1985	2.06	.34	.01
1990	2.45	.40	.01
1995	2.86	.48	.01

[1] Benefits and administrative expenses.
[2] Excludes expenditures for uninsured beneficiaries which are reimbursed from general revenues.

TABLE A9.—RATIO OF ADMINISTRATIVE EXPENSES TO BENEFIT PAYMENTS

Calendar year	Ratio (percent)
Historical data:	
1967	2.3
1968	2.4
1969	2.5
1970	3.1
1971	2.6
1972	2.9
1973	3.3
Projection:	
1974	3.8
1975	3.4
1976	3.2

(g) Population.

The population projections used in this report are based on unpublished revisions to those in *Actuarial Study Number 62*, Social Security Administration.

4. Sensitivity testing of long term cost estimates

During the four-year period preceding the Economic Stabilization Program, hospital reimbursement per capita under the Hospital Insurance program increased at an average annual rate of approximately 15%; during the following two years the average annual rate of increase was reduced to a level of between 9½% and 10%. The wide difference in cost increase experience between these two periods raises significant questions concerning the implications for the future. On one side of the spectrum is the thesis that the 9½% to 10% increases represent a temporary and artificial condition, created solely by the application of cost controls to medicare reimbursement: upon removal of direct controls, reimbursable cost increases would be expected to return to a considerably higher level, possibly including a period of excessively high increase rates in order to compensate for the period of depressed increase allowances under controls. On the other side of the spectrum is the argument that cost controls had virtually no effect on Medicare reimbursement and that the 9½% to 10% increases represent a natural and permanent cooling of cost increases in the hospital sector: removal of direct controls will have no significant impact on anticipated rates of increase. The assumptions underlying the projections in this report take an intermediate position: removal of direct controls will result in cost increases close to the pre-control level in the immediate future but that ultimately more modest increases will be experienced.

Table A10 compares the cost of the program as projected in this report with two alternative projections, based on different assumptions as to the rate of increase in hospital costs. The first alternative shows the current cost ratios that would occur if the rates of hospital cost increase in the short range were to revert to a level consistent with, but lower than, the corresponding rates experienced under Medicare prior to cost controls and in the long range were to decrease to the level of 9% per year. The second alternative shows corresponding figures that would occur if the rates of increase in the short range were to remain at a level consistent with those experienced under medicare during the period of cost controls and in the long range were to decrease to the level of 7.5% per year.

TABLE A10.—SUMMARY OF ALTERNATIVE PROJECTIONS OF THE COST OF THE HI PROGRAM

[In percent]

Year	This report	Alternative 1	Alternative 2
Assumed increase in hospital costs per capita:			
1974	9.6	11.4	9.1
1975	12.6	14.0	10.5
1980	11.0	12.5	10.5
1985	8.0	9.0	7.5
1990	8.0	9.0	7.5
1995	8.0	9.0	7.5
Current cost ratios and resulting actuarial balance:			
1974	1.63	1.67	1.59
1975	1.69	1.76	1.63
1980	2.07	2.32	1.97
1985	2.48	3.01	2.37
1990	2.94	3.81	2.81
1995	3.45	4.70	3.24
Average cost	2.63	3.29	2.50
Average tax	2.65	2.65	2.65
Actuarial balance	+.02	−.64	+.15

APPENDIX B.—SUMMARY OF PRINCIPAL PROVISIONS

Public Law 89–97, approved July 30, 1965, amended the Social Security Act and related provisions of the Internal Revenue Code by establishing the hospital insurance program. A summary of its provisions, as amended, is as follows:

I. COVERAGE PROVISIONS (FOR CONTRIBUTION PURPOSES)

(*a*) All workers covered by the old-age, survivors, and disability insurance system.

(*b*) All railroad workers (covered directly by the system, and not through the financial interchange provisions, if the railroad retirement taxable wage base is not the same as the hospital insurance base; if the bases are the same, the railroad retirement system collects contributions and transfers them to the hospital insurance trust fund through the financial interchange provisions).[1]

II. PERSONS PROTECTED (FOR BENEFIT PURPOSES)

(*a*) Insured persons—all individuals aged 65 or over who are eligible for any type of old-age, survivors, and disability insurance or railroad retirement monthly benefit (i.e., as insured workers, dependents, or survivors), without regard to whether retired (i.e., no earnings test).

