APPENDIX C

ORIGINAL ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) SKILLED NURSING FACILITY COINSURANCE AMOUNT, FOR CALENDAR YEAR 1990 1/

SUMMARY: This notice announces that the skilled nursing facility (SNF) coinsurance amount for calendar year 1990 for the 1st through 8th days of extended care services in a SNF under Medicare's hospital insurance program (Part A) is $26.50. The Medicare statute specifies the method to be used to determine this amount.

Effective Date: January 1, 1990.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813(a)(3) of the Social Security Act (the Act) required, until January 1, 1989, that the amount payable for extended care services in a skilled nursing facility (SNF) during a spell of illness was to be reduced by an amount equal to one-eighth of the hospital deductible, per day, for the 21st through 100th day of covered extended care services.

1/ Extracted from the notice entitled "Medicare Program; SNF Coinsurance Amount for 1990," which was published in the Federal Register on October 26, 1989 (Vol. 54, No. 206, pp. 43619-43620). The Medicare Catastrophic Coverage Repeal Act of 1989, enacted December 13, 1989, changed the skilled nursing facility (SNF) coinsurance amount for 1990 from $26.50 for the first eight days of covered care in a year, as announced here, to $74 for the 21st to 100th days of covered care in a benefit period. The Repeal Act changed the SNF benefit in other ways as well. As a result of the Repeal Act, the amount announced here was superseded, and there are higher estimated costs to beneficiaries than those shown in this notice. See appendix E for further information.

Section 102 of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360), enacted on July 1, 1988, amended section 1813(a)(3) and repealed section 1813(b)(3) of the Act to change the method of determining coinsurance for SNF care and to change the days subject to coinsurance. Beginning January 1, 1989, beneficiaries are liable for coinsurance for days one through eight of covered days spent in a SNF in a calendar year (rather than days 21 through 100 in a spell of illness), and the coinsurance amount per day is determined as discussed in Section II of this notice (rather than equalling one-eighth of the hospital deductible). The SNF coinsurance amount for 1989, the year the change in the statutory coinsurance formula went into effect, was $25.50 (53 FR 41242). Notice of the coinsurance amount applicable to extended care services in the succeeding year must be published in September.

As required by section 1813(a)(3) of the Act, we have determined this amount based on the law in effect at the time we were required to make the determination. We recognize that Congress is considering amendments to the Medicare provisions and that some of these amendments may affect the method of computation, estimated costs, or other amounts on which the determination was made. Unless Congress specifically mandates a change in the method of computation for this coinsurance amount, the coinsurance amount itself will not change. However, the estimate costs related to the SNF benefit could change.

II. Skilled Nursing Facility Coinsurance Amount for 1990

Before September 1 of each year, HCFA will estimate the national average per diem cost for extended care services furnished in the succeeding year. The SNF coinsurance for those extended care services is 20 percent of that estimated national average per diem cost. The amount is rounded to the nearest multiple of $.50. (If it is a multiple of $.25 but not of $.50, the amount is rounded to the next highest multiple of $.50.) The SNF coinsurance amount for calendar year 1990 is $26.50.

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

As discussed in section II of this notice, the SNF coinsurance rate for 1990 is equal to 20 percent of the estimated national average per diem cost for Medicare extended care services for 1990. The national average per diem cost is determined on a reasonable cost basis and includes any cost sharing costs paid by the beneficiary.

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

We have completed the above steps, basing our projections for 1990 on (a) current historical data from 1988 and (b) projection assumptions from the Midsession Review of the President's Fiscal Year 1990 Budget. It is estimated that in calendar year 1990 the

national average per diem cost for Medicare extended care services is $132.70. Thus, 20 percent of this cost is $26.54, and the coinsurance rate is $26.50.

IV. Costs to Beneficiaries

The coinsurance amount for 1990 represents a $1 increase from coinsurance for 1989. We estimate that in 1990 there will be about 3.35 million days subject to coinsurance at $26.50 per day versus about 3.27 million days subject to coinsurance at $25.50 per day in 1989. The increased cost to beneficiaries is about $5.39 million.

