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1976 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

COMMUNICATION

FROM

THE BOARD OF TRUSTEES, FEDERAL HOSPITAL INSURANCE TRUST FUND

TRANSMITTING

THE 1976 ANNUAL REPORT OF THE BOARD, 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, May 24, 1976.

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

SIR: We have the honor to transmit to you the 1976 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (the 11th such report), in compliance with the provisions of section 1817(b) of the Social Security Act.

Respectfully,

WILLIAM E. SIMON,
Secretary of the Treasury,
Managing Trustee of the Trust Fund.

W. J. USERY, JR.,
Secretary of Labor.

DAVID MATHEWS,
Secretary of Health, Education, and Welfare.

JAMES B. CARDWELL,
Commissioner of Social Security

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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 1976, the eleventh such report.

HIGHLIGHTS

(a) Disbursements of the hospital insurance trust fund were $10.6 billion in fiscal year 1975, an increase of 32 percent over fiscal year 1974. Most of this increase was due to substantial increases in the cost of institutional health care.

(b) Income to the trust fund amounted to $12.6 billion, representing an increase of 8 percent in fiscal year 1975 over 1974. The majority of this increase was due to higher average earnings for persons in covered employment and increases in the maximum taxable amount of annual earnings.

(c) The trust fund increased $2 billion, to $9.9 billion at the end of fiscal year 1975. The effective annual rate of interest earned by the assets of the hospital insurance trust fund during fiscal year 1975 was 7.2 percent.

(d) The Secretary of Health, Education, and Welfare promulgated a $104 inpatient deductible for calendar year 1976 and a $45 monthly premium for noninsured enrollees for the 12-month period beginning July 1976.

(e) Approximately 22 million persons aged 65 and over were protected by the hospital insurance program in July 1975. This represents about 96 percent of the aged population. An additional 2.2 million disabled beneficiaries had protection in the same month.

(f) The current financing schedule of the program over the next 10 years is adequate to provide for program expenditures. However, tax rates scheduled after the mid-1980's are not sufficient to sustain the system, resulting in an average 25-year deficit of 0.64 percent of tax able payroll.

NATURE OF THE TRUST FUND

The Federal Hospital Insurance Trust Fund was established on July 30, 1965, as a separate account in the United States 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 includes workers covered under the old-age, survivors, and disability insurance program and those covered under the railroad retirement program.

All employees, and their employers, in employment covered by the program are required to pay contributions with respect to the wages of individual workers (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 contribution rates applicable to taxable earnings in each of the calendar years 1966 and later are shown in table 1. For 1977 and later, the contribution rates shown are the rates scheduled in the provisions of present law. The maximum amount of annual earnings taxable in each year, 1966-76, is also shown. Beginning with 1975, the maximum amount of earnings taxable each year is determined in the preceding year under the automatic increase provisions in Section 230 of the Social Security Act, unless modified by intervening Congressional action.

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 contributions, (2) old-age, survivors, and disability insurance contributions, and (3) individual income taxes are not separately identified in collection reports received by the Treasury Department.

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 contributions he paid on such excess wages. The amount of contributions subject to refund for any period is a charge against the trust fund.

TABLE 1.—CONTRIBUTION RATES AND MAXIMUM TAXABLE AMOUNT OF ANNUAL EARNINGS

Calendar years	Maximum taxable amount of annual earnings	Contribution rate (Percent of taxable earnings)	
		Employees and employers, each	Self-employed
Past experience:			
1966	$6,600	0.35	0.35
1967	6,600	.50	.50
1968-71	7,800	.60	.60
1972	9,000	.60	.60
1973	10,800	1.00	1.00
1974	13,200	.90	.90
1975	14,100	.90	.90
1976	15,300	.90	.90
Changes scheduled In present law:			
1977	[1]	.90	.90
1978-80	[1]	1.10	1.10
1981-85	[1]	1.35	1.35
1986 & later	[1]	1.50	1.50

[1]Subject to automatic increase.

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 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 authorize annual reimbursements from the general fund of the Treasury to the hospital insurance trust fund for any costs arising from the granting of noncontributory wage credits for military service, according to periodic determinations made by the Secretary of Health, Education, and Welfare.

Section 231 of the Social Security Act authorizes reimbursement from the general fund of the Treasury to the hospital insurance trust fund for any costs arising from the granting of noncontributory wage credits to individuals who were interned during World War II at a place within the United States operated by the Federal Government for the internment of persons of Japanese ancestry.

