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1972 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

L E T T E R

FROM

**BOARD OF TRUSTEES,
FEDERAL HOSPITAL INSURANCE
TRUST FUND**

TRANSMITTING

THE 1972 ANNUAL REPORT OF THE BOARD OF TRUSTEES, OF THE TRUST FUND, PURSUANT TO SECTION 1817(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE TRUST FUND
Washington, D.C, June 6, 1972.

THE SPEAKER OF THE HOUSE OF REPRESENTATIVES,
Washington, D.C.

SIR: We have the honor to transmit to you the 1972 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (the seventh such report), in compliance with the provisions of section 1817(b) of the Social Security Act, as amended.

Respectfully,

JOHN B. CONNALLY,
Secretary of the Treasury,
and Managing Trustee of the Trust Funds.

J. D. HODGSON,
Secretary of Labor.

ELLIOT L. RICHARDSON,
Secretary of Health, Education, and Welfare.

ROBERT M. BALL,
Commissioner of Social Security
and Secretary, Board of Trustees

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1972 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

THE BOARD OF TRUSTEES

The Federal hospital insurance trust fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1817(b) of the Social Security Act, as amended. The Board is comprised of three members who serve in an ex officio capacity. The members of the Board are the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Secretary of the Treasury is designated by law as the Managing Trustee. The Commissioner of Social Security is Secretary of the Board. The Board of Trustees reports to the Congress once each year in compliance with section 1817 (b) (2) of the Social Security Act. This Report is the annual report for 1972, the seventh such report.

HIGHLIGHTS

The more important developments since the 1971 Report, discussed in more detail in later sections, are indicated below.

(*a*) The growth of the hospital insurance trust fund during fiscal year 1971 was close to that predicted in the 1971 Report. Income for fiscal 1971 amounted to $6.0 billion, up by 7 percent over fiscal1970. Benefit payments and administrative expenses totalled $5.6 billion, 13 percent more than in fiscal1970. The fund increased by $0.4 billion in fiscal 1971 to the level of $3.1 billion on June 30, 1971.

(*b*) Approximately 20.4 million persons were protected by the hospital insurance program by the end of June 1971. About 4.5 million persons actually received benefits as a result of covered institutional care during the year. An estimated 93 million workers had earnings in calendar year 1970 that were taxable and creditable toward benefits under the program.

(*c*) The trust fund earned $181 million in interest during the year, equivalent to an annual rate of 6.5 percent.

(*d*) The report of the 1971 Advisory Council on Social Security was received, and its recommendations concerning the financing of the hospital insurance program were carefully evaluated.

(*e*) A wage-price freeze became effective in August 1971 and the Phase II Economic Stabilization Program in November 1971. The Price Commission guidelines were issued in December 1971. The Economic Stabilization program is expected to have a pronounced effect on the level of benefit payments under the hospital insurance program.

SOCIAL SECURITY AMENDMENTS SINCE 1971 REPORT

There have been no amendments affecting the Federal hospital Insurance Trust Fund since the passage of Public Law 92-5, approved on March 17, 1971. The changes brought about by the passage of the 1971 legislation were only with respect to the maximum taxable earnings base, raised to $9,000 beginning in 1972.

Legislation which would substantially modify the current law was introduced into the House of Representatives as H.R. 1, was favorably

reported by the Ways and Means Committee on May 26, 1971, and was passed by the House of Representatives on June 22, 1971. As of the submission of this report, H.R. 1 is a matter of pending business before the Senate, but it has not become law. This report necessarily assumes current law, and does not consider the changed situation when and if H.R. 1 (or any modification thereof) is enacted.

NATURE OF THE TRUST FUND

The Federal hospital insurance trust fund was established on July 30, 1965, as a separate account in the U.S. Treasury to hold the amounts accumulated under the hospital insurance program. All the financial operations which relate to the system of hospital insurance are handled through this fund.

The major sources of receipts of this fund are (1) amounts appropriated to it under permanent appropriation on the basis of contributions paid by workers and their employers, and by individuals with self-employment income, in work covered by the hospital insurance program and (2) amounts deposited in it representing contributions paid by workers employed by State and local governments and by such employers with respect to work covered by the program. The coverage of the hospital insurance program is identical with that of the old-age, survivors, and disability insurance program.

All employees in covered employment are required to pay contributions with respect to their wages, and their employers are also required to pay contributions with respect to their wages (cash tips, covered as wages beginning in 1966 under the 1965 amendments, are an exception to this; employees pay contributions with respect to cash tips, but employers do not). All covered self-employed persons are required to pay contributions with respect to their self-employment income. In general, an individual's contributions are computed on annual wages or self-employment income, or both wages and self-employment income combined, up to a specified maximum annual amount with the contributions being determined first on the wages and then on any self-employment income necessary to make up the annual maximum amount.

The maximum amount of annual earnings taxable in each of the calendar years 1966 and later is shown in the table below. The contribution rate applicable to taxable earnings in each year is also shown. The table, for 1971 and earlier, is a historical record based on continually changing law. For 1972 and later the table indicates the provisions of present law, as last amended in 1971.

CONTRIBUTION RATES AND MAXIMUM AMOUNT OF ANNUAL EARNINGS

Calendar years	Maximum taxable amount of annual earnings	Contribution rates (percent of taxable earnings)	
		Employees and employers, each	Self-employed
1966	$6,600	0.35%	0.35%
1967	6,600	.50	.50
1968-71	7,800	.60	.60
1972	9,000	.60	.60
1973-75	9,000	.65	.65
1976-79	9,000	.70	.70
1980-86	9,000	.80	.80
1987 and after	9,000	.90	.90

Except for amounts received by the Secretary of the Treasury under State agreements (to effectuate coverage under the program for State and local government employees) and deposited directly in the trust fund, all contributions are collected by the Internal Revenue Service and deposited in the general fund of the Treasury as internal revenue collections; then, on an estimated basis, the contributions received are immediately and automatically appropriated to the trust fund. The exact amount of contributions received is not known initially since (1) hospital insurance taxes, (2) old-age, survivors, and disability insurance taxes, and (3) individual income taxes are not separately identified in tax-collection reports received by the Treasury Department from the district offices of the Internal Revenue Service. Periodic adjustments are subsequently made to the extent that the estimates are found to differ from the amounts of contributions actually payable on the basis of reported earnings.

An employee who worked for more than one employer during the course of a year and paid contributions on wages in excess of the statutory maximum can receive a refund of the taxes he paid on such excess wages. The amount of taxes subject to refund for any period is a charge against the trust fund.

Another source from which receipts of the trust fund are derived is interest received on investments held by the fund. The investment procedures of the fund are described later in this section.

The income and expenditures of the trust fund are also affected by the provisions of the Railroad Retirement Act of 1937 which provide for a system of coordination and financial interchange between the railroad retirement program and the hospital insurance program.

Sections 217(g) and 229(b) of the Social Security Act authorized annual reimbursements from the general fund of the Treasury to the hospital insurance trust fund for any costs arising from the granting of noncontributory credits for military service, according to periodic determinations made by the Secretary of Health, Education, and Welfare.

Section 1833 of the Social Security Act provides that pathology and radiology services rendered by physicians after March 1968 to hospital inpatients are not subject to the deductible and coinsurance provisions of the supplementary medical insurance program. Hospitals, at their option, are permitted to combine their billing for both hospital and physician components of radiology and pathology services rendered hospital inpatients by hospital-based physicians. Where hospitals elect this billing procedure, payments are made initially from the hospital insurance trust fund, with reimbursement from the supplementary

medical insurance trust fund. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.

Section 103 of the Social Security Amendments of 1965 provides hospital insurance benefits to certain uninsured persons aged 65 and over. Such payments are made initially from the hospital insurance trust fund, with later reimbursement, with interest, from the general fund of the Treasury for the costs, including administrative expenses, of the payments. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.

Expenditures for benefit payments and administrative expenses under the hospital insurance program are paid out of the trust fund. All expenses incurred by the Department of Health, Education, and Welfare and by the Treasury Department in carrying out the provisions of title XVIII of the Social Security Act and of the Internal Revenue Code relating to the collection of contributions, are charged to the trust fund. The Secretary of Health, Education, and Welfare certifies benefit payments to the managing trustee, who makes the payment from the trust funds in accordance therewith.

Congress has authorized expenditures from the trust fund for construction of office buildings and related facilities for the Social Security Administration. The costs of such construction are included as part of the administrative expenses in the financial statements of operations of the trust fund as set forth in subsequent sections of this report. The net worth of the resulting facilities—just as the net worth of all other capital assets—is not carried as an asset in such statements.

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, on a daily basis, in interest-bearing obligations of the U.S. Government, 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.

