NALYSIS OF EXPERIENCE UNDER HOSPITAL INSURANCE PROGRAM

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ANALYSIS OF EXPERIENCE UNDER HOSPITAL INSURANCE PROGRAM

In the continuing analysis of the Hospital Insurance program, the Office of the Actuary has been particularly concerned with utilization of benefits, average costs, and amount of reimbursements. The trends in these factors have been analyzed regularly, and refinements have been made in available data to the extent possible. Emphasis has been placed on securing total data rather than a sample, in order that estimates of future costs, reimbursements due from general revenues to the Hospital Insurance Trust Fund to cover payments for noninsured beneficiaries, and annual promulgation of the inpatient hospital deductible will be based on complete and accurate data.

This Actuarial Study presents and analyzes the tabulated data, which are virtually complete as to 1966-67 and substantially complete as to 1968. This tabulation has been updated through July 11, 1969.

Source of Data

In the administration of the program, bills for services furnished to each individual beneficiary are submitted to the fiscal intermediaries for payment and are then forwarded to the Social Security Administration. Each bill is verified, both for internal consistency and by comparison with the beneficiary's master record to determine his eligibility for payment for the service. The verified bills are posted to the beneficiary records monthly. After this updating, all of the bills, for all beneficiaries, are summarized.

Each bill shows the date that the service it covers began and the date that service ended. Two tabulations are prepared, one summarizing the bills with each assigned to the month in which the benefits it covers began, and the other summarizing the same bills with each assigned to the month in which the benefits it covers ended. The information shown on a bill so assigned does not necessarily relate to a "spell of illness" (as defined in the law for benefit purposes) or to a hospital or extended care facility stay, although it may do so. If all bills were rendered on a monthly basis, there would be the same result for these two tabulations. However, most hospitals render bills for the entire duration of each stay (except that two separate

bills are prepared when the stay falls within two different fiscal years of the hospital). Thus, there is often "straddling" of two or more months in one hospital bill. Many extended care facilities now render monthly bills, although such was not the case in the early months of operation.

Analysis of the benefit experience under the program must be made on an incurred basis to eliminate the effect of administrative lag. The true values of data for services rendered in a month, on an accrual basis, should fall between the amount tabulated according to bills beginning in that month and the amount tabulated according to bills ending in that month. The summary data contained in the two tabulations of all bills are thus averaged, so as to obtain the best estimate of results for the total beneficiary population. The data presented in this analysis are derived from this average, unless otherwise indicated. A comparison of data from these two tabulations is also included.

The data are shown for total beneficiaries, and for insured and noninsured beneficiaries separately. The insured include all persons aged 65 or over who are eligible for any Social Security or Railroad Retirement monthly benefit, either as worker, dependent, or survivor, whether or not they are retired and actually receiving such benefits.

The noninsured include persons aged 65 and over who attained that age before 1968, provided they are citizens or resident aliens with at least 5 consecutive years of residence; certain retired Federal employees and their dependents, covered under a separate program, are excluded from eligibility on this basis. Noninsured persons attaining age 65 after 1967 must have some Social Security coverage to be eligible for HI benefits; the coverage requirement merges with that for monthly benefits in 1974, so that the number of noninsured persons attaining age 65 and becoming eligible for HI benefits will decline each year, reaching zero in 1975.

Benefits for insured persons are financed by payroll taxes deposited in the HI Trust Fund. Benefits for noninsured persons are paid initially from this trust fund and are subsequently reimbursed from the General Fund of the Treasury.

Brief Description of Benefit Provisions

The benefits provided relate to a "spell of illness", which

begins with the first day of hospitalization and ends when the individual has been out of both a hospital and an extended care facility for 60 consecutive days. Inpatient hospital benefits provide the cost of all hospital services in semi-private accommodations for 60 days, after an initial deductible (and a deductible for the cost of the first 3 pints of blood), and for 30 additional days with daily coinsurance equal in amount to 25% of the initial deductible. Beginning in 1968, an additional lifetime reserve of 60 days with daily coinsurance equal in amount to 50% of the initial deductible is available for use at any time. The term "hospital services" does not include any physician services, except those of interns and residents-in-training under approved teaching programs. Certain special duration limitations apply to inpatient psychiatric hospitalization (notably, a lifetime maximum benefit period of 190 days).

Extended care facility benefits, first available in 1967, are provided following at least 3 days of hospitalization (and within 14 days thereof), for 100 days in a spell of illness, with daily coinsurance equal in amount to 12½% of the initial deductible, for all days after the 20th.

Home health service benefits of 100 visits are available in the year following discharge from a hospital or extended care facility (if there was hospitalization of at least 3 days and the home health service plan was established within 14 days of discharge from the hospital or ECF).

Outpatient hospital diagnostic service benefits, available from July 1966 through March 1968, covered 80% of the cost of the non-physician component of such services after a deductible of $20, for services rendered by the same hospital in a 20-day period.

The inpatient hospital deductible (from which the several daily coinsurance amounts are determined) was specified by the law to be $40 for July 1966 through December 1968. Thereafter, it varies with changes in the average daily cost of hospitalization for insured persons, and is $44 for 1969.

Extent of Lag

The tabulation summarizing bills by the month in which benefits began has been analyzed regularly since the inception of the program. On the average, about 75% of total interim reimbursements for benefits beginning in a given month are processed during the succeeding 3 months. It is not possible to eliminate

the effect of adjustment bills correcting errors in bills already processed, so as to assess exactly the extent of true delayed processing of old bills, including those rejected for error, returned to the intermediaries, and resubmitted. It is expected that data for a month will be largely complete in about 1 year, with small changes occurring for about 2 more years.

Table 1 shows percentages of total reimbursements processed in the tabulation covering bills received for tabulation in the period, June 13 through July 11, 1969 relative to those processed in all previous tabulations as well as this one, by type of benefit.

The amounts for 1966, about 0.2% of the total, are somewhat higher than might be expected after the passage of 2½ years. This is due in part to (a) current clearing of backlogs of open items and adjustment bills and (b) insofar as inpatient hospital benefits are concerned, bills just received as a result of the provision in the 1967 Amendments permitting limited payment for nonemergency hospitalization in 1966-67 in hospitals not participating in the program.

For this month's update, the amounts added for 1966 and 1967 are less than 0.5%, and for the first six months of 1968 are less than 1%. Even for December 1968, the lag is only about 2-3% of the total.

Inpatient hospital reimbursements, representing 92% of the total, appear to be the most nearly complete, with extended care and home health showing somewhat more lag. For outpatient diagnostic services, not provided after March 1968, bill processing appears to be virtually complete, with about 0.05% of total reimbursements processed in the latest tabulation.