Under Section 103 of the Social Security Amendments of 1965, hospital insurance benefits are provided to certain uninsured persons aged 65 and over. Such payments are made initially from the hospital insurance trust fund, with reimbursement 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.

Section 1818 of the Social Security Act provides that certain persons not eligible for hospital insurance protection either on an insured basis or on the uninsured basis described in the previous paragraph may obtain protection by enrolling in the program and paying a monthly premium.

Section 201(i) of the Social Security Act authorizes the Managing Trustee to accept and deposit in the trust fund unconditional money gifts or bequests made for the benefit of the fund or any activity financed through the fund.

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 pertaining to the hospital insurance program 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 fund in accordance therewith.

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.

The Social Security Amendments of 1967 and 1972 authorize the Secretary of Health, Education, and Welfare to develop and conduct a broad range of experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under the hospital insurance and supplementary medical insurance programs. The costs of such experiments and demonstration projects are paid out of the hospital insurance and supplementary medical insurance programs.

Congress has authorized expenditures from the trust funds for construction, rental, and lease or purchase contract of office buildings and related facilities for the Social Security Administration. Both the capital costs of construction financed directly from the trust funds and the rental, lease, or purchase contract costs of acquiring facilities are included in trust fund expenditures. In 1974, construction of several large facilities was begun under purchase contract authority, wherein initial capital costs are borne by the private sector. Under this method of facilities acquisition, trust fund expenditures for use and ultimate Government ownership of a facility are made over periods of from 10 to 30 years. Whatever the manner of acquisition, the net worth of facilities and other fixed capital assets is not carried in the statements of the operations of the trust fund presented in this report. This is because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures, and therefore is not viewed as being a consideration in assessing the actuarial status of the funds.

That portion of the trust fund which, in the judgment of the Managing Trustee, is not required to meet current expenditures for benefits and administration is invested, on a daily basis, in interest-bearing obligations of the U.S. Government (including special public-debt obligations described below), in obligations guaranteed as to both principal and interest by the United States, or in certain federally sponsored agency obligations that are designated in the laws authorizing their issuance as lawful investments for fiduciary and trust funds under the control and authority of the United States or any officer of the United States. These obligations may be acquired on original issue at the

issue price or by purchase of outstanding obligations at their market price.

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall bear interest at a rate based on the average market yield (computed 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 1975

A statement of the income and disbursements of the Federal Hospital Insurance Trust Fund during fiscal year 1975 and of the assets of the fund at the beginning and the end of the fiscal year is presented in table 2. Comparable amounts for fiscal year 1974 are also shown in the table.

The total assets of the trust fund amounted to $7,914 million on June 30, 1974. During fiscal year 1975, total receipts amounted to $12,568 million and total disbursements were $10,612 million. The assets of the trust fund thus increased $1,956 million during the year to a total of $9,870 million on June 30, 1975.

Included in total receipts during fiscal year 1975 were $10,132 million representing contributions appropriated to the trust fund and $1,214 million representing amounts received by the Secretary of the Treasury in accordance with State agreements for coverage of State and local government employees and deposited in the trust fund. As an offset, $55 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 $11,291 million, representing an increase of 6 percent over the amount for the preceding fiscal year. This growth in contribution income resulted primarily from (1) the higher level of taxable earnings and (2) the two increases in the maximum annual amount of earnings taxable-from $10,800 to $13,200 and from $13,200 to $14,100-that became effective on January 1, 1974, and January 1, 1975, respectively. Although the first increase in the maximum annual amount of earnings taxable, from $10,800 to $13,200, became effective in 1974, the first full fiscal year during which earnings between $10,800 and $13,200 were taxable was 1975.

Reference has been made in an earlier section to provisions of the Social Security Act under which certain persons aged 65 and over but not otherwise eligible for hospital insurance protection may obtain such protection by enrolling in the program and paying a monthly premium. Premiums collected from such voluntary participants in fiscal year 1975 amounted to about $6 million.

In accordance with the 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, the Railroad Retirement Board and the Secretary of Health, Education, and Welfare determined

that a transfer of $130,636,000 from the railroad retirement account to the hospital insurance trust fund would place this fund in the same position, as of June 30, 1974, 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 September 1974 together with interest to the date of transfer amounting to $1,861,000.