In addition, 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 have maturities fixed with due regard for the needs of the trust fund and shall bear interest at a rate based on the average market yield (computed by the managing trustee 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.

SUMMARY OF THE OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1971

A statement of the income and disbursements of the Federal hospital insurance trust fund during fiscal year 1971 and of the assets of the fund

at the beginning and the end of the fiscal year is presented in table 1. Also appearing in the table are comparable amounts for fiscal year 1970.

The total assets of the trust fund amounted to $2,677 million on June 30, 1970. By the end of fiscal year 1971, the assets amounted to $3,103 million, an increase of $426 million.

Net receipts of the trust fund amounted to $6,018 million. Of this total, $4,477 million represented tax collections appropriated to the trust fund and $486 million represented amounts received by the Secretary of the Treasury in accordance with State coverage agreements and deposited in the trust fund. As an offset, $65 million was transferred from the trust fund into the Treasury as repayment for the estimated amount of contributions subject to refund to employees who worked for more than one employer during the course of a year and paid contributions on wages in excess of the statutory maximum earnings base.

Net contributions amounted to $4,898 million, representing an increase of 2.4 percent over the amount for the preceding fiscal year. This growth in contribution income resulted primarily from the somewhat higher level of taxable earnings.

TABLE 1.—STATEMENT OF OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING FISCAL YEARS 1970 AND 1971
[In thousands]

	Fiscal Year 1970	Fiscal Year 1971
Total assets of the trust fund, beginning of year	$2,016,521	$2,677,401
Receipts:		
Contributions:		
Appropriations	4,389,125	4,477,040
Deposits arising from State agreements	444,864	485,873
Gross Contributions	4,833,989	4,962,913
Less payment into the Treasury for contributions subject to refund	49,200	64,934
Net Contributions	4,784,789	4,897,979
Percentage increase in net contributions, 1970 to 1971	2.4	
Transfer from railroad retirement account	63,537	65,945
Reimbursement from the general fund of Treasury for costs of—		
Noncontributory credits for military service	11,000	11,000
Benefits for uninsured persons:		
Benefit payments	596,211	819,201
Administrative expenses	12,974	26,925
Interest	8,077	16,723
Total reimbursement for costs of benefits for uninsured persons	617,262	862,849
Interest:		
Interest on Investments	133,441	181,366
Interest on adjustments in provisional transfers from the supplementary medical insurance trust fund for reimbursement of benefits paid initially from the hospital insurance trust fund [1]	4,511	−800
Interest on amounts of interfund transfers due to adjustment in allocation of administrative expenses and construction costs [1]	−759	−229
Total interest	137,193	180,337
Total receipts	5,613,782	6,018,110
Disbursements:		
Gross benefit payments	4,966,942	5,480,271
Less transfers from the supplementary medical insurance trust fund for reimbursement of benefits paid initially from the hospital insurance trust fund [2]	162,700	37,300
Net benefit payments	4,804,242	5,442,971
Percentage increase in benefit payments, 1970 to 1971	13.3%	
Administrative expenses:		
Department of Health, Educations, and Welfare [3]	125,729	142,633
Treasury Department	6,220	6,379
Construction of facilities for Social Security Administration	616	171
Interfund transfers due to adjustment in allocation of—		
Administrative expenses	15,251	280
Construction costs	853	22
Gross administrative expenses	148,669	149,485
Less receipts from sale of surplus supplies, materials, etc.	9	51
Net administrative expenses	148,660	149,434
Total disbursements	4,952,902	5,592,405
Net addition to the trust fund	660,879	425,705
Total assets of the trust fund. end of year	2,677,401	3,103,106

[1] A positive figure represents a transfer of interest to the hospital insurance trust fund from the other social security trust funds. A negative figure represents a transfer of interest from the hospital insurance trust fund to the other social security trust funds.
[2] For explanation, see text.
[3] Includes administrative expenses of the intermediaries.

Reference has been made in an earlier section to provisions of the Railroad Retirement Act which coordinate the railroad retirement and the hospital insurance programs and which govern the financial interchange arising from the allocation of costs between the two systems. In accordance with these provisions, the Railroad Retirement Board and the Secretary of Health, Education, and Welfare determined that a transfer of $65,364,000 from the railroad retirement account to the hospital insurance trust fund would place this fund in the same position, as of June 30, 1970, as it would have been if railroad employment had

always been covered under the Social Security Act. This amount was transferred to the trust fund in August 1970, together with interest to the date of transfer amounting to $581,000.

Reference has also been made earlier to provisions under which the hospital insurance trust fund is to be reimbursed annually from the general fund of the Treasury for the costs of granting noncontributory credits for military service performed before 1957. In accordance with these provisions, the Secretary of Health, Education, and Welfare determined, in September 1965, that the annual amount due this trust fund was $14.2 million. An annual reimbursement amounting to $11 million was received in December 1970.

Again, reference has been made earlier to provisions under which the hospital insurance trust fund is to be reimbursed from the general fund of the Treasury for costs of paying benefits under this program to certain uninsured persons. The reimbursement in fiscal year 1971 amounted to $863 million, of which $819 million was for benefit payments, $27 million was for administrative expenses, and $17 million was for interest.

The remaining $180 million of receipts consisted of interest on the investments of the trust fund, adjusted for interest on amounts of interfund transfers among the four trust funds, old-age and survivors insurance, disability insurance, hospital insurance, and supplementary medical insurance.

Disbursements from the trust fund during fiscal year 1971 totaled $5,592 million. Of this total, $5,480 million represented gross benefit payments from the trust fund. As an offset, $37 million was transferred from the supplementary medical insurance trust fund with respect to certain costs for radiology and pathology services that were paid from the hospital insurance trust fund but that are liabilities of the supplementary medical insurance trust fund. (Reimbursements for such costs are made on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.) Net benefit payments from the trust fund in fiscal year 1971, therefore, amounted to $5,443 million, an increase of 13.3 percent over the corresponding amount paid in fiscal year 1970. The remaining $149 million of disbursements was for net administrative expenses. Administrative expenses arc allocated and charged directly to each of the four trust funds on the basis of provisional estimates. Periodically, as actual experience develops and is analyzed, adjustments to the allocations of administrative expenses, and costs of construction, for prior periods are effected by interfund transfers, with appropriate interest allowances.

Table 2 compares the actual experience in fiscal year 1971 with the estimates presented in the 1970 and 1971 Annual Reports of the Board of Trustees. Reference was made in an earlier section to the appropriation of contributions to the trust funds on an estimated basis, with subsequent periodic adjustments to account for differences from the amounts of contributions actually payable on the basis of reported earnings. In interpreting the figures in table 2, it should be noted that the "actual" amount of contributions in fiscal year 1971 reflects the aforementioned type of adjustments to contributions for prior fiscal years. On the other hand, the "actual" amount of contributions in fiscal year 1971 does not reflect adjustments to contributions for fiscal year 1971 that were to be made after June 30, 1971. The estimated con-

tributions in both the 1970 and 1971 reports were quite close to the actual experience. Actual benefit payments were 13 percent lower than estimated in the 1970 report, while the corresponding figure with respect to the 1971 report is only 3 percent.

The assets of the trust fund at the end of fiscal year 1971 totaled $3,103 million, consisting of $2,980 million in the form of obligations of the U.S. Government, $50 million in securities of federally sponsored agencies, and $73 million in undisbursed balances. Table 3 shows a comparison of the total assets of the fund and their distribution at the end of fiscal years 1970 and 1971.

The net increase in the par value of the investments held by the fund during fiscal year 1971 amounted to $377 million. New securities at a total par value of $7,116 million were acquired during the fiscal year, through the investment of receipts and the reinvestment of funds made available from the maturity of securities. The par value of securities redeemed during the fiscal year was $6,739 million.

The effective annual rate of interest earned by the assets of the hospital insurance trust fund during fiscal year 1971 was 6.5 percent. The interest rate on public-debt obligations issued for purchase by the trust fund in June 1971 was 6⅛ percent, compounded semiannually.