Inpatient Hospital Benefits

Inpatient hospital benefits represent the major part of the HI program, accounting for 92% of total reimbursements for the first 2½ years of operation.

Inpatient hospital utilization rates for each month since the inception of the program are derived from the average of the days of care reported in bills covering a period beginning in the month and bills covering a period ending in the month. The rates are obtained by applying the appropriate factor for each month to annualize the data according to the number of days in the

month, and then dividing by the estimated number of persons eligible for benefits. The data for 1966 are virtually complete, but a small proportion of data are not yet in for 1967, and a larger proportion for 1968 (especially the second half of the year).

Results for the tabulated data for first 2 years of operation, without adjustment for incurred but not reported or processed claims, are summarized as follows:

Period	Type of Beneficiary		
	Total	Insured	Noninsured
Inpatient Hospital Utilization Rates (days per person per year)			
July-December 1966	3.71	3.57	4.64
January-June 1967	3.86	3.73	4.82
July 1966-June 1967	3.78	3.65	4.73
July-December 1967	3.73	3.60	4.77
January-June 1968	4.01	3.86	5.16
July 1967-June 1968	3.87	3.74	4.97
Percent Increase over Corresponding Period of Preceding Year			
July-December 1967	0.7%	0.7%	2.8%
January-June 1968	3.8	3.7	7.0
July 1967-June 1968	2.4	2.4	5.0

If the foregoing data are adjusted for estimated incompleteness of reporting, the results are as follows:

Period*	Type of Beneficiary		
	Total	Insured	Noninsured
	Inpatient Hospital Utilization Rates (days per person per year)		
July-December 1966 (½%)	3.73	3.59	4.66
January-June 1967 (1¼%)	3.91	3.78	4.88
July 1966-June 1967 (7/8%)	3.81	3.68	4.77
July-December 1967 (2-3/4%)	3.83	3.70	4.90
January-June 1968 (4-1/2%)	4.19	4.03	5.39
July 1967-June 1968 (3-5/8%)	4.01	3.88	5.15
	Percent Increase over Corresponding Period of Previous Year		
July-December 1967	2.7%	3.1%	5.2%
January-June 1968	7.2	6.6	10.5
July 1967-June 1968	5.2	5.4	8.0

*Figures in parentheses are adjustments for incomplete reporting.

With respect to both total and insured beneficiaries, the rates for January-June 1967, adjusted for estimated incompleteness, are about 5% higher than for the preceding 6 months, and then decline about 2% in July-December 1967. The rates for the last half of 1967 are about 3% above the rates for the last half of 1966. Part of these trends is due to hospital utilization generally being somewhat higher in the first half of the calendar year than in the second half. The rates for January-June 1968 are about 7% higher than the corresponding period of 1967 and 9% higher than the preceding 6 months. The rates for noninsured beneficiaries are about 30% higher than for insured and show a greater rate of increase, due in large part to the increasingly higher average age of this virtually closed group.

Table 2 shows the utilization rates unadjusted for incurred but not reported or processed claims by months by type of beneficiary. The data for July-September 1966 are affected both by hospitalization delayed until the program started, and by persons already hospitalized on July 1. This resulted in a heavy beginning incidence in July and a heavy ending incidence in September when the 90 days of hospitalization provided under the program was exhausted. The rates are lower for December, when hospitalization is generally at a lower level because of the holiday season. Starting with October 1967, the rate for each of the next 10 months is higher than the rate for the corresponding month one year earlier. There will be some further increase in the rates, especially for 1968, when all lag in tabulated bills is eliminated.

The trend of the cost of inpatient hospital services is of major importance in determining the future cost of the HI program. The average daily cost--interim reimbursements to the hospital from the program, plus the deductible and coinsurance amounts for which the beneficiary is responsible, is shown in Table 3 for various periods by type of beneficiary. The effect of the incomplete reporting, especially significant for the latter periods, is relatively minor as to the average daily costs (unlike the situation for utilization rates); from previous tabulations, it appears that generally, as the tabulation for a period becomes more complete, the average cost decreases slightly.

The average daily cost was significantly lower for July 1966, because of the carryover into this month of many persons who had been hospitalized earlier and who were in the long-duration portion of their hospital stays, when the daily cost tends to be lower. For total beneficiaries, beginning with the higher figure of $36.47 for August 1966, there was a steady increase in the following months, except for September 1966, when there was a heavy incidence of benefits exhausted. During the 24-month period from August 1966 through July 1968, the increase in average daily cost was 34%, an annual rate of increase of about 16%. This large increase may be due in part to the fact that interim reimbursements for later months may be closer to actual cost minus cost-sharing payments received from beneficiaries than in the early months, when on the average they were too low, thus resulting in a larger apparent differential.

The average daily cost for noninsured beneficiaries is about 10% lower than for insured persons. The reason is probably the longer average stay for noninsured, because they are older, which results in a lower average daily cost (although a higher total cost per stay).

The average daily cost of hospitalization for insured beneficiaries is the basis for the annual determination of the inpatient hospital deductible. This is done by multiplying $40 by the ratio of the average daily cost in the preceding year to the average daily cost in 1966 (then rounding to the nearest multiple of $4). Promulgation of the amount determined is made in the third quarter of the year and is effective for spells of illness beginning in the following year. The annual averages are shown below:

Year	Average Daily Cost	Ratio to 1966 Average	Ratio Times $40
1966	$37.95	--	--
1967	42.95	1.132	$45.28
1968	49.34	1.300	52.00

These data confirm the inpatient hospital deductible of $44 effective for 1969, and determine that the amount for 1970 will be $52.

The average reimbursement per day, which excludes the effect of deductibles and coinsurance, is compared with the average daily cost for various years and beneficiary categories, as follows:

Type of Beneficiary	Year	Average Daily Cost	Average Daily Reimbursement	
			Amount	Percent of Cost
Total	1966	$37.28	$34.33	92.1%
	1967	42.29	39.42	93.2
	1968	48.60	45.50	93.6
Insured	1966	37.95	34.98	92.2
	1967	42.95	40.06	93.3
	1968	49.34	46.24	93.7
Noninsured	1966	33.74	30.84	91.4
	1967	38.57	35.77	92.7
	1968	43.91	40.82	93.0

In considering the foregoing data, it should be recognized that the cost-sharing provisions affect the reimbursements in an aggregate manner and not uniformly on a day-by-day basis, as might seem to be indicated by the presentation of data on an average daily basis.