In accordance with provisions for annual reimbursement from the general fund of the Treasury for the costs of granting noncontributory credits for military service, 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 for military service performed before 1957, arising from payment that have been made since July 1966 and that will be made in future years, taking into account the amounts of annual appropriations in fiscal years 1966-71 that have been deposited into the trust funds. The annual amount resulting from this determination was $48 million. Thus, a reimbursement amounting to $48 million was received by the trust fund in December 1974.

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 in behalf of certain uninsured persons. The reimbursement in fiscal year 1975 amounted to $482 million, consisting of $470 million for benefit payments, $11 million for administrative expenses, and $1 million due the trust fund for interest on adjustments to costs in prior fiscal years.

In accordance with provisions referred to in an earlier section under which money gifts or bequests may be deposited in the trust fund, the trust fund received gifts amounting to about $8,000 in fiscal year 1975.

The remaining $608 million of receipts consisted almost entirely of interest on the investments of the trust fund.

Of the $10,612 million in total disbursements, $10,359 million represented benefits paid directly from the trust fund for health services covered under Title XVIII of the Social Security Act. As offsets to benefit payments, transfers were made from the supplementary medical insurance trust fund amounting to $6 million for certain costs of radiology and pathology services that were paid initially from the hospital insurance trust fund but that were liabilities of the supplementary medical insurance trust fund. Net benefit payments from the trust fund in fiscal year 1975, therefore, amounted to $10,353 million, an increase of 32.6 percent over the corresponding amount paid in fiscal year 1974. An additional $2 million in disbursements constituted payment for costs of experiments and demonstration projects in providing health care services.

The remaining $256 million of disbursements was for net administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds-old-age and survivors insurance, disability insurance, hospital insurance, and supplementary medical insurance-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 transfers among the four trust funds, with appropriate interest allowances.

Table 3 compares the actual experience in fiscal year 1975 with the estimates presented in the 1974 and 1975 annual reports. 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 3, it should be noted that the "actual" amount of contributions in fiscal year 1975 reflects the aforementioned type of adjustments to contributions for prior fiscal years. On the other hand, the "actual" amount of contributions in fiscal year 1975 does not reflect adjustments to contributions for fiscal year 1975 that were to be made after .June 30, 1975. The estimated contributions in both the 1974 and 1975 annual reports were quite close to the actual experience. Actual benefit payments were 10 percent higher than estimated in the 1974 report and only one percent higher than estimated in the 1975 report.

The assets of the trust fund at the end of fiscal year 1975 totaled $9,870 million, consisting of $9,761 million in the form of obligations of the U.S. Government or of federally sponsored agency obligations, and an undisbursed balance of $109 million. Table 4 shows a comparison of the total assets of the fund and their distribution at the end of fiscal years 1974 and 1975.

The net increase in the par value of the investments held by the fund during fiscal year 1975 amounted to $1,897 million. New securities at a total par value of $14,111 million were acquired during the fiscal year, through the investment of receipts and the reinvestment of funds made available from the redemption of securities. The par value of securities redeemed during the fiscal year was $12,215 million. Included in these amounts is $12,048 million in certificates of indebtedness that were acquired and redeemed within the fiscal year.

The effective annual rate of interest earned by the assets of the hospital insurance trust fund during fiscal year 1975 was 7.2 percent. The interest rate on public-debt obligations issued for purchase by the trust fund in June 1975 was 7⅜ percent, payable semiannually.

TABLE 2.—STATEMENT OF OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING FISCAL YEARS 1974 AND 1975
[In thousands of dollars]