TABLE 2.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, FISCAL YEAR 1971

[Dollar amounts in millions]

Item	Actual amount	Comparison of actual experience with estimates for fiscal year 1971 published in—				
		1971 report			1970 report	
		Estimated amount	Actual as percentage of estimate		Estimated amount	Actual as percentage of estimate
Net contributions	$4,898	$4,954	99		$5,005	98
Benefit payments	5,443	5,600	97		6,250	87

TABLE 3.—ASSETS OF THE HOSPITAL INSURANCE TRUST FUND, BY TYPE, AT END OF FISCAL YEARS 1971 AND 1972

	June 30, 1970		June 30, 1971	
	Par value	Book value [1]	Par value	Book value [1]
Investments In public-debt obligations sold only to this fund (special Issues)—Notes:				
4¾ percent, 1973	$24,056,000	$24,056,000.00		
4¾ percent, 1974	$415,179,000	$415,179,000.00		
5⅝ percent, 1975	$495,529,000	$495,529,000.00	$400,116,000	$400,116,000.00
6⅛ percent, 1978			931,182,000	931,182,000.00
6½ percent, 1978	729,200,000	729,200,000.00	729,200,000	729,200,000.00
7⅞ percent, 1977	919,358,000	919,358,000.00	919,358,000	919,358,000.00
Total public-debt obligations sold only to this fund (special issues)	2,583,322,000	2,583,322,000.00	2,979,856,000	2,979,856,000.00
Investments in federally-sponsored agency obligations:				
Participation certificates:				
Federal Assets liquidation Trust—Government National Mortgage Association:				
5.20 percent, 1982	50,000,000	50,000,000.00	50,000,000	50,000,000.00
Federal Assets Financing Trust—Government National Mortgage Association:				
6.30 percent, 1971	20,000,000	20,000,000.00		
Total investments in federally-sponsored agency obligations	70,000,000	70,000,000.00	50,000,000	50,000,000.00
Total Investments	2,653,322,000	2,653,322,000.00	3,029,856,000	3,029,856,000.00
Undisbursed balance		24,078,515.94		73,249,599.39
Total assets		2,677,400,515.94		3,103,105,599.39

[1] Par value, plus unamortized premium, less discount outstanding.

TABLE 4.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, ON CASH BASIS, FISCAL YEARS 1969-74

[In millions of dollars]

	Actual			Estimated		
Item	1969	1970	1971	1972	1973	1974
Income:						
Contributions	$4,423	$4,785	$4,898	$5,213	$6,110	$6,822
Interest on investments	96	137	181	171	147	120
Transfers from Railroad retirement account	54	64	66	66	65	73
Reimbursement for uninsured persons	749	617	863	503	468	548
Reimbursement for military wage credits	22	11	11	48	48	48
Total income	5,344	5,614	6,018	6,001	6,838	7,611
Disbursements:						
Benefits payments	4,654	4,804	5,443	6,265	6,950	7,965
Administrative expenses	104	149	149	169	179	209
Total disbursements	4,758	4,953	5,592	6,434	7,129	8,174
Net increase in fund	586	661	426	−433	−291	−563
Fund at end of year	2,017	2,677	3,103	2,670	2,379	1,816

EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND DURING THE PERIOD JULY 1, 1971 TO JUNE 30, 1974

The income and disbursements of the hospital insurance program are affected by general economic conditions, hospital costs, and the expansion and rate of use of hospital services. Because it is difficult to forecast these factors, particularly the last, the resulting cost estimates presented here are subject to some uncertainty, which should be considered in interpreting the result.

Table 4 presents data on the actual operations of the hospital insurance trust fund on a cash basis for fiscal years 1969-71. It also presents estimates of the expected operations of the trust fund for fiscal years 1972-74.

The income estimates are based. on the assumption that earnings will increase each year through 1974 in accordance with earnings increase

assumptions derived for the federal budget. The increases in income from contributions also assume an increase in the maximum amount of earnings taxable and creditable under the program, effective January 1, 1972, and the scheduled increase in contribution rate effective on January 1, 1973.

Similarly, the disbursements shown for 1972-74 are consistent with those included in the federal budget and used to test the adequacy of the financing of the program. A more detailed analysis of these estimates appears in Appendix I.

It is anticipated that disbursements will exceed income in fiscal year 1972 and thereafter, under the provisions in present law. As a result, the fund will decrease beginning in fiscal year 1972, until it is exhausted during fiscal year 1976, unless improvements are made in program financing.

Reference has been made earlier to the financial interchanges between the railroad retirement account and the trust fund under the provisions of the Railroad Retirement Act. The estimates shown in Table 4 reflect the effect of future financial interchange.

Section 217 (g) of the Social Security Act provides that the trust fund shall be reimbursed from general revenues for expenditures resulting from the provisions that granted noncontributory $160 monthly wage credits to persons who served in the Armed Forces at some time during the period September 16, 1940, through December 31, 1956, and from the provisions enacted in 1946 that granted survivor protection to certain World War II veterans for a period of 3 years after leaving service. In accordance with section 217(g), the Secretary of Health, Education, and Welfare made a determination in 1970 of the level annual appropriations to the trust fund necessary to amortize over a 44-year period, beginning in fiscal year 1972, the estimated total additional costs arising from payments that have been made since July 1966 and that will be made in future years, after taking into account the amounts of annual appropriations in fiscal years 1966-71 that have been deposited into the trust funds. The annual amount of this determination for the hospital insurance trust fund was $48 million. The estimates shown in table 4 reflect the effect of past and expected future reimbursements under section 217 (g).

As described in an earlier section, hospital insurance benefits for certain uninsured persons are provided from the hospital insurance trust fund with later reimbursement from the general fund of the Treasury. These reimbursements, net of corrections for previous years, are also shown in table 4.

The ratios of assets at the beginning of each calendar year to total expenditures during the year are shown in table 5. Actual historical values are shown for 1967-71. Estimated values, consistent with the fiscal year estimates shown in table 4, are presented for calendar years 1972-74.

The ratio of assets to expenditures built up gradually until it reached the level of approximately one-half year's expenditures as of the beginning of 1971. However, this ratio has fallen slightly since then, and can be expected to decline rather rapidly under the contribution schedules in present law.

Table 6 shows administrative expenses paid in fiscal years 1967-71 as a percent of benefit payments. Administrative expenses paid since the beginning of the program amount to 2.7 percent of benefits paid.

TABLE 5.— ASSETS AT THE BEGINNING OF THE YEAR, RELATED TO EXPENDITURES DURING THE YEAR FOR THE HOSPITAL INSURANCE TRUST FUND, CALENDAR YEARS 1967-74

Calendar Year	Ratio of assets, at beginning of year to expenditures during the year
Historical Data:	
1967	0.28
1968	.25
1969	.43
1970	.47
1971	.54
Estimated future experience:	
1972	.45
1973	.36
1974	.27

TABLE 6.— RELATIONSHIP OF NET ADMINISTRATIVE EXPENSES OF THE HOSPITAL INSURANCE PROGRAM TO BENEFIT PAYMENTS, FISCAL YEARS 1966-71

Fiscal Year	Administrative expenses as a percentage of benefit payments
1966-67	3.5
1968	2.1
1969	2.2
1970	3.1
1971	2.7
1966-71	2.7

REPORT OF THE 1971 ADVISORY COUNCIL ON SOCIAL SECURITY

Pursuant to Section 706 of the Social Security Act an Advisory Council on Social Security was appointed by the Secretary of Health, Education, and Welfare in May 1969. The Council submitted its report on April 5, 1971. Among its findings and recommendations are those concerning changes in the benefit provisions and coverage of the hospital insurance program. These do not directly affect the financing or the operation of the trust fund and are not referred to further. The Council has made certain other recommendations which do affect the financing of the trust fund. As to these, the Trustees have the responsibility of a careful evaluation, and the transmittal of the Trustee's views as a part of this, or subsequent, reports.

The Council has organized its findings in the financing area under twelve headings. Eleven of these (numbers 1-6 and 8-12) concern the financing of the hospital insurance trust fund and are discussed below.

C. FINANCING

Actuarial Soundness of the Program

1. *Current Status.—Unless income is increased, the hospital insurance trust fund will be exhausted in 1973.*

The Board of Trustees agrees that the hospital insurance program is not adequately financed. Current projections, which take into account the Price Commission guidelines, indicate that the fund will last until fiscal year 1976 without an improvement in financing provisions.

Management and Investment of the Trust Funds

2. *Investment Policy.—The Managing Trustee of the social security trust funds should adopt a policy of investing in special obligations with maturity dates equal to the maximum maturity date of Treasury notes (at*

present 7 years) rather than maturity dates of 15 years from date of purchase.

The Board of Trustees concurs in this recommendation of the Advisory Council, and the Managing Trustee will adopt such a policy.

3. *Interest Rate Formula.—The interest rate on special obligations issued to the trust funds should be equal to the average market yield on all marketable Treasury notes that are not due or callable until 4 or more years from the time the special obligations are issued.*

The Board of Trustees has no position as to this recommendation at the present time, pending further study as to whether the interest-rate on special obligations will be higher or lower under the Advisory Council's recommendation than under current law.

4. *Securities Issued by Federally Sponsored Agencies.—The Council believes that there is adequate statutory authority for investment of trust fund money in securities issued by federally sponsored agencies. The Council recommends that the Managing Trustee establish a policy of purchasing a portion of new obligations issued by such agencies as investments for the trust funds.*

The Board of Trustees is still investigating the implications of this recommendation, and has no position at the present time.