V. Regulatory Impact Statement

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

Dated: September 28, 1989.

Louis B. Hays,
Acting Administrator,
Health Care Financing Administration

Approved: October 23, 1989.

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

APPENDIX D

ANNOUNCEMENT OF THE MEDICARE PART A (HOSPITAL INSURANCE) MONTHLY PREMIUM RATE FOR THE UNINSURED AGED, FOR CALENDAR YEAR 1990 1/

SUMMARY: This notice announces the hospital insurance premium for the uninsured aged for calendar year 1990 under Medicare's hospital insurance program (Part A). The monthly Medicare Part A premium for the 12 months beginning January 1, 1990 for individuals who are not insured under the Social Security or Railroad Retirement Acts and do not otherwise meet the requirements for entitlement to Part A is $175. Section 1818(d) of the Social Security Act specifies the method to be used to determine this amount.

Effective Date: January 1, 1990.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare hospital insurance program (Medicare Part A), subject to payment of a monthly premium, of certain persons age 65 and older who are uninsured for social security

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1/ Extracted from the notice entitled "Medicare Program; Part A Premium for the Uninsured Aged for 1990," which was published in the Federal Register on November 22, 1989 (Vol. 54, No. 224, pp. 48322-48323).

or railroad retirement benefits and do not otherwise meet the requirements for entitlement to Part A. (Persons insured under the Social Security or Railroad Retirement Acts need not pay premiums for hospital insurance.)

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

Section 1818(d) of the Act, as amended by section 103 of Public Law 100-360, requires the Secretary to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services performed and for related administrative costs incurred in the following year with respect to individuals age 65 and over who will be entitled to benefits under Part A. The Secretary must then, during September of each year, determine the monthly actuarial rate (the per capita amount estimated above divided by 12) and publish the dollar amount to be applicable for the monthly premium in the succeeding year. If the premium is not a multiple of $1.00, the premium is rounded to the nearest multiple of $1.00 (or if it is a multiple of 50 cents but not of $1.00, it is rounded to the next highest $1.00). The first premium under this new method was $156 and was effective January 1989. (See 53 FR 45161; November 8, 1988.)

II. Premium Amount for 1990

Under the authority of section 1818(d)(2) of the Act (42 U.S.C. 1395i-2(d)(2)), the Secretary has determined that the monthly Medicare Part A hospital insurance premium for the uninsured aged for the 12 months beginning January 1, 1990 is $175. This premium amount is based on the law in effect at the time we were required to make this determination. We recognize that Congress is considering amendments to the Medicare provisions in the law and that, if enacted, these amendments may affect the method of computation, estimated costs, or other amounts upon which this premium determination was made.

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

As discussed in section I of this notice, the monthly premium for the uninsured aged for 1990 is equal to the estimated monthly actuarial rate for 1990 rounded to the nearest multiple of $1. The monthly actuarial rate is defined to be one-twelfth of the average per capita amount that the Secretary estimates will be paid from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in 1990 for individuals age 65 and over who will be entitled to benefits under the hospital insurance program. Thus, the number of individuals age 65 and over who will be entitled to hospital insurance benefits and the costs incurred on behalf of these beneficiaries must be projected to determine the premium rate.

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

We have completed all of the above steps, basing our projections for 1990 on (a) current historical data and (b) projection assumptions from the Midsession Review of the President's Fiscal Year 1990 Budget. It is estimated that in calendar year 1990, 30.081 million people age 65 and over will be entitled to Part A benefits (without premium payment), and that these individuals will, in 1990, incur $63.278 billion of benefits for services performed and related administrative costs. Thus, the estimated monthly average per capita amount is $175.30, and the monthly premium is $175.