(*b*) Noninsured persons transitionally eligible without charge—all other individuals aged 65 or over before 1968 who are citizens or aliens lawfully admitted for permanent residence with at least 5 consecutive years of residence and who are not retired Federal employees (or dependents of such individuals) covered under the Federal Employees Health Benefits Act of 1959 (including certain individuals who could have been covered if they had so elected). Those individuals in this category attaining age 65 after 1967 must have certain amounts of OASDI (or railroad retirement) coverage to be eligible for HI benefits—namely, 3 quarters of coverage for each year after 1966 and before age 65, so that the provision becomes ineffective after 1975, since then the "regular" OASDI insured status conditions are as easy to meet.

(*c*) Other noninsured persons aged 65 or over—beginning July 1973, other persons over age 65 who meet the residence and citizenship requirements for transitional eligibility can elect to enroll in HI under the same conditions applicable to SMI. Continued coverage depends on payment of the standard monthly premium rate and on continued enrollment in the SMI program.

(*d*) Disabled beneficiaries under age 65 who have been entitled to disability insurance benefits for 24 months or longer—benefits for such individuals continue through the month after recovery.

(*e*) Persons under age 65 with chronic kidney disease, requiring dialysis or renal transplant—such individuals (if fully or currently insured, or spouse of dependent child of such insured person, or a monthly beneficiary) are covered under HI, beginning with the 3rd month after month in which course of treatment began and ending with 12th month after month of transplant (or after dialysis terminated).

III. BENEFITS PROVIDED

(*a*) Hospital benefits—the full cost of all hospital services (i.e., including room and board; operating room; laboratory tests and X-rays; drugs; dressings; general nursing services; and services of interns and residents in training) for semi-private accommodations for up to 90 days in a "spell of illness" (a period beginning with the first day of hospitalization and ending after the person has been out of a hospital or skilled nursing facility for 60 consecutive days) is provided, after payment of the inpatient deductible ($84 in 1974), the cost of the first 3 pints of blood, and copayments of one-fourth of the inpatient deductible ($21 in 1974) per day for the 61st through the 90th day. A lifetime reserve of 60 days with copayments of

[1] Public Law 89–212, approved September 20, 1965, provided that the railroad retirement wage base will, in the future, be automatically adjusted so as to be the same as the earnings base under the hospital insurance system.

one-half of the inpatient deductible ($42 in 1974) is available for each eligible individual in addition to the days of coverage otherwise available (90 days per spell of illness). There is a lifetime maximum of 190 days for psychiatric hospital care. The inpatient deductible is automatically adjusted each year to reflect changes in hospital costs (see Appendix C for the inpatient deductible promulgated for 1974).

(*b*) Skilled nursing facility (skilled nursing home or convalescent wing of hospital—formerly called "extended care facility") benefits—following at least 3 days of hospitalization and beginning within 14 days of leaving the hospital (under certain conditions, an additional 14-day extension may be granted), such care, which is needed on a daily basis and which can only be provided by such a facility on an inpatient basis, is provided for a period of up to 100 days in a spell of illness, with copayments of one-eighth of the inpatient deductible ($10.50 in 1974) per day for all days after the 20th.

(*c*) Home health services benefits—following at least 3 days of hospitalization and beginning within 14 days of leaving the hospital or skilled nursing facility, such care is provided for an amount of up to 100 visits in the next 365 days and before the beginning of the next spell of illness; these services are essentially for homebound persons and include visiting nurse services and various types of therapy treatment, including outpatient hospital services when equipment cannot be brought to the home.

(*d*) Services not covered—services obtained outside the United States (except for emergency services for an illness occurring in the United States or in transit in Canada between Alaska and another state, and except for illness of a person treated in a hospital which is nearer his residence than any in the U.S.), elective "luxury" services (such as private room or television), custodial care, hospitalization for services not necessary for the treatment of illness or injury (such as elective cosmetic surgery), services performed in a Federal institution (such as a Veterans Administration hospital), and cases eligible under workmen's compensation.

(*e*) Administration—by the Department of Health, Education, and Welfare, through fiscal intermediaries (such as Blue Cross, other health insurance organizations, or state agencies) who are able to assist the providers of services in applying safeguards against over-utilization of services. Each provider of services can nominate a fiscal intermediary or can deal directly with the Department. The providers of services are reimbursed on a "reasonable cost" basis, and the fiscal intermediaries are reimbursed for their reasonable costs of administration. Establishment of utilization review committees is required for hospitals and skilled nursing facilities, and the latter must develop transfer agreements with hospitals. Special reimbursement provisions apply to Health Maintenance Organizations which elect and are offered at-risk contracts which may reward them financially for more favorable operating experience.