5. *Boards of Trustees.—The Council recommends that two non-government members, to be appointed by the President subject to confirmation by the Senate, be added to the Boards of Trustees of the social security trust funds.*

The Board of Trustees supports this recommendation of the Advisory Council, and recommends to Congress that the law be changed to add two non-government members.

6. *The Trust Funds and the Unified Budget.—Even though the operations of the social security trust funds and other Federal trust fund programs are combined with the general operations of the Federal Government in the unified Federal budget, policy decisions affecting the social security program should be based on the objectives of the program rather than on any effect that such decisions might have on the Federal budget. The operations of the social security and other Federal trust funds should continue to be identified as such and separated from the general operations of the Government.*

The Board of Trustees agrees that the Social Security System should be financed in accordance with the financial principles of the program, and that the contribution rate should not be set out of considerations of broad fiscal policy or because of the impact of the financing provisions on the unified budget balance.

8. *Single Best Estimate.—Contribution rates should be based on a single, best estimate derived from a single set of assumptions that reflect likely future trends in the factors that affect income and outgo of the program, rather than on an average of a low-cost and a high-cost estimate, as has been the case in the past; and there should be a series of estimates which show the extent to which the best estimate might vary if experience with respect to any of the major factors were to differ from the assumptions.*

The Board of Trustees concurs in this recommendation of the Advisory Council, and the estimates contained in this Report are based on a single set of assumptions. The principle of sensitivity testing is developed in Appendix I, and will be further developed in future Reports.

9. *Valuation Period for Health Insurance.—The Council recommends that the valuation period for estimating health insurance program costs be reduced from 25 years to 10 years.*

The Board has presented a 25-year evaluation in the present report in order to show the long-range implication, just as the Board has in the past. The Board will study further the proposal to limit the valuation period to 10 years.

10. *Current Cost Financing.—The financing of the program should be on a current-cost basis, with the trust funds maintained at a level approximately equal to one year's expenditures.*

The Board of Trustees concurs with this recommendation of the Advisory Council. It notes that the Council specifically recommends *that the law be changed to require the Board of Trustees to report immediately to the Congress whenever it is expected that the size of any of the trust funds will fall below three-quarters of the amount of the following year's estimated expenditures, or will reach more than one and one-quarter times such expenditures.* The Board of Trustees supports the Council's specific proposal. The Board recognizes that the hospital insurance trust fund is currently only about one-half of one year's expenditures and recommends that the contribution rates be so set that the fund is projected to increase to the level of a full year's expenditures.

General Revenue Financing of Medicare

11. *Gradual increase in General Revenue Financing of Medicare.—The combined Medicare program should be financed with a general-revenue contribution equal to one-third of total program costs, with such share being lower than one-third at first and gradually increasing over a period of years to the one-third level.*

The Board of Trustees agrees with the Council's recommendation to combine the supplementary medical insurance trust fund and the hospital insurance trust fund for financing purposes. The Board of Trustees, however, does not accept the Council's recommendation for a general revenue contribution equal to one-third of total program costs.

12. *Contribution Rates.—The Council believes that the contribution rate schedule for the next 10 years should be designed to follow closely the principle of current-cost financing. Contribution rates for the Medicare program would not extend beyond a 10-year period since the Council does not believe that it is feasible to make realistic estimates for this program for a larger period.*

The Board of Trustees concurs with the first sentence of this recommendation, while recognizing that several different contribution rate schedules would fit the recommendation depending on the time over which the fund is built to the recommended level. The Board will study further the proposal to restrict future contribution rates established in the law to 10 years.

ACTUARIAL STATUS OF THE TRUST FUND

This section provides a history of the financing of the hospital insurance program, and a 25-year projection of the anticipated financial requirements. The latter is then compared with the financing provisions of the present law.

The tables in this section are presented on an incurred basis. They reflect contribution income earned and services provided, rather than income collected and disbursements made, in. the calendar year indi-

cated. In this sense they are different from results presented earlier, but the differences are only with respect to timing.

Table 7 shows for past years the incurred cost of benefits and administrative expense, for persons insured under the hospital insurance program, as a percent of taxable payroll. Incurred expenditures have increased from less than 1.0 percent of taxable payroll in 1967, to approximately 1.3 percent in 1971. It is clear from table 7 that benefits have increased at a more rapid rate than taxable payroll.

The projection of the future costs of the program as a percent of taxable payroll is shown as table 8. The results shown are comparable with table 7, with the exception that table 8 includes a provision for building the trust fund from its present level of about one-half year's expenditure to a full year by 1985, and to maintain it at that level thereafter.

The projected taxable payroll used in table 8 assumes that earnings in covered employment will rise in the future at a rate of 5 percent annually, and that the taxable earnings base will increase at the same rate.

Table 8 indicates that hospital insurance outlays are expected to continue to increase faster than taxable payroll. Part of this increase arises from growth in the insured population and to increases in the days per capita spent in medical institutions. However, the greatest portion of the increase is due to an increase in cost per hospital day.

TABLE 7.— INCURRED COSTS [1] OF HOSPITAL INSURANCE SYSTEM FOR THE INSURED ONLY AS A PERCENT OF TAXABLE PAYROLL

Calendar year	Incurred cost in percent
1967 [2]	0.95
1968	1.03
1969	1.09
1970	1.17
1971	[3] 1.30

[1] Benefit payments and administrative expenses.
[2] 1967 was the first full calendar year of the hospital insurance program.
[3] Preliminary estimate.

TABLE 8.— INCURRED COSTS [1] OF HOSPITAL INSURANCE SYSTEM FOR THE INSURED ONLY AS A PERCENT OF TAXABLE PAYROLL [2]

Calendar year	Incurred cost in percent
1972	1.50
1973	1.60
1974	1.70
1975	1.80
1980	2.20
1985	2.27
1990	2.46
1995	2.58
25-year average	2.21

[1] Benefit payments and administrative expenses plus a provision for trust fund growth equal to 1 year's expenditures for 1985 and thereafter.
[2] Earnings in covered employment and taxable earnings base assumed to rise 5 percent annually.

It is assumed in these projections that the Economic Stabilization Program will have an immediate and continuing influence, holding down the rate of inflation in hospital costs. As long as the present wage-price control strategy is maintained, the Social Security Administration will not recognize, for reimbursement purposes, increases in hospital costs

beyond those permitted by the Price Commission guidelines, so that in the short run at least, hospital cost increases will be close to those assumed. The cost estimates assume also that effective controls will be maintained indefinitely and in the long run become increasingly more restrictive. It is assumed that after 1980 increases in hospital costs will drop below the level experienced in the decade preceding the enactment of Medicare. It seems realistic to anticipate these results only if wage and price controls prove to be effective, and if long-range costs are contained by both restraint on the part of providers and by the force of public influence. The specific assumptions as to the future rates of increase in the cost of hospital care that underlie table 8, appear in table D in Appendix I, together with the assumptions concerning extended care facility and home health agency services. This appendix also illustrates future costs of the hospital insurance program if hospital costs increase relative to average earnings at a rate comparable to that which occurred in the decade before the hospital insurance program began.

Table 9 compares the average of table 8 results for the twenty-five year period 1972 to 1996 with the average combined contribution rate provided under present law for the same period. The negative actuarial balance (−0.61% of taxable payroll) indicates that the system under present law is seriously underfinanced. The contribution schedule in present law should be increased by nearly 40 percent to bring the financing into balance with the projected expenditure.

TABLE 9.— ESTIMATED ACTUARIAL BALANCE[1] OF HOSPITAL INSURANCE PROGRAM AS A PERCENT OF TAXABLE PAYROLL

	Percent
Average rate[2] in present contribution schedule	1.60
Average cost of system	2.21
Actuarial balance	−0.61

[1] For the 25-year period 1972-96.

[2] Combined employer-employee rate, adjusted for self-employed.

CONCLUSION

The hospital insurance trust fund at the beginning of 1972 is 48 percent of the projected expenditures for that year, and is therefore below the level of one year's expenditures recommended by the Advisory Council. Under the financing schedule in current law, the ratio of the fund to expenditures will decline, with the fund now projected to be exhausted during 1976. Clearly, higher contribution rates for the hospital insurance portion of the Social Security system are required. The Trustees support increased rates for the hospital insurance program, such as those provided in H.R. 1, although the Board recognizes that the goal of an actuarially sound hospital insurance program could be reached with a variety of contribution schedules.

For 1972 the financing for both the old-age, survivors, and disability insurance and the hospital insurance systems can be improved by a reallocation of the contribution rate to provide a larger portion for hospital insurance.