The reimbursement for insured beneficiaries has increased from 92.1% of cost in 1966 to 93.6% in 1968, reflecting the diminished effect of the $40 deductible and the $10 daily coinsurance in the face of rising hospital costs. It should be kept in mind that the cost-sharing provisions were on a static basis during 1966-68, but that thereafter they are on a dynamic basis, being adjusted to changes in hospital costs. The $20 coinsurance rate for lifetime reserve days, first available in 1968, no doubt served to prevent an even larger increase. For noninsured persons, the percentage is slightly lower than for insured persons in each year, probably due to a relatively higher use of coinsurance days. The average daily reimbursement, by months, is shown in Table 4.

<u>Extended Care Facility Benefits</u>

This benefit was first available in January 1967, and represents about 8% of reimbursements since that time. Table 5 shows the utilization rates separately for total, insured, and noninsured beneficiaries. The rates, without taking into account the claims incurred but not reported or processed, are relatively level at about 1.0 day per person per year for total beneficiaries and about 1.8 days per person per year for the noninsured. This higher rate for the noninsured probably arises because of the much older average age of this group. If adjustment is made for claims incurred but not reported, there would probably be shown a slowly rising trend of utilization.

Table 6 shows the average daily cost by months, by type of beneficiary. The increase from 1967 to 1968 was about 16%. The average daily cost is slightly lower (about 6%) for noninsured than for insured beneficiaries, again probably due to their longer average stay.

The average daily cost may be compared with the average daily reimbursement from the program, thus excluding the effect of the daily coinsurance for which the beneficiary is responsible for the 21st day through the 100th day, as follows:

Type of Beneficiary	Year	Average Daily Cost	Average Daily Reimbursement	
			Amount	Percent of Cost
Total	1967	$17.32	$13.92	80.4%
	1968	20.02	16.70	83.4
Insured	1967	17.52	14.15	80.8
	1968	20.26	16.97	83.8
Noninsured	1967	16.58	13.08	78.9
	1968	19.00	15.57	81.9

The reimbursement as a percentage of cost has increased for both insured and noninsured beneficiaries, probably largely because costs increased about 16% between the two years, while the co-insurance rate was unchanged. These data indicate that the average length of stay for total beneficiaries is about 60 days (since, for a stay of 60 days and an average daily cost of $20.02, the reimbursement proportion is 83.3%), and is about 5 days longer for noninsured beneficiaries than for insured beneficiaries. The average daily reimbursement by months is shown in Table 7.

Home Health Services Benefits

The utilization rate for home health services, shown by months in Table 8, has increased substantially--from 7 visits per 100 persons per year in 1966 to 15 in 1967 and 19 in 1968 (and the latter figure will be somewhat higher when all data are reported). The utilization rate for noninsured persons is higher than that for insured beneficiaries (by 39% in 1968)--and increased much more rapidly.

The average reimbursement per visit (no cost-sharing by the beneficiary is involved in this benefit), shown by months in Table 9, increased from $7.76 in 1966 to $9.69 in 1968, an increase of 25%, or almost as much as the increase in the average daily cost of hospitalization. The average reimbursement per visit is virtually the same for insured and noninsured beneficiaries (the latter, however, being consistently about 1% lower).

Outpatient Diagnostic Services Benefits

Effective April 1, 1968, this benefit was transferred to the Supplementary Medical Insurance program and is no longer provided in connection with the HI program.

No meaningful data on utilization and average cost are available, because one outpatient visit may involve a simple treatment or a series of complex laboratory tests. Also, tests may be performed without requirement for the patient's presence, so that a bill might show zero visits and still contain a reimbursable cost. Therefore, no real significance can be attached to average costs or to average payments.

Aggregate reimbursements for this service from July 1966 through March 1968 were $12 million, about 0.2% of total reimbursements during that period.

Benefit Reimbursements

Although efforts are made by the Social Security Administration, in accordance with the intent of the law, to reimburse hospitals and extended care facilities on an accrual basis, not all hospitals have taken advantage of such procedures. For such hospitals, there is a lag in filing and in adjudicating claims. This was particularly true in the early months of operation, and is still true to some extent.

Another complicating factor is that current payments are on an interim basis, subject to later adjustment when final cost audit is made at the end of the provider's fiscal year. In the long run, such adjustments should be relatively small, as providers and intermediaries become familiar with the reimbursement principles. However, in the initial period of operation, the interim payments were, on the average, too low (by somewhat more than 5%).

For the 2½-year period, July 1966 to December 1968, interim reimbursements with respect to noninsured persons represented 13.5% of the total, decreasing from 14.3% in fiscal year 1967 to 13.6% in fiscal year 1968 to 12.2% in the first 6 months of fiscal year 1969 (see Table 10). The proportion will continue to decrease over the long run, as the noninsured population declines in size. The proportion was slightly lower for inpatient hospital benefits and considerably higher for extended care facility benefits, as follows for the 2½-year period (amounts in millions):

Benefit	Type of Beneficiary			Percent Noninsured of Total
	Total	Insured	Noninsured	
Inpatient Hospital	$7,520	$6,534	$986	13.1%
Extended Care	590	478	112	19.0
Home Health	66	56	10	15.2
Outpatient Diagnostic	12	11	1	10.7
Total	8,188	7,079	1,109	13.5

Table 11 shows interim reimbursements for inpatient hospital benefits by months. Since they represent about 92% of total reimbursements, the trends shown are the same as in Table 10, with the proportion for the noninsured declining from 14% in fiscal year 1967 to 13% in fiscal year 1968.

The average monthly interim reimbursements for extended care facility benefits are currently about $28 million, when allowance is made for the incompleteness of the data (see Table 12), or about 8% of total HI reimbursements. The reimbursements with respect to noninsured beneficiaries represented 21% of the total in fiscal year 1967 and 19% in fiscal year 1968.

Table 13 shows that the monthly interim reimbursements for home health benefits have increased significantly, rising to $1 million by the end of 1966, and continuing to rise to $3 million by the end of 1968 (after making allowance for the incompleteness of the data). Reimbursement amounts with respect to noninsured persons account for about 15% of the total throughout the period, appreciably more than for inpatient hospital benefits.

Outpatient diagnostic benefit interim reimbursements, shown in Table 14 by months, represent a minute portion of the total, averaging only about $500,000 per month. Noninsured reimbursements therefor represent only about 11%--lower than for any other category of benefit.