IV. FINANCING

(*a*) Insured persons—on a long range self-supporting basis (the same as for OASDI) through a separate schedule of increasing tax rates on covered workers, with the same maximum taxable earnings base as scheduled for OASDI; the same rate applies to employees, employers, and self-employed (unlike OASDI).

(*b*) Noninsured persons transitionally eligible—from general revenues, through the HI Trust Fund.

(*c*) Other noninsured who enroll—through a standard monthly premium rate which is approximately self-supporting. The rate is $36 in fiscal year 1975 and will be increased thereafter at the rate of increase in the inpatient deductible (see Appendix D for the premium promulgated for fiscal year 1975).

(*d*) Reimbursement from general revenues for expenditures resulting from noncontributory wage credits granted to persons who served in the armed forces. The Secretary of Health, Education, and Welfare must determine the level annual appropriations to the trust fund necessary to amortize the estimated total additional costs arising from these payments.

APPENDIX C.—DETERMINATION AND ANNOUNCEMENT OF "INPATIENT HOSPITAL DEDUCTIBLE FOR 1974" [1]

Section 1813(b)(2) of the Social Security Act (42 U.S.C. 1 395(b)(2)), as amended, requires that the dollar amount for the inpatient hospital deductible, be set on the basis of the average daily cost of hospital care under the hospital insurance program. For purposes of section 1813(a) of the Act, as amended, there-

[1] This statement was published in the Federal Register for October 11,1973 (Vol. 38, No. 196, pp. 28102-3).

fore, the amount shall be $84 in the case of any spell of illness beginning during 1974.

The Social Security Act provides that for calendar years after 1968, the inpatient hospital deductible shall be equal to $40 miltiplied by the ratio of (1) the current average per diem rate for inpatient hospital services for the calendar year preceding the year in which the promulgation is made (in this case, 1972) to (2) the current average per diem rate for such services for 1966. The law provides that, if the amount so determined is not an even multiple of $4, it shall be rounded to the nearest multiple of $4. Further, it is provided that the current average per diem rates referred to shall be determined by the Secretary of Health, Education, and Welfare from the best available information as to the amounts paid under the program for inpatient hospital services furnished during the year by hospitals who are qualified to participate in the program, and for whom there is an agreement to do so, for individuals who are entitled to benefits as a result of insured status under the Old-Age, Survivors, and Disability Insurance program or the Railroad Retirement program.

The data available to make the necessary computations of the current average per diem rates for calendar years 1966 and 1972 are derived from individual inpatient hospital bills that are recorded on a 100-percent basis in the records of the program. These records show, for each bill, the total inpatient days of care, the interim reimbursement amount, and the total interim cost (the sum of interim reimbursement, deductible, and coinsurance).

Each individual bill is assigned both an initial month and a terminal month, as determined from the first day covered by the bill and the last day so covered. Insofar as the initial month and the terminal month fall in the same calendar year, no problems of classification occur.

Two tabulations of interim reimbursements are prepared, one summarizing the bills with each assigned to the year in which the period it covers begins, and the other summarizing the same bills with each assigned to the year in which the period it covers ends. The true value with respect to the interim costs for a given year on an accrual basis should fall between the amount of total costs shown for bills beginning in that year and the amount shown for bills ending in that year.

The average interim per diem rate for inpatient hospital services for calendar year 1966, on the basis described, is $37.92, while the corresponding figure for calendar year 1972 is $79.07. It may be noted that these averages are based on about 30 million days of hospitalization in 1966 and 64 million days of hospitalization in 1972. The ratio of the 1972 rate to the 1966 rate is 2.085.

In order to reflect accurately the change in the average per diem hospital cost under the program, the average interim cost (as shown in the tabulations) must be adjusted for (i) the effect of final cost settlements made with each provider of services after the end of its fiscal year to adjust the reimbursement to the provider from the amount paid during that year on an interim basis to the actual cost of providing covered services to beneficiaries, and for (ii) changes in the benefit structure since the base year, 1966. To the extent that the ratio of final cost to interim cost is different in the current year than it was in 1966, the increase in average interim per diem costs will not coincide with the increase in actual cost that has occurred. The inclusion of the lifetime reserve days in the current tabulation of the average interim per diem cost when such days were not included in the corresponding tabulation for the base year, 1966, will understate the estimate of the increase in cost that has occurred, because the average cost per day of very long confinements in a hospital is less than the average for all confinements.