As the Trustees look beyond the current calendar year, they recognize that legislation is likely to be enacted which would change both the benefits and the financing of the hospital insurance system. The trustees recommend that the financing schedules be designed in accordance with the current-cost financing principles recommended by the Advisory

Council, with the hospital insurance trust fund projected to reach the level of one year's expenditures sometime within the next 15 years.

The Trustees recognize that the hospital insurance cost estimates presented in this report for years beyond the immediate future are dependent on a continuation of controls on hospital cost increases and on future public influence toward reducing the rate of increase in hospital expenditure. The cost estimates will prove to be low should the rate of inflation in the cost of hospital services that has been experienced in the past continue.

APPENDICES

APPENDIX I.—ASSUMPTIONS AND METHODOLOGY FOR LONG-RANGE COST ESTIMATES

The basic methodology and assumptions for the long-range cost estimates for the hospital insurance program are described in this appendix.

(1) Methodology

The adequacy of financing for the hospital insurance program for the next 25 years is expressed in this report as an actuarial balance. The actuarial balance is calculated as the difference between the average tax rates specified in current law and the average current cost rate for the 25-year period. The current cost rate for any year is the incurred cost of benefits and administration for insured persons divided by the incurred effective payroll for that year, plus an amount (expressed as a percent of payroll) required to build the trust fund balance to the level of a full year's benefits by 1985 and maintain it at that level thereafter. In projecting the incurred payroll, it is assumed that the wage base is adjusted periodically to keep pace with rising earnings.

The actuarial balance is −0.61 percent of payroll indicating that the program is seriously underfinanced.

(2) Principal problems in forecasting the cost of the hospital insurance program

The principal problems involved in forecasting the future costs of the hospital insurance program are (1) establishment of the current cost of the services provided by type of service, to serve as a base for projecting the future, and (2) forecasting of the increase in the cost of hospital services (which account for approximately 95 percent of the cost of the program).

(a) *Problems involved in establishing the current cost of services incurred as a base for forecasting future costs.*—In order to establish a suitable base from which to forecast the future costs of the hospital insurance program, it is necessary to eliminate the effect of any transitory factors. Thus the initial problem is to find the incurred cost of services provided for the most recent year for which reliable estimates can be made. To do this, the non-recurring effects of any changes in regulations or administration of the program and of any irregularities in the system of payments to providers must be eliminated.

The reimbursement system of the hospital insurance program is intended to reimburse institutions for the actual cost of providing covered services concurrently with the provision of the services. Payment is initially made on an "interim" or temporary basis. In theory, the rate at which such interim payments are made is an estimate of the actual average cost of providing the services. Actually, on the average, these rates are set lower than the estimated costs, as recovery of any overpayment is thought to pose a serious problem for the institutions' management. Due to the time required for (1) the institutions to bill intermediaries, (2) for the intermediaries to query the Social Security Administration to determine the spell of illness status of the patient, determine that the services are covered, and draw checks for approved services; and (3) for the institutions to present these checks for payment—there is a lag between the date on which services are

performed and on which payment therefor on an interim basis is received.

In order to bring interim reimbursements up to a current basis, an amount, not exceeding the program liability for services performed but for which no payment has been made, can be advanced to the institution. Such amounts are referred to as "current financing" payments.

Another method of interim reimbursement, called the "periodic interim payment" method, achieves the same results as current financing by making regular payments to the hospitals at short intervals throughout the year. The payments are based on cost studies of past experience and are not delayed until individual bills are submitted.

In order to adjust interim payments to the actual cost of providing services (as determined by an audited cost report which makes the necessary allocations of all of an institution's costs on a functional basis), a series of settlements are made with each institution. These payments have run 4 percent to 5 percent of interim payments during the early years of the program. Due to the time that has been required to obtain cost reports from institutions and to verify and audit these reports, the settlements have lagged behind the liability for such payments, as much as several years for many institutions. The final cost of the program has not been completely determined even for the initial year of the program, and more uncertainty exists as to the final cost of subsequent years. An additional complication stems from the policy of reimbursing the hospital insurance program from the SMI program for the cost of certain salaried physicians. If a hospital has an agreement with salaried radiologists and pathologists under which the institution bills for the professional component of these services, interim payments are made from the hospital insurance trust fund and later reimbursed from the supplementary medical insurance trust fund on the basis of that hospital's cost report. There is no reliable statistical information concerning these costs, which must be estimated from the settlements. Interim transfers arc also made from the supplementary medical insurance trust fund to the hospital insurance trust fund for the estimated difference between current incurred costs and cash settlements for these services. Since the beginning of the hospital insurance program, the incidence of payments other than those for interim costs have been irregular, and consequently have distorted the cash expenditure figures. For example, in the early years of the program, relatively few cost settlements were made. In later years, there was some catching up, through making more than one settlement payment to some hospitals in the same year. These changes in the incidence of payment undermine judgments as to the ongoing cost of the program from the present cost. Further, inadequate aggregate data concerning the periods for which the various payments other than interim costs have been made, and the incomplete filing of audited cost reports—have prevented accurate reconstitution of the actual costs.

Additional problems are posed by changes in administrative or reimbursement policy which have a substantial effect on either the amount or incidence of payment. For example, the 2 percent allowance for unallocated costs that was paid during the initial years of the program was discontinued in July 1969. The extent and incidence with which this change was incorporated into interim payment rates is not known.

Further, regulations were promulgated in July 1971 which specify that a similar allowance will be made for the higher than average cost of performing certain services (e.g. nursing) for aged patients. Reimbursement will be made retroactively for these "differential" costs, which will add approximately $100 million of non-recurring expenditures which should be paid during fiscal 1972, but may be paid partially in subsequent years. The new allowance for differential costs will also increase the liability of the program in all future years. Allocating the various payments to the proper periods, using incomplete data and estimating the impact of administrative actions present very difficult problems-the solution of which can only be approximate. Under the circumstances, the best that can be expected is that the actual incurred cost of the program for a recent period can be estimated within a few percent. This situation has the dual effect of (1) increasing the error of forecast directly, through incorporating any error in estimating the base year into all future years, and (2) lengthening the periods that must be forecast, since a projection of the most recent year is more accurate than an attempt to reconstruct the actual cost in that year.

Hospital insurance program data from 1968 indicate that aged patients used 4.13 days per capita of hospital services and 1.08 days per capita of extended care facility services.

Program data for 1970, corrected for anticipated final settlements with providers, indicates that the average cost of a day of hospital care for the aged was $62.17 per day for insured persons and $5.5.28 per day for the uninsured. The insured paid 6.3 percent of their costs themselves in the form of the inpatient deductible and coinsurance. In 1970, the average cost per day in extended care facilities for services covered by the hospital insurance program was $22.19 for insured persons and $20.56 for uninsured persons. The unit cost of home health services was approximately $12.30 in 1970.

(b) *Problem involved in forecasting the increase in hospital costs.*—In order to evaluate the adequacy of a tax schedule to support the hospital insurance program, it is necessary to relate the increases in the costs of institutional care to the increases in covered earnings which support those costs. Hospital insurance cost increases due to increases in covered population are fairly stable and predictable. The cost of the services provided per capita, however, have varied substantially from year to year. The next section discusses in detail the problems involved in forecasting hospital costs.

(3) Principal assumptions used in forecasting future costs of the hospital insurance program

(*a*) *Trend in hospital costs and the impact of the Economic Stabilization Program.*—The increase in the cost per capita of hospital services may be analyzed into the following components:

(1) The number of days of confinement in a hospital per capita: the level of use of inpatient care by the covered population.

(2) Factor prices: the increase in unit costs that would result if every function was performed in precisely the same way by the same people and only the salaries of the people employed or the cost of the equipment and other supplies used changed.

(3) Increases due to changes in the services provided per patient day and the method of provision consisting of:

(*a*) Change in the method of providing services, i.e., any increase (or decrease) in unit costs for providing the same

services, other than those due to factor price increases. This component consists of two different types of influences:

(*i*) Improvements to a given service, normally increasing the unit cost.

(*ii*) The effect of more efficient techniques or use of labor saving equipment, which normally decrease the unit cost.

(*b*) Provision of new services not previously provided (normally new, technically advanced services).

(*c*) Number and composition by relative expense of services furnished per day of care.

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

Hospital use, as measured by the number of inpatient days per capita, depends on many factors such as medical practice, administrative policies of health insurers, and chance fluctuations in morbidity.