IV. Costs to Beneficiaries

The 1990 Part A premium is 12 percent higher than the $156 monthly premium amount for the 12-month period beginning January 1, 1989. This increase results from the recalculation of the monthly actuarial rate described above.

The estimated cost of this increase to the approximately 19 thousand enrollees who do not otherwise meet the requirements for entitlement to hospital insurance will be about $4.33 million.

V. Regulatory Impact Statement

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

Dated: September 26, 1989.

Louis B. Hays,
Acting Administrator,
Health Care Financing Administration

Approved: October 26, 1989.

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

APPENDIX E

ANNOUNCEMENT OF THE REVISED MEDICARE PART A (HOSPITAL INSURANCE) INPATIENT HOSPITAL DEDUCTIBLE AND COINSURANCE, AND SKILLED NURSING FACILITY COINSURANCE, FOR CALENDAR YEAR 1990 1/

SUMMARY: This notice announces that the inpatient hospital deductible for calendar year 1990 under Medicare's hospital insurance program (Part A) remains the same as announced on September 29, 1989 at 54 FR 40205. However, the repeal of the Medicare Catastrophic Coverage Act of 1988 by the Medicare Catastrophic Coverage Repeal Act of 1989 restored 1988 Part A coverage and cost-sharing rules, including the benefit period provisions, coinsurance charges, and the three-day prior hospitalization requirement for skilled nursing facility (SNF) care.

Because the Part A catastrophic benefits under the Medicare Catastrophic Coverage Act of 1988 were in effect in 1989, the Medicare Catastrophic Coverage Repeal Act of 1989 included several provisions that apply to beneficiaries who were inpatients of hospitals or SNFs both at the end of 1989 and the beginning of 1990.

Effective Date: [30 days after publication in the Federal Register].

1/ Preliminary version of a notice entitled "Medicare Program; Inpatient Hospital Deductible and Coinsurance and Skilled Nursing Facility Coinsurance for 1990 Medicare," which will soon be published in the Federal Register. The announced amounts and other information in this notice, which supersede amounts and information displayed in appendices B and C, are a direct result of the Medicare Catastrophic Coverage Repeal Act of 1989, enacted December 13, 1989.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. The amount and methodology for the determination of the inpatient hospital deductible were published on September 29, 1989 at 54 FR 40205, and neither was affected by the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) or its repeal by the Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101-234). However, Pub. L. 101-234 restored the requirements in effect before enactment of Pub. L. 100-360 concerning the frequency of the application of the inpatient hospital deductible, the number of covered days, and the coinsurance provisions. The inpatient hospital deductible amount remains the same.

Pub. L. 101-234 also restored the limitations on extended care services; that is, the coinsurance structure (the applicable days and the methodology for determining the coinsurance amount), the number of covered days, and the prior hospitalization requirement that were in effect before enactment of Pub. L. 100-360 are restored.

II. Inpatient Hospital Provisions

Before the Part A provisions in Pub. L. 100-360 became effective on January 1, 1989, the inpatient hospital deductible was linked to a benefit period. A benefit period began

when a beneficiary entered a hospital and ended when he or she had not been an inpatient in a hospital or in a skilled nursing facility (SNF) for 60 days. For each benefit period, one deductible was imposed for the first 60 days of inpatient care. Days in excess of 60, and up through 90, were subject to a daily coinsurance charge in an amount equal to 1/4 of the hospital deductible. After 90 days, for hospitals excluded from the prospective payment system, the inpatient hospital coverage ended, unless the beneficiary elected to use lifetime reserve days. For hospitals paid under the prospective payment system, lifetime reserve days need not have been elected to continue inpatient hospital coverage if the beneficiary had one or more regular (that is, not lifetime reserve) benefit days available at the time of admission and the length of stay did not exceed the day outlier threshold. Each beneficiary was entitled to sixty lifetime reserve days with a daily coinsurance charge equal to 1/2 the deductible amount.