In order to estimate the increase in average per diem cost that has occurred, a comparison must be based on similar benefits in the two periods (1972 and 1966); thus the effect of lifetime reserve days, must be eliminated from the current year tabulation. Actuarial analysis of the data available indicates that these adjustments do not change the ratio shown above by enough to result in a different deductible for 1974. The values shown in this report do not reflect these adjustments for final cost settlements or lifetime reserve days.

When the ratio of 2.085 is multiplied by $40 it produces an amount of $83.40, which must be rounded to $84. Accordingly, the inpatient hospital deductible for spells of illness beginning during the calendar year 1974 is $84.

The Cost of Living Council has analyzed the increase and has determined that the proposed increase is not inconsistent with the Council's policies and regulations now governing price adjustments in the health industry. This authorization reflects certain interpretative changes in the Cost of Living Council's regulatory policy which have occurred since the October 1972 Price Commission ruling which restricted the increase for calendar year 1973.

Dated: October 5, 1973.

CASPAR W. WEINBERGER,
Secretary.

APPENDIX D.—DETERMINATION AND ANNOUNCEMENT OF THE HOSPITAL INSURANCE PREMIUM RATE FOR THE UNINSURED AGED FOR FISCAL YEAR 1975 "PREMIUM RATE FOR THE UNINSURED AGED" [1]

Pursuant to authority contained in section 1818(d)(2) of the Social Security Act (42 U.S.C. 1395i–2(d)(2)), as added by section 202 of the Social Security Amendments of 1972, Pub. Law 92–603, I hereby determine and promulgate that the hospital insurance premium for the uninsured aged, applicable for the 12-month period beginning July 1, 1974, is $36.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

Dated: December 29, 1973.

STATEMENT OF ACTUARIAL ASSUMPTIONS AND BASES EMPLOYED IN DETERMINING THE PREMIUM RATE FOR THE HOSPITAL INSURANCE PROGRAM FOR UNINSURED AGED BEGINNING JULY 1974

Section 1818 of the Social Security Act provides for voluntary enrollment in the Hospital Insurance program (Part A of Medicare) by certain uninsured persons age 65 and older who are otherwise ineligible. Section 1818(d)(2) of the Act requires the Secretary to determine and promulgate, during the final quarter of 1973, the dollar amount which will be the monthly Part A premium for voluntary enrollment, for months occurring in the 12-month period beginning July 1, 1974. As required by statute, this amount must be $33 times the ratio of (1) the 1974 inpatient hospital deductible to (2) the 1973 inpatient hospital deductible, rounded to the nearest multiple of $1, or if midway between multiples of $1, to the next higher multiple of $1.

Under section 1813(b)(2) of the Act, the 1974 inpatient hospital deductible was determined to be $84. The 1973 deductible was actuarially determined to be $76, but to comply with a ruling by the Cost of Living Council, it was promulgated at $72. Using the actuarially determined amount of the 1973 deductible, $76, the computation is $33 x (84/76) = $36.47, which is rounded to $36.

The purpose of the premium formula is to adjust the original $33 premium for changes in the cost of providing hospital care. The ratio of the inpatient hospital deductibles does this approximately, since the deductible as calculated under section 1813(b)(2), is based on the average daily cost of providing hospital care under the Hospital Insurance program. It was also the intent of the provision that the full costs of providing Part A coverage to the uninsured enrollees be borne by the enrollees themselves. The actuarially determined inpatient hospital deductible amount for 1973—$76—is the appropriate amount for use in the premium formula, since it more accurately reflects actual program experience.

Assuming that the average incurred cost per premium enrollee is the same as the average incurred cost per insured aged enrollee, the following comparison can be made:

MONTHLY HOSPITAL INSURANCE PREMIUM

Fiscal year	Wth 1973 deductible=$72	With 1973 deductible=$76	Estimated actual cost
1974	$33	$33	$32
1975	39	36	36

Thus, the premium of $36, derived by using $76 for the 1973 inpatient hospital deductible, is adequate to cover the projected costs of the uninsured enrollees indicated. Accordingly, the Hospital Insurance monthly premium for fiscal year 1975 is $36.

[1] This statement was published in the Federal Register for January 10, 1974 (Vol. 39, No. 7, p. 1523).

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