TABLE A.—COMPONENTS OF INCREASE IN COST OF HOSPITAL SERVICES PER CAPITA FOR THE AGED

[Percent increase in year shown over previous year]

Year	(1) Patient days per capita [1]	(2) Factor prices [2]	(3) Due to change in services and how provided [3]	(4) Total increase [1]
I. Historical Data:				
1956-65		3.5	3.2	
1966		1.5	6.7	
1967	2.4	6.7	7.6	17.6
1968	7.3	7.6	7.2	23.4
1969	1.5	7.8	5.5	15.4
1970	−2.0	8.4	4.5	10.9
II. Forecast:				
1971	−1.5	7.1	4.6	10.3
1972	1.0	5.7	4.5	11.6
1973	.5	5.7	4.4	11.1
1974	.5	5.7	4.3	11.1
1975	.5	5.6	4.2	10.6
1980	0	4.6	2.8	7.5
1983 and later	0	4.1	1.8	6.0

[1] Historical data from health insurance program.
[2] See table B.
[3] See table C.

TABLE B.—PRICE INCREASES FOR FACTORS USED BY HOSPITALS

[Percent increase in year shown over previous year]

Year	Average earnings in covered employment [1]	Average wages of hospital employees [2]	CPI all items	Average factor prices
I. Historical Data:				
1956-65	3.6	4.7	1.6	3.5
1966	4.4	.6	2.9	1.5
1967	6.3	9.3	2.9	6.7
1968	7.0	9.9	4.2	7.6
1969	6.0	9.4	5.4	7.8
1970	4.8	10.1	5.9	8.4
II. Forecast:				
1971	5.7	9.0	4.3	7.1
1972	5.5	7.5	3.0	5.7
1973	5.5	7.5	3.0	5.7
1974	5.5	7.5	3.0	5.7
1975	5.4	7.4	3.0	5.6
1980	5.0	5.8	2.9	4.6
1983 and later	5.0	5.0	2.8	4.1

[1] Average earnings subject to OASDI taxes in first quarter.
[2] Historical data from American Hospital Association.

The past three decades have witnessed a long term increasing trend in the number of days of hospital care per capita. In 1970 and 1971, however, use of hospital facilities decreased for the aged population, due to a shorter average length of stay. By contrast, the admission rate per capita continued to grow. In view of this two-year downturn in utilization, the estimates of future increases in utilization have been substantially decreased from those shown in last year's report, assuming an increase of only one-half percent per year through 1977 and no increase thereafter. An additional increase of one-half percent is assumed in 1972 to provide an allowance for the expected value of additional hospital stays due to influenza epidemics, none of which occurred in the base year. Table A shows the actual experience under the health insurance program for 1967-1968 and the assumptions used to project hospital costs for subsequent years.

Hospital factor prices can be divided into those for personnel and those for non-personnel expenditures. Approximately 60 percent of hospital costs are for personnel. For several years preceding the beginning of the hospital insurance program, average hospital wages and salaries (as reported by the American Hospital Association) increased at a rate of about 1 percent per year more than the rate of increase in earnings in OASDI covered employment. Since the beginning of the hospital insurance program, this differential has been about 3 percent per year.

The Pay Board has restricted wage increases to the range 5 percent to 6 percent per year, but has exempted very low paid workers from this standard and has approved many settlements at a higher rate. More important, the Price Board has ruled that the costs established by the Social Security Administration for reimbursement purposes are prices and that such reimbursements cannot recognize any increase in wages and salaries higher than 5}percent per year (although with unlimited provision for exceptions through rulings). Part of the increase in average wages has been due to a change in composition of the work force so as to include relatively more higher paid personnel; this part of the increase is not restricted by the wage guidelines. The cost estimates assume that the immediate impact of these controls will be to reduce the average increase in hospital wages to 7½ percent per year during 1972-74, still higher than the 5½percent assumed for all workers. Eventually, this

difference should disappear entirely as hospital workers' wages become comparable to those for similar workers in other industries and the proportion of highly trained personnel grows very large; this has been assumed to occur by 1983.

Increases in the prices of the goods and services hospitals purchase are treated as a function of increases in the Consumer Price Index for all items. There is some question as to whether this index is appropriate since hospitals purchase a large volume of services. No index of hospital non-personnel factor prices is available, however. The price increases that may be recognized for reimbursement under the Price Commission guidelines are limited to 2½ percent per year. Part of the increase is due to the mix of goods and services purchased, which is not subject to this limit. Table B summarizes the historical data used and the comparable forecasts in estimating the increase in factor prices.

Since the beginning of the hospital insurance program, the number of hospital workers per adjusted 100 census count in non-federal short-term general hospitals has been increasing about 3 percent per year (as reported by the American Hospital Association). Statistics adjusted for changes in outpatient care are not available prior to 1966, but some indicators suggest a level of about 2 percent per year.

TABLE C.—INCREASES IN HOSPITAL COSTS PER PATIENT DAY DUE TO CHANGES IN SERVICES AND METHOD OF PROVISION[1]

[Percent increase in year shown over previous year]

Year	Employees per patient day[2]	Nonemployee increases[3]	Increases due to changes in services and method of provision[1]
I. Historical Data:			
1956-65	2.0	5.0	3.2
1966	5.8	8.2	6.7
1967	1.7	16.5	7.6
1968	2.5	14.0	7.1
1969	4.0	8.0	5.6
1970	3.1	6.6	4.5
II. Forecast:			
1971	3.0	7.0	4.6
1972	2.9	6.9	4.5
1973	2.8	6.8	4.4
1974	2.7	6.7	4.3
1975	2.6	6.6	4.2
1980	2.0	4.0	2.8
1983 and later	1.0	3.0	1.8

[1] See text for explanation.

[2] Historical data are from American Hospital Association. These increases apply only to that part of hospital expenses due to personnel, which are approximately 60 percent of hospital costs.

[3] Actually a residual; i.e., the increase in hospital costs not explained by increases in days of inpatient care per capita, factor cost increases, or the number of employees per patient day. Expressed so as to apply to nonpersonnel costs.

A residual item is required to balance the historical increases in hospital costs, which allows for the effect of changes in the services provided and method of provision not accounted for by an increase in the number of personnel (this item is stated so as to apply only to non-personnel costs). Before 1966, this residual averaged about 5% per year. After a surge in the early years of the hospital insurance program, 16½% in 1967 and 14% in 1968, the residual has declined to a level of around 7% in 1969-1970.

Hospital cost increases due to changes in the services provided and method of provision will be partially restricted under the Price Commission guidelines, which specify that "aggregate expenses for new technology such as new equipment and new services directly related to

health care, to the extent they are not charged directly to persons benefiting directly from that equipment or those services, which exceed 1.7% of total annual expenses" cannot be recognized for reimbursement purposes. This limitation thus applies jointly to items (3) (a) and (3) (b), but not to (3) (c)—assuming hospital managements will charge users for any new services offered, including services that in the absence of controls would have been included in the room and board charge. To use the data base available, a judgment is thus required as to the portion of the total increase due to changes in the services provided and method of provisions that is due to new services; the rest of this component is restricted to 1.7% per year. There are, however, many items whose attribution in cost accounting is not clearly designated. With constraints on other costs, there is pressure on hospital managements to adopt policies which allocate more of the cost of overhead items to new services than might otherwise have been the case. The historical data related to increases in cost due to changes in the services, analyzed by personnel and non-personnel subcomponents, are shown in table C, together with the forecast for the future. It is assumed that the current rate of increase in the number of personnel per adjusted census of around 3% per year will continue for a few years and then gradually decrease to a level of about 1% per year, a level lower than obtained before the hospital insurance program. The 1% per year is assumed to persist over the full period for which estimates are prepared.

The restriction on increases due to changes in the services and method of provision is estimated to reduce moderately the non-labor portion of this component of the increase in the immediate future. It is assumed that ultimately this rate will drop to 3% per year, a level substantially lower than that which prevailed during the decade before the hospital insurance program began.

Table A shows the increases in hospital costs that have occurred under the hospital insurance program, and those resulting from compounding the forecasts for each of the three principal components into which such increases were analyzed. It can be noted that the long run increases are assumed to be higher than the long run increases in earnings, and hence in income, so that the current cost of the program rises indefinitely. Such increases assume a willingness on the part of the public to spend part of the increases in real income resulting from the differences between earnings and consumer prices on higher quality hospital care, at a rate of 1% per year. As emphasized throughout this report, this rate is below the historical average and far below the rate experienced since the beginning of the hospital insurance program. It thus presumes a significant amount of public pressure to reduce the increases in hospital costs as the cost of these services bite deeper into disposable income, either directly through payment of higher charges or indirectly in the form of higher insurance premiums and taxes to support government programs. It is also assumed that the investments of federal programs in quality of hospital management should in the longer run reduce the cost of care.

b. Assumptions as to increases in the cost per capita of extended care facility benefits.—Utilization of extended care facilities dropped very sharply in 1970 and moderately in the first quarter of 1971 as a result of strict enforcement of regulations separating convalescent from custodial care. Adjusted for the trend to increasing use of these facilities, the current level of utilization is a little over half of that which occurred

during the early years of the program. It is anticipated that increases in utilization are to be anticipated over the next several years, however, as providers and patients become more familiar with the level of care covered in these institutions under the new administrative policies.