Analyses such as those in Table 10 are the foundation of reliable estimates of the necessary transfers from the General Fund of the Treasury to the HI Trust Fund for benefits paid with respect to noninsured persons. There will be adjustments to take into account the final settlements made with the providers of service, after total reasonable costs for hospital insurance beneficiaries are compared with total interim payments plus cost-sharing amounts.

To date, the reimbursements from the General Fund of the Treasury to the HI Trust Fund with respect to HI benefit costs of noninsured persons have been computed, for each fiscal year, by multiplying the benefit expenditures from the trust fund by the percentage that interim reimbursements on an accrual basis for noninsured persons is of such reimbursements for total persons.

Cost-Sharing

Cost-sharing payments made by eligible beneficiaries have represented about 9% of total reimbursements by the HI program in the first 2½ years of operation, from July 1966 through December 1968. During this period, based on data tabulated through July 11, 1969, these payments were $734 million, as follows (amounts in millions):

Item	Cost-Sharing Payments: Amount	Cost-Sharing Payments: Percent of Reimbursements
Inpatient Hospital	$548	7.3%
$40 deductible	437	5.8
$10 coinsurance*	111	1.5
Extended Care Facility		
$5 coinsurance	130	22.0
Outpatient Diagnostic	56	456.6
$20 deductible	53	431.5
20% coinsurance	3	25.0
Total Cost-Sharing	734	9.0

*$20 coinsurance for lifetime reserve days in 1968.

Elimination of such provisions would have increased the program's cost by at least this amount, and probably by much more, because there would then have been increased utilization. The outpatient diagnostic deductible saving was actually much larger than the $56 million shown, because claims of less than $20 were not submitted in many cases, and further they were not recorded when submitted. It should be noted, however, that the $20 deductible was available for utilization for benefit payments under the Supplementary Medical Insurance program.

Table 15 shows more details on interim reimbursements and cost-sharing payments (deductibles and coinsurance) for 1966-68, by type of benefit and by type of beneficiary.

For insured beneficiaries, the inpatient hospital deductible has decreased from 7.1% of interim reimbursements in 1966 to 5.9% in 1967 and 5.2% in 1968, reflecting the effect of the static deductible during this period of increasing hospital costs. The percentages for noninsured persons were slightly higher. Coinsurance was about 1.5% of interim reimbursements for insured persons and 2% for noninsured persons, being higher for the latter due to their longer average stay and to their higher use of lifetime reserve days (with a higher coinsurance rate) in 1968.

Coinsurance for extended care facility benefits for insured beneficiaries declined from 24% of interim reimbursements in 1967 to 19% in 1968. The percentage for noninsured persons also declined, from 27% to 22%. The higher proportion for 1967 than for 1968 reflects the longer duration of stay in the initial months of availability of this benefit.

Incidence of Benefits

The foregoing data were derived from average of the data tabulated separately for bills beginning in the month and for bills ending in the month. They do not necessarily, therefore, relate precisely to services furnished during a month. Some variation results from seasonal patterns in the utilization of services, and some from billing practices. Some providers bill monthly, and some render a bill at the end of a hospital or extended care facility stay, or at the end of a plan of home health treatment. Providers are required to submit a bill for all services rendered at the end of their accounting period, even though services are still being supplied, for purposes of interim reimbursement adjustments with the final cost reports.

Table 16 shows inpatient hospital days separately for the two tabulations, as compared with the average. After the initial months of operation of the program, the range between the two tabulations is relatively small except for December-January, with a high ending incidence in December due to the holiday season. There is an exception for March-April 1968, which may represent a change in accounting year, since providers may select an accounting period when accountants are not pressed with annual statements and tax returns.

Table 17 shows similar data for extended care facility days, again with relatively small variation after the initial months. In fact, there tends to be less variation than for inpatient hospital days. Probably this is the case because extended care facilities much more frequently bill on a monthly basis, whereas hospitals generally bill only after the stay has been completed.

For home health agency visits, there is considerably more range between the two tabulations, as shown in Table 18. This occurs in part because a series of visits lasting 2 or 3 weeks, but spanning 2 calendar months, may not be billed until after the final visit. In addition, the same providers also supply services under the Supplementary Medical Insurance program, for which separate bills must be submitted for services rendered in two calendar years. This practice may account for the high "ending" bills in December and "beginning" bills in January.

The pattern for total interim reimbursements follows that for the other items considered, and is summarized by months in Table 19.

On an annual basis, the variation as between the beginning-month data and the ending-month data is minimal, as shown below:

Item	Range as Percent of Average		
	1966	1967	1968
Inpatient Hospital Days	14%	*	2%
Extended Care Facility Days	--	4%	2
Home Health Agency Visits	9	1	*
Interim Reimbursements	14	1	1

*Less than 0.5%.

Table 1

PERCENT OF REIMBURSEMENTS PROCESSED IN LATEST TABULATION, TOTAL BENEFICIARIES

Period	Inpatient Hospital	Extended Care	Home Health
Bills Beginning in Period			
1966	.2%	-	.3%
1967	.3	.4%	.3
1968	.8	1.1	1.2
January-June 1968	.4	.6	.7
July-December 1968	1.1	1.6	1.6
Bills Ending in Period			
1966	.2%	-	.3%
1967	.3	.3%	.3
1968	.6	1.0	1.1
January-June 1968	.4	.6	.5
July-December 1968	.8	1.4	1.6

Table 2

INPATIENT HOSPITAL UTILIZATION RATES[a]

Days Per Person Per Year

Period		Type of Beneficiary: Total	Insured	Noninsured
1966:	July	3.92	3.74	5.13
	August	3.55	3.43	4.36
	September	3.88	3.71	5.02
	October	3.69	3.57	4.45
	November	3.68	3.57	4.46
	December	3.54	3.42	4.38
	Year	3.71	3.57	4.64
1967:	January	3.90	3.77	4.89
	February	3.81	3.68	4.72
	March	3.88	3.75	4.84
	April	3.90	3.77	4.88
	May	3.87	3.73	4.84
	June	3.79	3.65	4.79
	July	3.67	3.54	4.72
	August	3.62	3.48	4.63
	September	3.70	3.57	4.65
	October	3.79	3.66	4.82
	November	3.80	3.67	4.83
	December	3.82	3.67	4.98
	Year	3.80	3.66	4.80
1968:	January	4.29	4.11	5.76
	February	4.03	3.88	5.22
	March	4.03	3.89	5.13
	April	3.98	3.84	5.06
	May	3.88	3.75	4.90
	June	3.83	3.70	4.90
	July	3.73	3.60	4.81
	August	3.60	3.48	4.58
	September	3.68	3.57	4.68
	October	3.72	3.61	4.63
	November	3.66	3.56	4.53
	December	3.68	3.58	4.51
	Year	3.84	3.71	4.90