Under Section 102 of Pub. L. 100-360, a beneficiary was only responsible for one deductible per calendar year, all inpatient hospital coinsurance was abolished, and there was no limitation on the number of covered inpatient hospital days (other than the inpatient psychiatric hospital days limitations, which were not changed by Pub. L. 100-360). These provisions remained in effect only for calendar year 1989, because they were repealed by Section 101(a) of Pub. L. 101-234. Effective January 1, 1990, provisions in sections 1812, 1813, and 1861 of the Act, prior to the enactment of Pub. L. 100-360, were restored by sections 101(a) and (d) of Pub. L. 101-234, to provide that a beneficiary is no longer allowed hospital days subject to only one annual deductible, and coverage is once again linked to a benefit period. For each benefit period, one deductible is imposed for the first 60 days of care, days 61 through 90 are subject to daily coinsurance charges equal to 1/4

of the current Part A deductible amount, and lifetime reserve days as previously described in this section are again applicable.

Section 101(b)(1) of Pub. L. 101-234 prohibits days spent in a hospital or SNF before January 1, 1990, from being counted in determining the beginning date of a benefit period. Also, days spent in a hospital in 1989 are not counted in determining the amount of lifetime reserve days used, although lifetime reserve days used before 1989 are counted toward the 60-day lifetime reserve. In addition, a new inpatient hospital deductible will not apply to a beneficiary who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990, if a deductible was imposed in 1989. If a beneficiary begins a benefit period during January 1990, a new deductible will not apply if a deductible was imposed during December 1989.

III. Extended Care Services

Prior to 1989, provisions in sections 1812, 1813, and 1861 of the Act provided up to 100 days of extended care services in an SNF in a benefit period but only after the beneficiary had spent at least three consecutive covered days in a hospital. The first 20 days were paid in full and the remaining 80 days were subject to a daily coinsurance charge equal to 1/8 of the inpatient hospital deductible amount.

Effective January 1, 1989, sections 101 and 102 of Pub. L. 100-360 changed the number of SNF covered days to 150 per calendar year, eliminated the prior hospitalization requirement, and changed the coinsurance amount to 1/5 of the estimated national average

per diem reasonable cost for extended care services in calendar year 1989 for each of the first eight days of care, with the remaining days covered in full.

Effective January 1, 1990, section 101(a) of Pub. L. 101-234 repealed the SNF benefit expansions enacted by Pub. L. 100-360, and reinstated the SNF coverage provisions that were in effect prior to 1989. Thus, section 1812(a)(2) of the Act currently provides coverage for up to 100 days in a benefit period; the first 20 days are for full coverage followed by 80 coinsurance days. The coinsurance charge for each day is equal to the lesser of 1/8 of the inpatient hospital deductible amount or the actual total SNF charge per day.

Under section 101(b)(1)(c) of Pub. L. 101-234, the requirement for hospitalization prior to covered SNF services does not apply to an individual receiving covered SNF services during a continuous period that began before (and includes) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital services or extended care services.

This means that a beneficiary whose stay in a SNF (or at the SNF level of care in a swing-bed hospital) continues from 1989 into 1990 is initially exempt from the post-hospital requirement that is reinstated effective January 1, 1990, if all other requirements for Medicare payment for extended care services are met for a continuous period that includes at least December 31, 1989 and January 1, 1990. If Medicare payment cannot be made for extended care services furnished on both December 31, 1989 and January 1, 1990, this transition exemption does not apply. The exemption from the prior hospitalization requirement ceases at the end of a period of 30 consecutive days for which

no Medicare payment is made for either inpatient hospital services or extended care services.

For SNF benefit purposes, a beneficiary who is in a hospital or SNF on January 1, 1990, is considered to begin a new benefit period on that date, regardless of whether he or she used SNF benefit days prior to 1990. Consequently, a beneficiary whose stay in an SNF (or at the SNF level of care in a swing-bed hospital) began in 1989 and included more than 20 days in 1990, is required to pay the 1990 coinsurance charges even if the 1989 coinsurance charges were paid, because Pub. L. 101-234 made no transition exception for this situation.