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

The average cost per day of extended care facility services covered by the program increased by approximately 10% in 1970 over 1969. It is assumed that a similar level of cost increases will prevail for a few years and then gradually decrease so as to merge with the annual rate of increase in general wages by 1982. The resulting increases in the cost per capita of extended care facility services are shown in table D.

TABLE D.—INCREASES IN COST PER CAPITA BY TYPE OF SERVICE ASSUMED FOR FORECASTING THE CURRENT COST RATES OF THE HOSPITAL INSURANCE PROGRAM IN THE 1972 TRUSTEES REPORT (INCREASE OVER PRIOR YEAR)

[In percent]

Year	Hospitals	Extended care facilities	Home health agencies
1970	11.4	−26.0	19.5
1971	10.5	0.0	19.5
1972	11.5	15.0	19.5
1973	11.0	22.0	19.0
1974	11.0	21.0	18.0
1975	10.5	19.0	18.0
1976	10.5	16.0	15.0
1977	9.5	12.0	11.0
1978	8.5	11.0	10.0
1979	8.0	9.0	8.0
1980	7.5	7.0	7.0
1981	7.0	6.0	6.0
1982	6.5	5.0	5.0
1983 and later	6.0	5.0	5.0

The long run assumption that increases in the cost per day of care in extended care facilities will be equal to the increases in the average earnings after 1981 requires increases in productivity to offset the higher than average increases in earnings anticipated for nurses and any tendency to upgrade the quality of services. As in the case of hospitals, public pressure to contain these costs will be required, through legislation if necessary.

c. Assumptions as to home health service benefits.—Data on utilization of home health services are very slow in reaching the Social Security Administration. Early in the program, increases in utilization were very large, running around 30% per year; but it now appears that the rate of increase may be substantially lower, perhaps 10% per year. The assumptions used in the cost estimates are shown in table D.

d. Administrative expenses.—Total administrative expenses are assumed to be 2½% of benefits through 1977. After that, the projection

assumes that the per capita expenses increase at 4% each year—that is, 1% less than the projected increase in all wages in covered employment.

e. Interest rate.—It has been assumed that trust fund investments will earn an average of 6% interest per annum. The actual rate earned on the hospital insurance trust fund during fiscal 1971 was 6.5%.

f. Population.—The population projections used in this report are based on those in *Actuarial Study Number 62*, Social Security Administration.

(*4*) *Sensitivity testing of long term cost estimates*

Sensitivity testing has always been incorporated in examination of the cost of the hospital insurance program; but the results of these sensitivity studies have not been shown explicitly in the reports. Sensitivity testing reported here is limited to investigating the effect of a single change in the assumptions as to the long term increases in hospital costs, to reflect a weaker degree of public pressure to contain such costs. For this test the rate of hospital cost increases for 1981 and later is held at the 1980 level (7.5%), rather than declining to 6% for 1983 and later as assumed in the cost estimates. The higher level after 1980 assumes the same excess of hospital cost increases over factor cost increases that prevailed in the decade before the beginning of the hospital insurance program.

A summary of the assumptions used in this test appears in table E and the resulting current cost ratios appear in table F.

(*5*) *Accuracy of past estimates*

Table G compares the actual incurred expenditures for the hospital insurance program with the estimates of such expenditures prepared at various times in the past. Since the estimates of incurred expenditures are used primarily to recommend and test the financing of the program, the appropriate test of these estimates is to compare the estimated current cost rates to the actual results.

The earliest of these estimates, prepared before any program experience was available, underestimated the first year and one half of expenditures by around 8%, but because of too little allowance for what proved to be a steep trend, underestimated 1971 expenditure by 27%.

The 1967 estimate was about 10% low for 1968, and 18% low for 1971, again indicating that the increase in hospital costs over the period was sharper than anticipated.

TABLE E.— INCREASES IN COST PER CAPITA BY TYPE OF SERVICE ASSUMED FOR FORECASTING THE CURRENT COST RATES FOR THE HOSPITAL INSURANCE PROGRAM IF THE LONG-RANGE INCREASE IN HOSPITAL COSTS IS COMPARABLE TO THAT IN THE DECADE BEFORE 1966 (INCREASE OVER PRIOR YEAR)

[In percent]

Year	Hospitals	Extended care facilities	Home health agencies
1970	11.4	−26.0	19.5
1971	10.5	0.0	19.5
1972	11.5	15.0	19.5
1973	11.0	22.0	19.0
1974	11.0	21.0	18.0
1975	10.5	19.0	18.0
1976	10.0	16.0	15.0
1977	9.5	12.0	11.0
1978	8.5	11.0	10.0
1979	8.0	9.0	8.0
1980	7.5	7.0	7.0
1981	7.5	6.0	6.0
1982	7.5	5.0	5.0
1983 and later	7.5	5.0	5.0

TABLE F.— INCURRED COSTS [1] OF HOSPITAL INSURANCE PROGRAM (FOR THE INSURED ONLY) AS A PERCENT OF TAXABLE PAYROLL [2]

Calendar year:	Incurred cost (percent)
1972	1.50
1973	1.60
1974	1.70
1975	1.80
1980	2.20
1985	2.40
1990	2.76
1995	3.08
25-year average	2.38

[1] Benefit payments and administrative expenses, plus a provision for trust fund growth equal to 1 year's expenditures for 1985 and thereafter.

[2] Earnings in covered employment and taxable earnings base assumed to rise 5 percent annually.

TABLE G.—COMPARISON OF PREVIOUS COST ESTIMATES EXPRESSED AS A PERCENT OF TAXABLE PAYROLL WITH ACTUAL RESULTS [1]

	Date estimate made			
	July 1965 [2]	December 1967 [3]	March 1970 [4]	Actual [5]
Estimate of experience in—				
1966	0.41			0.39
1967	.82			.95
1968	.82	0.93		1.03
1969	.87	.98		1.09
1970	.91	1.03	1.19	1.17
1971	.95	1.07	1.32	1.30

[1] The estimated benefits and administrative expenses shown are divided by the effective payroll, i.e., that payroll which when multiplied by the combined tax rate for employers and employees together, will produce the estimated contribution Income..

[2] Committee on Ways and Means, Committee Print 51-291, July 30, 1965, The contributions for 1966 and 1967 were adjusted to an incurred basis using the assumption made in 1965 that the average lag between incurred and cash contributions is 1 month.

[3] Committee on Ways and Means, Committee Print 87-369, Dec. 11, 1967.

[4] 1970 "Trustees' Report" for the HI program.

[5] See Table 7.

The 1970 estimate proved to be very accurate for each of its first two years, this time overestimating the expenditure by a small margin. Much more information was available for this estimate than for those made earlier.

The estimates shown are not strictly comparable, due to the changes in legislation or regulations between the date on which an estimate was prepared and the year for which it was made. For example, for the initial

estimates prepared for the House Ways and Means Committee in February 1965 (and reported in the Committee Report published on July 30, 1965) the following adjustments should be made for comparability:

(1) Increase in benefits as a result of the 1967 Amendments, raising the cost of the program by approximately ½% per year after 1967.

(2) Change in the earnings base applicable to 1968 and subsequent years from $6,600 to $7,800, which increased the covered payroll by approximately 7% in 1968, by 6% in 1971, and by lower amounts in later years.

(3) Passage of legislation including hospital workers under the minimum wage.

(4) Payment to hospitals of an allowance of 2% of costs in addition to all determinable costs. For reimbursement for services provided after June 1969, this allowance was reduced to approximately 1.2% of costs.

(5) Payment during the initial years of the program for services in a very large number of extended care facilities which did not meet the standards set forth under the law but that were taking steps to overcome the deficiencies that prevented meeting such standards. (Most of these institutions were subsequently dropped.)

(6) Payment during the initial years of the program for a larger proportion of the services in extended care facilities than specified in the law. (This situation was subsequently corrected, resulting in a decrease in extended care patient days per capita of approximately 50%.)

There are also many less important differences between specifications at the time of enactment and the actual program that developed. Rates comparable to the 1965 estimates that have been standardized for the above factors (except the minimum wage legislation) would be as follows:

[In percent]

Year	Estimate	Standardized	Actual	Ratio to actual
1966	0.41	0.42	0.39	1.08
1967	.82	.87	.95	.92
1968	.82	.82	1.03	.80
1969	.87	.86	1.09	.79
1970	.91	.89	1.17	.76
1971	.95	.93	1.30	.72

The standardized rates are only 4% low for the first year and one half of the program, but are 28% low for 1971.