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 3

INPATIENT HOSPITAL AVERAGE DAILY COSTS[a/]

Period		Type of Beneficiary		
		Total	Insured	Noninsured
1966:	July	$34.81	$35.59	$30.96
	August	36.47	37.11	33.03
	September	36.27	37.04	32.40
	October	38.22	38.80	35.04
	November	38.82	39.39	35.66
	December	39.35	39.95	36.07
	Year	37.28	37.95	33.74
1967:	January	39.75	40.37	36.33
	February	40.58	41.18	37.21
	March	40.90	41.50	37.55
	April	41.42	42.07	37.75
	May	41.75	42.39	38.11
	June	41.90	42.55	38.21
	July	42.19	42.84	38.50
	August	42.68	43.37	38.81
	September	43.23	43.87	39.48
	October	43.73	44.42	39.74
	November	44.49	45.18	40.43
	December	44.86	45.54	40.93
	Year	42.29	42.95	38.57
1968:	January	45.02	45.75	40.87
	February	46.16	46.89	41.84
	March	46.96	47.69	42.53
	April	47.37	48.10	42.89
	May	48.27	49.00	43.74
	June	48.27	49.03	43.48
	July	48.70	49.44	44.09
	August	49.31	50.03	44.72
	September	49.97	50.69	45.25
	October	50.70	51.42	45.92
	November	51.38	52.11	46.43
	December	52.01	52.73	47.06
	Year	48.60	49.34	43.91

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 4

INPATIENT HOSPITAL AVERAGE DAILY REIMBURSEMENTS[a]

Period		Type of Beneficiary		
		Total	Insured	Noninsured
1966:	July	$31.48	$32.23	$27.78
	August	33.68	34.31	30.34
	September	33.31	34.08	29.39
	October	35.37	35.92	32.27
	November	35.95	36.51	32.85
	December	36.45	37.04	33.22
	Year	34.33	34.98	30.84
1967:	January	36.89	37.50	33.55
	February	37.72	38.31	34.41
	March	38.02	38.61	34.73
	April	38.53	39.17	34.94
	May	38.86	39.49	35.32
	June	38.97	39.61	35.37
	July	39.33	39.97	35.74
	August	39.80	40.46	36.00
	September	40.33	40.95	36.68
	October	40.89	41.56	36.95
	November	41.65	42.32	37.67
	December	41.96	42.63	38.12
	Year	39.42	40.06	35.77
1968:	January	41.95	42.69	37.77
	February	43.09	43.82	38.74
	March	43.79	44.51	39.41
	April	44.31	45.04	39.83
	May	45.14	45.85	40.63
	June	45.11	45.87	40.33
	July	45.60	46.34	40.99
	August	46.20	46.92	41.65
	September	46.83	47.55	42.13
	October	47.66	48.37	42.89
	November	48.37	49.10	43.43
	December	48.89	49.59	43.99
	Year	45.50	46.24	40.82

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 5

EXTENDED CARE FACILITY UTILIZATION RATES[a/]
Days Per Person Per Year

Period		Type of Beneficiary		
		Total	Insured	Noninsured
1967:	January	.85	.74	1.63
	February	.92	.81	1.67
	March	1.12	.99	2.04
	April	1.17	1.04	2.18
	May	1.01	.90	1.79
	June	1.03	.92	1.85
	July	1.04	.92	1.88
	August	1.05	.93	1.90
	September	1.04	.93	1.88
	October	1.03	.92	1.87
	November	1.01	.91	1.85
	December	1.00	.89	1.82
	Year	1.02	.91	1.86
1968:	January	1.03	.92	1.88
	February	1.07	.96	1.94
	March	1.07	.96	1.98
	April	1.05	.94	1.90
	May	1.00	.90	1.80
	June	.98	.89	1.75
	July	.98	.89	1.75
	August	.95	.86	1.70
	September	.91	.83	1.62
	October	.88	.80	1.53
	November	.85	.78	1.48
	December	.82	.76	1.42
	Year	.97	.87	1.73

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 6

EXTENDED CARE FACILITY AVERAGE DAILY COSTS[a/]

Period		Type of Beneficiary		
		Total	Insured	Noninsured
1967:	January	$15.84	$16.01	$15.28
	February	16.33	16.49	15.77
	March	16.55	16.70	16.00
	April	16.68	16.86	16.04
	May	17.18	17.37	16.47
	June	17.37	17.56	16.65
	July	17.51	17.73	16.70
	August	17.67	17.88	16.90
	September	17.84	18.06	17.04
	October	18.06	18.27	17.24
	November	18.21	18.42	17.41
	December	18.32	18.55	17.44
	Year	17.32	17.52	16.58
1968:	January	18.67	18.89	17.82
	February	18.97	19.21	18.06
	March	19.18	19.43	18.21
	April	19.54	19.79	18.52
	May	19.74	19.98	18.75
	June	19.95	20.18	18.96
	July	20.20	20.43	19.27
	August	20.40	20.63	19.43
	September	20.64	20.86	19.66
	October	21.04	21.27	20.00
	November	21.26	21.50	20.14
	December	21.35	21.58	20.25
	Year	20.02	20.26	19.00

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 7

EXTENDED CARE FACILITY AVERAGE DAILY REIMBURSEMENTS[a/]

Period		Type of Beneficiary		
		Total	Insured	Noninsured
1967:	January	$13.72	$13.92	$13.05
	February	12.97	13.17	12.27
	March	12.87	13.06	12.21
	April	13.03	13.24	12.29
	May	13.74	13.96	12.94
	June	13.91	14.13	13.08
	July	14.02	14.27	13.11
	August	14.19	14.42	13.32
	September	14.36	14.60	13.47
	October	14.60	14.84	13.70
	November	14.76	15.00	13.85
	December	14.89	15.15	13.90
	Year	13.92	14.15	13.08
1968:	January	15.33	15.57	14.40
	February	15.68	15.93	14.68
	March	15.84	16.12	14.75
	April	16.12	16.41	14.95
	May	16.40	16.68	15.28
	June	16.63	16.89	15.55
	July	16.88	17.13	15.84
	August	17.07	17.33	15.99
	September	17.30	17.56	16.18
	October	17.77	18.03	16.60
	November	18.03	18.30	16.82
	December	18.13	18.39	16.93
	Year	16.70	16.97	15.57