	Fiscal Year 1974	Fiscal Year 1975
Total assets of the trust fund, beginning of period	$4,368,666	$7,913,699
Receipts:		
Contributions:		
Appropriations	9,595,278	10,131,791
Deposits arising from State agreements	1,099,424	1,214,297
Gross Contributions	10,694,702	11,346,088
Less payment into the Treasury for contributions subject to refund	92,432	55,000
Net Contributions	10,602,270	11,291,088
Premiums collected from voluntary participants	4,281	5,685
Transfer from railroad retirement account	99,182	132,497
ReimReimbursement from the general fund of Treasury for costs of—		
Noncontributory credits for military service	48,000	48,000
Benefits for uninsured persons:		
Benefit payments	445,000	470,000
Administrative expenses	8,101	11,353
Gross reimbursement for costs for benefits for uninsured persons	453,101	481,353
Interest on adjustments to costs in prior fiscal years [1]	−2,321	1,052
Total reimbursement for costs for benefits for uninsured persons	450,780	482,405
Interest:		
Interest on Investments	405,523	607,134
Interest on amounts of interfund transfers due to adjustment in allocation of administrative expenses and construction costs [2]	−269	1,054
Total interest	405,254	608,189
Gifts	([3])	8
Total receipts	11,609,767	12,567,872
Disbursements::		
Benefit payments:		
Paid directly from the trust fund for the costs of health services	7,811,980	10,359,011
Less transfers from the supplementary medical insurance trust fund for reimbursement of interest loss related to transfer payments made in conjunction with the costs of radiology and pathology services [1]	6,000	6,000
Net benefit payments	7,805,980	10,353,011
Costs of experiments and demonstration projects [4]	707	2,379
Administrative expenses:		
Department of Health, Educations, and Welfare [5]	243,893	258,613
Treasury Department	11,142	7,808
Construction of facilities for Social Security Administration	172	206
Interfund transfers due to adjustment in allocation of construction costs		
Administrative expenses [6]	2,827	−10,690
Construction costs [6]	38	205
Gross administrative expenses	258,066	256,142
Less receipts from sale of supplies, materials, etc.	18	
Net administrative expenses	258,048	256,142
Total disbursements	8,064,735	10,611,532
Net addition to the trust fund	3,545,032	1,956,340
Total assets of the trust fund. end of period	7,913,699	9,870,039

[1] A positive figure represents a transfer of interest to the hospital insurance trust fund from the general fund of the Treasury. A negative figure represents a transfer of interest from the hospital insurance trust fund to the general fund of the Treasury.

[2] 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.

[3] A gift amounting to $12 was received in fiscal year 1974.

[4] For explanation, see text.

[5] Includes administrative expenses of the intermediaries.

[6] A positive figure represents a transfer from the hospital insurance trust fund to the other social security trust funds. A negative figure represents a transfer to the hospital insurance trust fund from the other social security trust funds.

TABLE 3.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND, FISCAL YEAR 1975
[Amounts in millions]

Item	Actual amount	Comparison of actual experience with estimates for fiscal year 1975 published in– 1975 report: Estimated amount	1975 report: Actual as percentage of estimate	1974 report: Estimated amount	1974 report: Actual as percentage of estimate
Net contributions	$11,291	$11,258	100	$11,264	100
Benefit payments	10,353	10,231	101	9,436	110

TABLE 4.—ASSETS OF THE HOSPITAL INSURANCE TRUST FUND, BY TYPE, AT THE END OF FISCAL YEARS 1974 AND 1975

	June 30, 1974		June 30, 1975	
	Par value	Book value [1]	Par value	Book value [1]
Investments In public-debt obligations sold only to this fund (special Issues):				
Notes:				
5¾ percent, 1979	$537,999,000	$537,999,000.00	$537,999,000	$537,999,000.00
6⅛ percent, 1978	931,182,000	931,182,000.00	931,182,000	931,182,000.00
6⅝ percent, 1980	2,159,064,000	2,159,064,000.00	2,159,064,000	2,159,064,000.00
7⅝ percent, 1977	534,947,000	534,947,000.00	368,194,000	368,194,000.00
Bonds:				
7⅜ percent, 1981			165,760,000	165,760,000.00
7⅜ percent, 1982			165,760,000	165,760,000.00
7⅜ percent, 1983			165,760,000	165,760,000.00
7⅜ percent, 1984			165,760,000	165,760,000.00
7⅜ percent, 1985			165,759,000	165,759,000.00
7⅜ percent, 1986			165,759,000	165,759,000.00
7⅜ percent, 1987			165,759,000	165,759,000.00
7⅜ percent, 1988			165,760,000	165,760,000.00
7⅜ percent, 1989			165,760,000	165,760,000.00
7⅜ percent, 1990			571,444,000	571,444,000.00
7⅝ percent, 1981	405,685,000	405,685,000.00	405,685,000	405,685,000.00
7⅝ percent, 1982	405,685,000	405,685,000.00	405,685,000	405,685,000.00
7⅝ percent, 1983	405,685,000	405,685,000.00	405,685,000	405,685,000.00
7⅝ percent, 1984	405,685,000	405,685,000.00	405,685,000	405,685,000.00
7⅝ percent, 1985	405,685,000	405,685,000.00	405,685,000	405,685,000.00
7⅝ percent, 1986	405,685,000	405,685,000.00	405,685,000	405,685,000.00
7⅝ percent, 1987	405,685,000	405,685,000.00	405,685,000	405,685,000.00
7⅝ percent, 1988	405,684,000	405,684,000.00	405,684,000	405,684,000.00
7⅝ percent, 1989	405,684,000	405,684,000.00	405,684,000	405,684,000.00
Total public-debt obligations sold only to this fund (special issues)	7,814,355,000	7,814,355,000.00	9,710,883,000	9,710,883,000.00
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
Total Investments	7,864,355,000	7,864,355,000.00	9,760,883,000	9,760,883,000.00
Undisbursed balance		49,343,611.03		109,155,746.55
Total assets		7,913,698,611.03		9,870,038,746.55