The more past experience available at the time of an estimate, and the shorter the time period between date of estimate and the year being estimated, the more accuracy one should expect. Experience with the hospital insurance program to date bears out this expectation. There is nonetheless much that can go wrong in the estimation process, and present estimates for years far in the future must be considered to have a relatively large likelihood for substantial error.

APPENDIX II.—SUMMARY OF PRINCIPAL PROVISIONS

Public Law 89-97, approved July 30, 1965, amended the Social Security Act and related provisions of the Internal Revenue Code by establishing the hospital insurance program. A summary of its provisions, as of December 31, 1971, is as follows:

I. COVERAGE PROVISIONS (FOR CONTRIBUTION PURPOSES)

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

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

II. PERSONS PROTECTED (FOR BENEFIT PURPOSES)

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

(*b*) Uninsured persons—individuals who attain age 65 before 1968 who are not eligible for any type of monthly benefit under the old-age, survivors, and disability insurance or railroad retirement programs, who are citizens or aliens lawfully admitted for permanent residence with at least 5 consecutive years of residence, and who are not covered under the Federal Employees Health Benefits Act of 1959 (including certain individuals who could have been covered if they had so elected) and have not been convicted of any offense listed in section 202(u) of the Social Security Act. (Sec. 103(b) (1) of Public Law 89-97 also excluded individuals who are members of any organization referred to in section 210(a) (17) of the Social Security Act. This provision was held to be unconstitutional by a Federal court, and its enforcement was enjoined). Those in this category attaining age 65 after 1967 must have certain amounts of old-age, survivors, and disability insurance or railroad retirement coverage to be eligible for hospital insurance benefits-namely, three quarters of coverage for each year after 1966 and before age 65, so that the provision becomes ineffective for men attaining age 65 after 1975 (for women, 1974), since then the "regular" insured status conditions for cash benefits are easier to meet.

III. BENEFITS PROVIDED

(*a*) Hospital benefits—full cost of all hospital services (i.e., including room and board, operating room, laboratory tests and X-rays, drugs, dressings, general nursing services, and services of interns and residents in training) for semiprivate accommodations for up to 90 days in a "spell

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

of illness" (a period beginning with the 1st day of hospitalization and ending after the person has been out of a hospital and an extended care facility for 60 consecutive days), after a deductible of $40 and coinsurance of $10 per day for all days after the 60th one and also a deductible of the cost of the first three pints of blood; in addition to such 90 days per spell of illness, a lifetime reserve of 60 days with coinsurance of $20 per day is available; after 1968, the deductible and the coinsurance amounts will be automatically adjusted to reflect changes in hospital costs after 1966; lifetime maximum of 190 days for psychiatric hospital care.

(*b*) Extend care facility (skilled nursing home or convalescent wing of hospital) benefits—following at least 3 days of hospitalization, beginning within 14 days of leaving hospital, and for continued care of a condition for which a person was hospitalized, up to 100 days of such care in a spell of illness, with coinsurance of $5 per day for all days after the 20th one; after 1968, the $5 coinsurance will be automatically adjusted to reflect changes in hospital costs after 1966.

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

(*d*) Services not covered—services obtained outside of the United States (except for emergency services for an illness occurring in the United States and the foreign hospital involved was closer, or substantially more accessible than the nearest adequate U.S. hospital), elective "luxury" services (such as private room or television), custodial care, hospitalization for services not necessary for the treatment of illness or injury (such as elective cosmetic surgery), services performed in a Federal institution (such as a Veterans' Administration hospital), and cases eligible under workmen's compensation.

(*e*) Administration—by Department of Health, Education, and Welfare. Each provider of services can nominate a fiscal intermediary (such has Blue Cross, other health insurance organizations, or State agencies) or can deal directly with the Department. The providers of services are reimbursed on a "reasonable cost" basis, and the fiscal intermediaries are reimbursed for their reasonable costs of administration. The providers of services must meet certain standards, including establishment of utilization review committees for hospitals, and extended care facilities, development of transfer agreements between hospitals and extended care facilities, and quality care.

IV. FINANCING.

(a) Insured persons-on a long-range self-supporting basis (just as under the old-age, survivors, and disability insurance system), through separate schedule of increasing tax rates on covered workers (see table in "Nature of the Trust Fund" section), with same maximum taxable earnings base as scheduled for the old-age, survivors, and disability insurance system, $9,000; same rate applies to employees, employers, and self-employed (unlike under the old-age, survivors, and disability insurance system).

(b) Hospital insurance trust fund-separate trust fund, with separate board of trustees (same membership as for old-age and survivors insurance and disability insurance trust funds) and with same investment procedures.

(c) Uninsured persons-from general revenues, through the hospital insurance trust fund.

APPENDIX III.—DETERMINATION AND ANNOUNCEMENT OF "INPATIENT HOSPITAL DEDUCTIBLE FOR 1972"[2]

Pursuant to the requirements of section 1813(b) (2) of the Social Security Act (42 U.S.C. 1395e(b) (2)), as amended, I hereby determine and announce that the dollar amount which shall be applicable for the inpatient hospital deductible, for purposes of section 1813(a) of the Act, as amended, shall be $68 in the case of any spell of illness beginning during 1972.

There follows a statement of the actuarial bases employed in arriving at the amount of $68 for the inpatient hospital deductible for the calendar year 1972 (as contrasted with the figures of $40 applicable for the period from July 1966 through December 1968, $44 for calendar year 1969, $52 for calendar year 1970, and $60 for calendar year 1971). Certain other cost-sharing provisions under the Hospital Insurance program are also affected by changes in the amount of the inpatient hospital deductible.

The law provides that, for calendar years after 1968, the inpatient hospital deductible shall be equal to $40 multiplied by the ratio of (1) the current average per diem rate for inpatient hospital services for the calendar year preceding the year in which the promulgation is made (in this case, 1970) to (2) the current average per diem rate for such services for 1966. The law further provides that, if the amount so determined is not an even multiple of $4, it shall be rounded to the nearest multiple of $4. Further, it is provided that the current average per diem rates referred to shall be determined by the Secretary of Health, Education, and Welfare from the best available information as to the amounts paid under the program for inpatient hospital services furnished during the year by hospitals who are qualified to participate in the program, and for whom there is an agreement to do so, for individuals who are entitled to benefits as a result of insured status under the Old-Age, Survivors, and Disability Insurance program or the Railroad Retirement Program.

The data available to make the necessary computations of the current average per diem rates for calendar years 1966 and 1970 are derived from individual inpatient hospital bills that are recorded on a 100 percent basis in the records of the program. These records show, for each bill, the total inpatient days of care, the interim reimbursement amount, and the total cost (the sum of interim reimbursement, deductible, and coinsurance).

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

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

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[2] This statement was published in the *Federal Register* for October 1, 1971 (F.R. Doc.71-14499).

The current average per diem rate for inpatient hospital services for calendar year 1966, on the basis described, is $37.92, while the corresponding figure for calendar year 1970 is $63.14. Accordingly, the ratio of the 1970 rate to the 1966 rate is 1.665.

In order to accurately reflect the change in the average per diem hospital cost under the program, the average interim cost (as shown in the tabulations) must be adjusted for (i) the effect of final cost settlements made with each provider of services after the end of its fiscal year to adjust the reimbursement to that provider from the amount paid during that year on an interim basis to the actual cost of providing covered services to beneficiaries, and (ii) for changes in the benefit structure since the base year, 1966. To the extent that the ratio of final cost to interim cost is different in the current year than it was in 1966, the increase in average interim per diem costs will not coincide with the increase in actual cost that has occurred. The inclusion of the lifetime reserve days in the current tabulation of the average interim per diem cost when such days were not included in the corresponding tabulation for the base year, 1966, will understate the estimate of the increase in cost that has occurred, because the average cost per day of very long confinements in a hospital is less than the average for all confinements. In order to estimate the increase in average per diem cost that has occurred, a comparison must be based on similar benefits in the two periods (1970 and 1966); thus the effect of lifetime reserve days, must be eliminated from the current year tabulation. The best data available indicates that these adjustments do not change the ratio shown above by enough to result in a different deductible for 1972. The values shown in this report do not reflect these adjustments for final cost settlements or lifetime reserve days. When the ratio of 1.665 is multiplied by $40, it produces an amount of $66.60, which must be rounded to $68. Accordingly, the inpatient hospital deductible for spells of illness beginning during calendar year 1972 is $68.

Dated: September 29, 1971.

ELLIOT L. RICHARDSON,
Secretary.