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 8

HOME HEALTH SERVICES UTILIZATION RATES[a]
Visits Per Person Per Year

Period		Type of Beneficiary		
		Total	Insured	Noninsured
1966:	July	.02	.02	.02
	August	.04	.04	.04
	September	.06	.06	.06
	October	.08	.08	.09
	November	.09	.09	.10
	December	.11	.11	.13
	Year	.07	.06	.07
1967:	January	.12	.11	.14
	February	.12	.11	.14
	March	.14	.13	.16
	April	.14	.14	.17
	May	.15	.15	.19
	June	.17	.16	.21
	July	.15	.15	.20
	August	.16	.15	.21
	September	.17	.16	.22
	October	.18	.17	.23
	November	.16	.16	.21
	December	.18	.17	.24
	Year	.15	.15	.19
1968:	January	.19	.18	.25
	February	.17	.16	.23
	March	.19	.18	.25
	April	.20	.19	.26
	May	.19	.18	.25
	June	.19	.18	.25
	July	.19	.18	.26
	August	.18	.17	.24
	September	.18	.18	.26
	October	.20	.19	.28
	November	.18	.17	.25
	December	.19	.18	.27
	Year	.19	.18	.25

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 9

HOME HEALTH SERVICES AVERAGE REIMBURSEMENT PER VISIT[a/]

Period		Type of Beneficiary		
		Total	Insured	Noninsured
1966:	July	$7.39	$7.41	$7.24
	August	7.50	7.53	7.33
	September	7.64	7.65	7.60
	October	7.73	7.75	7.64
	November	7.89	7.88	7.91
	December	7.90	7.91	7.86
	Year	7.76	7.77	7.71
1967:	January	8.10	8.11	8.04
	February	8.19	8.21	8.09
	March	8.34	8.35	8.29
	April	8.49	8.50	8.46
	May	8.62	8.63	8.57
	June	8.67	8.68	8.59
	July	8.83	8.85	8.73
	August	8.84	8.85	8.76
	September	8.93	8.95	8.85
	October	9.06	9.09	8.91
	November	9.13	9.16	8.97
	December	9.21	9.23	9.09
	Year	8.75	8.77	8.66
1968:	January	9.36	9.38	9.24
	February	9.35	9.36	9.28
	March	9.33	9.36	9.17
	April	9.40	9.42	9.32
	May	9.54	9.54	9.53
	June	9.53	9.55	9.41
	July	9.75	9.75	9.72
	August	9.85	9.84	9.86
	September	9.94	9.94	9.90
	October	9.92	9.93	9.85
	November	10.12	10.13	10.07
	December	10.19	10.19	10.18
	Year	9.69	9.70	9.63

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 10

INTERIM REIMBURSEMENTS, BY TYPE OF BENEFICIARY[a]
(in millions)

Period		Total	Insured	Noninsured	Percent Noninsured of Total
1966:	July	$198	$168	$30	14.99%
	August	193	165	28	14.25
	September	202	173	30	14.59
	October	211	182	29	13.93
	November	208	179	29	13.89
	December	211	181	30	14.08
1967:	January	255	217	37	14.67
	February	230	197	33	14.40
	March	266	228	39	14.47
	April	264	226	38	14.34
	May	271	233	38	14.19
	June	259	223	37	14.18
Fiscal Year 1967		2,769	2,372	397	14.33
1967:	July	264	227	38	14.29
	August	264	227	37	14.13
	September	264	228	37	13.87
	October	283	245	39	13.74
	November	280	241	38	13.65
	December	292	251	41	13.94
1968:	January	326	281	46	14.02
	February	297	257	40	13.49
	March	323	280	43	13.26
	April	312	271	41	13.11
	May	320	278	41	12.88
	June	306	266	39	12.86
Fiscal Year 1968		3,530	3,051	479	13.58
1968:	July	312	272	40	12.95
	August	306	267	39	12.75
	September	306	267	38	12.49
	October	324	285	39	12.18
	November	313	276	37	11.95
	December	328	289	38	11.74

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 11

INPATIENT HOSPITAL INTERIM REIMBURSEMENTS[a/]
(in millions)

Period		Type of Beneficiary			Percent Noninsured of Total
		Total	Insured	Noninsured	
1966:	July	$198	$168	$30	15.0%
	August	192	165	27	14.3
	September	201	172	29	14.6
	October	210	181	29	13.9
	November	207	178	29	13.9
	December	209	179	29	14.1
1967:	January	233	201	33	14.0
	February	211	182	29	13.9
	March	240	207	33	13.8
	April	237	205	32	13.7
	May	246	212	34	13.7
	June	234	202	32	13.6
Fiscal Year 1967		2,618	2,251	367	14.0
1967:	July	237	204	33	13.7
	August	237	205	32	13.5
	September	238	206	32	13.3
	October	255	222	34	13.2
	November	253	220	33	13.1
	December	264	229	36	13.4
1968:	January	297	256	40	13.6
	February	268	233	35	13.0
	March	291	254	37	12.7
	April	282	246	35	12.6
	May	290	254	36	12.4
	June	277	242	34	12.4
Fiscal Year 1968		3,187	2,772	416	13.0
1968:	July	282	247	35	12.4
	August	276	242	34	12.2
	September	277	244	33	12.0
	October	295	260	35	11.7
	November	285	253	33	11.5
	December	300	266	34	11.3

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 12

EXTENDED CARE FACILITY INTERIM REIMBURSEMENTS[a/]
(in thousands)

Period		Type of Beneficiary			Percent Noninsured of Total
		Total	Insured	Noninsured	
1967:	January	$18,942	$14,683	$4,259	22.5%
	February	17,484	13,797	3,687	21.1
	March	23,389	18,467	4,923	21.0
	April	24,118	19,037	5,081	21.1
	May	22,643	18,102	4,541	20.1
	June	22,772	18,231	4,541	19.9
Fiscal Year 1967		129,348	102,318	27,031	20.9
1967:	July	23,845	19,090	4,755	19.9
	August	24,412	19,554	4,857	19.9
	September	23,764	19,074	4,690	19.7
	October	24,689	19,857	4,832	19.6
	November	23,876	19,207	4,669	19.6
	December	24,522	19,784	4,739	19.3
1968:	January	26,048	21,033	5,016	19.3
	February	25,784	20,896	4,888	19.0
	March	28,074	22,732	5,341	19.0
	April	27,037	22,031	5,007	18.5
	May	27,084	22,145	4,940	18.2
	June	26,144	21,435	4,709	18.0
Fiscal Year 1968		305,278	246,837	58,442	19.1
1968:	July	27,394	22,453	4,940	18.0
	August	26,997	22,182	4,815	17.8
	September	25,285	20,858	4,427	17.5
	October	25,998	21,571	4,427	17.0
	November	24,736	20,580	4,156	16.8
	December	24,880	20,771	4,109	16.5

