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.

(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 in 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 (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.

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	4.0818
1993	36.60	70.50	82.90	2.8525	3.5301
1994	41.10	61.80	76.10	2.0073	2.7032

[1] In 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.

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

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.

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	

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

[In thousands]

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

[1] A 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 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.

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] Estimated amount	1993 report[1] Actual as percentage of estimate	1992 report[1] Estimated amount	1992 report[1] 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

[1]Alternative II, which were the intermediate assumptions in those reports.
[2]Does 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 1993[1]

	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 3/4-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

[1]The 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 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.

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

Year ending June 30,	Average enrollment [millions]	All services	Physician	Outpatient 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	107.98	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
1983	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
1986	27.453	782.15	594.10	133.93	1.19	31.70	21.23
1987	28.013	905.31	671.19	164.69	0.98	42.88	25.57
1988	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

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

Year ending June 30,	Average enrollment [millions]	All services	Physician	Outpatient hospital	Home health agency[1]	GPPP[2]	Independent lab
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	31.86
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

[1]Since 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.

[2]Group practice prepayment plan

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

Year ending June 30,	Average enrollment [millions]	All services	Physician	Outpatient 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

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

Year ending June 30,	Average enrollment [millions]	All services	Physician	Outpatient hospital	Home health agency[1]	GPPP[2]	Independent lab
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	58.16	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
1983	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
1986	27.453	1,031.83	787.36	178.85	1.19	42.33	22.10
1987	28.013	1,185.89	883.26	218.24	0.98	56.82	26.59
1988	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	1,225.83	328.06	2.47	136.36	51.32
1992	30.383	1,810.86	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	383.36	83.85	6.61	5.86	5.21
1981	2.692	573.38	447.56	104.70	7.76	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	1,011.08	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

[1]Since 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.

[2]Group 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 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

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		
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

[1] The 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 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.

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

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		
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

[1]The 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

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
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

[1]Since 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.

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

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
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

[1]Since 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

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
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

[1]Since 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.

TABLE II.D8.—INCURRED REIMBURSEMENT AMOUNTS: ESTIMATES

Year ending June 30,	Average enrollment [millions]	Reimbursement amounts	
		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

TABLE II.D8.—INCURRED REIMBURSEMENT AMOUNTS: ESTIMATES

Year ending June 30,	Average enrollment (millions)	Reimbursement amounts	
		Per enrollee	Aggregate (millions)
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 299I 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	Average enrollment [thousands]		Reimbursement [millions]	
June 30,	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.

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

[1]For 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 1977-2002 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 assmumptions 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 1993-2003[1]

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

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