IV. Deductible and Coinsurance Amounts

The inpatient hospital deductible for calendar year 1990 is $592 and the coinsurance amounts are $148 for the 61st through the 90th days of hospitalization and $296 for the lifetime reserve days.

The daily coinsurance amount for extended care services in a skilled nursing facility is $74 per day for the 21st to the 100th day of covered confinement.

V. Cost to Beneficiaries

For inpatient hospital services, we estimate that in 1990 there will be about 7.7 million deductibles paid at $592 each, compared to about 6.0 million deductibles paid at

$560 each in 1989. In addition, we estimate that there will be about 3.0 million coinsurance charges of $148 each (for hospital days, 60 through 90), and about 1.1 million coinsurance charges of $296 for lifetime reserve days. The estimated total increase in cost to beneficiaries is about $1,970 million (rounded to the nearest $10 million) due to the increase in the amount of the deductible, the increase in the number of deductibles paid, and the coinsurance charges.

We estimate that in 1990 there will be about 8.9 million extended care days subject to coinsurance at $74.00 per day compared with about 4.5 million days subject to coinsurance charges of $25.50 per day in 1989. The coinsurance amount for 1990 extended care services represents a $48.50 increase from the coinsurance charge for 1989. The estimated total increase in cost to beneficiaries is about $540 million (rounded to the nearest $10 million).

These increased costs to beneficiaries are direct results of the Medicare Catastrophic Coverage Repeal Act of 1989. This Act, while eliminating benefit extensions such as lower beneficiary coinsurance, also discarded the income-based supplemental premium that was to be paid by beneficiaries and that was intended to finance the benefit extensions.

VI. Regulatory Impact Statement

This notice merely announces changes enacted by legislation. This notice is neither a proposed rule nor a final rule issued after a proposal. Therefore, we have determined,

and the Secretary certifies, that no analyses are required under Executive Order 12291, the Regulatory Flexibility Act (5 U.S.C. 601 through 612), or section 1102(b) of the Act.

Dated:

Louis B. Hays,
Acting Administrator,
Health Care Financing Administration

Approved:

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

APPENDIX F

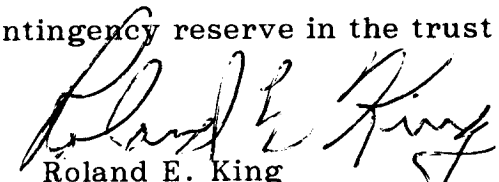
STATEMENT OF ACTUARIAL OPINION

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

The real earnings assumption is not consistent with reasonable expectations regarding future experience. There is a large discrepancy between past real earnings experience and the assumptions used in the projections, with no plausible explanation for the significant improvement which is assumed to occur in the future. During the first ten years of the projection period, the Trustees have assumed that real earnings in covered employment will increase at the rate of nearly 1.3 percent per year. This assumption is significantly different from actual experience during the ten-year period ending in 1988, when real earnings in the U.S. economy actually declined. During the 30-year period ending with 1988, real earnings increases averaged only 0.9 percent annually, but the Trustees' long-range intermediate assumption (Alternative II-B) is 1.28 percent, nearly 40 percent higher than the experience of the last 30 years.

The level-financing method used to express the long-range actuarial balance of the program is not appropriate because the Trustees have not endorsed advanced funding of the long-range deficit. In this context, the level-financing method understates the actuarial

deficit in the program by incorporating significant amounts of interest in excess of those projected to be earned. Although the hospital insurance trust fund is projected (under the Alternative II-B assumptions) to earn $144 billion in interest before it is depleted, the actuarial balance determined using the level-financing method incorporates over $50 trillion in assumed interest earnings. In addition, the actuarial balance does not provide for the cost of maintaining a minimum contingency reserve in the trust fund.



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