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 13

HOME HEALTH SERVICE INTERIM REIMBURSEMENTS[a/]
(in thousands)

Period		Type of Beneficiary Total	Insured	Noninsured	Percent Noninsured of Total
1966:	July	$211	$181	$30	14.1%
	August	521	453	67	12.9
	September	733	637	96	13.1
	October	971	833	138	14.2
	November	1,081	925	156	14.4
	December	1,380	1,177	203	14.7
1967:	January	1,527	1,305	223	14.6
	February	1,404	1,204	201	14.3
	March	1,846	1,581	264	14.3
	April	1,908	1,627	281	14.7
	May	2,161	1,842	319	14.7
	June	2,267	1,932	335	14.8
Fiscal Year 1967		16,010	13,698	2,312	14.4
1967:	July	2,242	1,909	333	14.9
	August	2,336	1,987	349	14.9
	September	2,373	2,015	358	15.1
	October	2,635	2,245	390	14.8
	November	2,401	2,057	344	14.3
	December	2,749	2,346	403	14.7
1968:	January	2,875	2,455	421	14.6
	February	2,471	2,112	359	14.5
	March	2,861	2,435	426	14.9
	April	2,944	2,513	432	14.7
	May	2,934	2,508	426	14.5
	June	2,827	2,420	407	14.4
Fiscal Year 1968		31,649	27,002	4,647	14.7
1968:	July	3,101	2,657	444	14.3
	August	2,894	2,473	421	14.6
	September	2,936	2,508	428	14.6
	October	3,285	2,810	475	14.5
	November	2,883	2,464	419	14.5
	December	3,247	2,772	476	14.6

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 14

OUTPATIENT DIAGNOSTIC INTERIM REIMBURSEMENTS[a/]
(in thousands)

Period		Type of Beneficiary			Percent Noninsured of Total
		Total	Insured	Noninsured	
1966:	July	$404	$357	$47	11.7%
	August	478	422	56	11.7
	September	459	407	53	11.5
	October	513	457	56	11.0
	November	494	439	54	11.0
	December	453	404	48	10.7
1967:	January	566	507	59	10.3
	February	509	453	56	11.0
	March	619	555	65	10.4
	April	589	525	64	10.9
	May	665	591	74	11.1
	June	617	551	65	10.6
Fiscal Year 1967		6,364	5,667	698	11.0
1967:	July	585	520	65	11.1
	August	646	576	71	10.9
	September	628	563	66	10.4
	October	701	628	73	10.4
	November	680	610	70	10.3
	December	596	534	62	10.4
1968:	January	695	625	69	10.0
	February	691	621	70	10.1
	March	726	654	72	10.0
	April	3	3	--	--
Fiscal Year 1968		5,950	5,332	617	10.4

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 15

EXTENT OF COST-SHARING PAYMENTS[a/]

(amounts in millions)

	Type of Beneficiary					
	Total		Insured		Noninsured	
Item	Amount	Percent of Re-imburse-ments	Amount	Percent of Re-imburse-ments	Amount	Percen of Re-imburs ments
	Calendar Year 1966					
Inpatient Hospital	$105	8.6%	$88	8.5%	$16	9.4
Deductible	87	7.1	74	7.1	13	7.3
Coinsurance	18	1.5	15	1.4	4	2.1
Outpatient Diagnostic	13	481.1	12	481.2	2	480.6
Deductible	13	455.9	11	456.0	1	455.5
Coinsurance	1	25.2	1	25.2	*	25.1
Hospital Insurance Total	118	9.7	100	9.6	18	10.2
Deductible	99	8.1	85	8.1	14	8.1
Coinsurance	19	1.5	15	1.4	4	2.1
	Calendar Year 1967					
Inpatient Hospital	211	7.3	180	7.2	31	7.8
Deductible	172	6.0	148	5.9	24	6.2
Coinsurance	38	1.3	32	1.3	6	1.7
Extended Care Facility Coinsurance	67	24.4	52	23.8	15	26.7
Outpatient Diagnostic	34	453.9	30	453.4	4	457.7
Deductible	32	428.9	28	428.4	3	432.7
Coinsurance	2	25.0	2	25.0	*	25.0
Hospital Insurance Total	311	9.7	262	9.6	49	10.9
Deductible	204	6.4	177	6.4	28	6.1
Coinsurance	107	3.4	85	3.1	22	4.8
	Calendar Year 1968					
Inpatient Hospital	233	6.8	201	6.7	32	7.6
Deductible	178	5.2	156	5.2	23	5.4
Coinsurance	55	1.6	46	1.5	9	2.2
Extended Care Facility Coinsurance	63	19.9	50	19.4	13	22.0
Outpatient Diagnostic	9	433.6	8	433.2	1	438.0
Deductible	9	408.6	8	408.1	1	413.0
Coinsurance	1	25.0	*	25.0	*	25.1
Hospital Insurance Total	305	8.1	259	7.9	45	9.4
Deductible	187	5.0	163	5.0	24	4.9
Coinsurance	118	3.1	96	2.9	22	4.5

*Less than $500,000.

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 16

INPATIENT HOSPITAL DAYS, TOTAL BENEFICIARIES[a]
(in thousands)

Period		From Tabulation of Bills: Beginning in Month	From Tabulation of Bills: Ending in Month	Average	Range as Percent of Average
1966:	July	9,201	3,348	6,275	93%
	August	5,871	5,530	5,701	6
	September	5,574	6,499	6,036	15
	October	6,014	5,860	5,937	3
	November	5,769	5,737	5,753	1
	December	5,498	5,963	5,731	8
	Year	37,927	32,938	35,432	14
1967:	January	6,645	6,014	6,329	10
	February	5,585	5,595	5,590	*
	March	6,308	6,339	6,324	*
	April	6,143	6,171	6,157	*
	May	6,281	6,355	6,318	1
	June	5,625	6,375	6,000	13
	July	6,313	5,738	6,026	10
	August	5,966	5,921	5,944	1
	September	5,699	6,080	5,890	6
	October	6,522	5,971	6,246	9
	November	6,124	6,008	6,066	2
	December	5,894	6,696	6,295	13
	Year	73,106	73,264	73,185	*
1968:	January	7,697	6,446	7,072	18
	February	6,049	6,393	6,221	6
	March	5,668	7,632	6,650	30
	April	7,226	5,501	6,363	27
	May	6,393	6,438	6,415	1
	June	5,617	6,647	6,132	17
	July	6,579	5,786	6,183	13
	August	5,901	6,035	5,968	2
	September	5,693	6,150	5,921	8
	October	6,467	5,907	6,187	9
	November	5,831	5,971	5,901	2
	December	5,368	6,894	6,131	25
	Year	74,488	75,801	75,144	2

*Less than 0.5%.

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 17

EXTENDED CARE FACILITY DAYS, TOTAL BENEFICIARIES[a/]
(in thousands)

Period		From Tabulation of Bills			Range as Percent of Average
		Beginning in Month	Ending in Month	Average	
1967:	January	1,971	791	1,381	85%
	February	1,405	1,292	1,348	8
	March	1,894	1,740	1,817	8
	April	1,664	2,038	1,851	20
	May	1,636	1,658	1,647	1
	June	1,626	1,648	1,637	1
	July	1,717	1,684	1,701	2
	August	1,717	1,725	1,721	*
	September	1,616	1,693	1,655	5
	October	1,688	1,693	1,691	*
	November	1,626	1,608	1,617	1
	December	1,589	1,705	1,647	7
	Year	20,149	19,277	19,713	4
1968:	January	1,771	1,628	1,700	8
	February	1,627	1,663	1,645	2
	March	1,677	1,867	1,772	11
	April	1,715	1,639	1,677	5
	May	1,661	1,642	1,651	1
	June	1,532	1,612	1,572	5
	July	1,640	1,604	1,622	2
	August	1,552	1,610	1,581	4
	September	1,413	1,510	1,462	7
	October	1,454	1,471	1,463	1
	November	1,359	1,384	1,372	2
	December	1,260	1,484	1,372	16
	Year	18,663	19,114	18,889	2

*Less than 0.5%.

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 18

HOME HEALTH AGENCY VISITS, TOTAL BENEFICIARIES[a/]
(in thousands)

Period		From Tabulation of Bills			
		Beginning in Month	Ending in Month	Average	Range as Percent of Average
1966:	July	47	9	28	136%
	August	90	49	69	59
	September	102	89	96	14
	October	141	110	126	25
	November	147	127	137	15
	December	131	218	174	50
	Year	659	602	631	9
1967:	January	242	134	188	57
	February	169	173	171	2
	March	224	218	221	3
	April	229	220	225	4
	May	265	237	251	11
	June	244	279	262	13
	July	274	233	254	16
	August	262	267	264	2
	September	245	287	266	16
	October	314	268	291	16
	November	269	257	263	5
	December	208	389	298	61
	Year	2,946	2,962	2,954	1
1968:	January	399	215	307	60
	February	261	268	264	3
	March	296	318	307	7
	April	327	299	313	9
	May	310	305	308	2
	June	271	322	297	17
	July	343	293	318	16
	August	286	302	294	5
	September	267	324	295	19
	October	349	314	331	11
	November	287	283	285	1
	December	237	401	319	51
	Year	3,632	3,643	3,637	*

*Less than 0.5%.

a/ Not adjusted for incurred but not reported or processed claims (see text).

Table 19

TOTAL INTERIM REIMBURSEMENTS, TOTAL BENEFICIARIES[a/]
(in millions)

Period		From Tabulation of Bills: Beginning in Month	From Tabulation of Bills: Ending in Month	Average	Range as Percent of Average
1966:	July	$287	$109	$198	90%
	August	199	187	193	6
	September	195	210	202	7
	October	217	206	211	5
	November	211	206	208	2
	December	202	219	211	1
	Year	1,310	1,138	1,224	14
1967:	January	276	233	255	17
	February	232	228	230	2
	March	267	265	266	1
	April	263	265	264	1
	May	270	272	271	1
	June	247	272	259	10
	July	275	252	264	9
	August	265	263	264	1
	September	258	271	264	5
	October	297	270	283	10
	November	284	276	280	3
	December	273	311	292	13
	Year	3,207	3,178	3,192	1
1968:	January	356	297	326	18
	February	292	302	297	3
	March	281	365	323	26
	April	253	271	312	26
	May	320	319	320	*
	June	285	326	306	13
	July	329	295	312	11
	August	303	308	306	2
	September	297	314	306	6
	October	340	308	324	10
	November	312	315	313	1
	December	287	369	328	25
	Year	3,754	3,789	3,772	1

*Less than 0.5%.

a/ Not adjusted for incurred but not reported or processed claims (see text).

Actuarial Studies Available from the Office of the Actuary*

46. Illustrative United States Population Projections--May 1957.

48. Long-Range Cost Estimates for Old-Age, Survivors, and Disability Insurance under 1956 Amendments--August 1958.

49. Methodology Involved in Developing Long-Range Cost Estimates for the Old-Age, Survivors, and Disability Insurance System--May 1959.

50. Analysis of Benefits, OASDI Program, 1960 Amendments--December 1960.

51. Present Values of OASI Benefits in Current Payment Status, 1960--February 1961.

52. Actuarial Cost Estimates for Health Insurance Benefits Bill--July 1961.

53. Medium-Range Cost Estimates for Old-Age, Survivors, and Disability Insurance and Increasing-Earnings Assumption--August 1961.

54. Estimated Amount of Life Insurance in Force as Survivor Benefits under OASI, 1959-60--October 1961.

55. Remarriage Tables Based on Experience under OASDI and U. S. Employees' Compensation System--December 1962.

56. Analysis of Benefits under 26 Selected Private Pension Plans--January 1963.

57. Actuarial Cost Estimates for Hospital Insurance Bill--July 1963.

60. Mortality Experience of Workers Entitled to Old-Age Benefits under OASDI, 1941-1961--August 1965.

61. History of Cost Estimates for Hospital Insurance--December 1966.

62. United States Population Projections for OASDHI Cost Estimates--January 1967.

63. Long-Range Cost Estimates for Old-Age, Survivors, and Disability Insurance System, 1966--January 1967.

Actuarial Studies Available from the Office of the Actuary* (Cont'd.)

64. Methods Used in Estimating Long-Range Costs for the Old-Age, Survivors, and Disability Insurance System. (In Preparation)

65. Termination Experience of Disabled-Worker Benefits under OASDI, 1957-63--March 1969.

66. Present Values of OASI Benefits in Current Payment Status, 1968--April 1969.

67. Present Value of DI Benefits in Current Payment Status, 1968--August 1969

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* Numbers not listed are out of print.