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

EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND DURING THE PERIOD JULY 1, 1975 TO DECEMBER 31, 1978

The expected operations of the trust fund during fiscal year 1976, the transition quarter July through September of 1976, and fiscal years 1977-78 (on the new October through September basis) are shown in Table 5, together with the past experience of the program. This statement of expected operations of the trust fund through December 31, 1978 is based on the intermediate set of projection assumptions labelled alternative II which are presented in detail in appendix A of this report.

The estimates of income from hospital insurance contributions are at a considerably higher level during the period projected than during the

earlier years of the program, primarily as a result of the increased hospital insurance tax rates beginning January 1, 1973 and the further increase scheduled in the law to be effective beginning January 1, 1978. Income during successive years of the projection is estimated by projecting increases in (1) the earnings bases, in accordance with the automatic adjustment provisions; (2) the number of persons working in covered employment; and (3) the average earnings for workers in covered employment.

Income received through the financial interchange between the railroad retirement account and the trust fund under the provisions of the Railroad Retirement Act is estimated on the same basis as income from hospital insurance contributions. Estimates of the corresponding outgo are included in the disbursement items.

Estimated income to the trust fund appropriated from general revenues, to reimburse the program for the cost of noninsured persons for coverage which is financed through general revenues, is the same as the estimates of disbursements for such persons, net of corrections for differences between costs and amounts transferred for previous years. Premium income and disbursements for other noninsured persons over age 65 who may enroll in the hospital insurance program on a voluntary basis are based on an estimated enrollment of 16 thousand in fiscal year 1976.

Reimbursement from general revenues for military wage credits is projected at $141 million in each year. This is based on the determination made by the Secretary of Health, Education, and Welfare in 1975 of the level annual appropriations necessary to amortize the additional costs arising from these wage credits.

The investment of new assets received during fiscal years 1976-78 is assumed to be in the form of special public-debt obligations bearing interest rates of 7% percent, payable semiannually. The average prospective rate of interest on the assets held by the hospital insurance trust fund on June 30, 1975 was 7.1 percent.

Disbursements for benefits and administrative expenses are projected to increase sharply in fiscal years 1976-78, primarily as a result of the high rate of increase in hospital costs reimbursable under the program. The expenditures for benefit payments shown in Table 5 are slightly higher than those shown in the federal budget for fiscal year 1977, since they do not reflect the implementation of certain proposed changes in regulations which were included in the budget.

The actual operation of the hospital insurance program is, in general, organized on a calendar year basis. Earnings subject to taxation and the applicable tax rates are established by calendar year, as are the inpatient deductible and other cost sharing amounts. The projected operations of the trust fund on a calendar year basis are shown in Table 6, according to the same basis as used in Table 5. The following discussion of the financing of the program is on a calendar year basis.

The ratios of the balance in the trust fund at the beginning of each calendar year to the total disbursements during that year are shown in Table 7 for past years and as projected through 1978. The ratio of the fund to such disbursements grew gradually until it reached approximately the level of one half of a year's expenditures as of the beginning of 1971. After dropping slightly during both of the following two years, it increased to 69 percent in 1974 and 79 percent in 1975. The ratio is projected to decline during the next three years to 57 percent at the beginning of 1978.

TABLE 5.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING FISCAL YEARS 1967-78
[In millions of dollars]

	Income							Disbursements			Trust Fund	
Fiscal year[1]	Payroll taxes	Transfers from Railroad retirement account	Reimburse-ment for uninsured persons	Premiums from voluntary enrollees	Reimburse-ment for military wage credits	Interest on investments	Total income	Benefits payments	Adminis-trative expenses[2]	Total disburse-ments	Net increase in fund	Fund at end of year
Historical Data:												
1967	2,689	$16	$327		$11	$46	$3,089	$2,508	$89	$2,597	$492	$1,343
1968	3,514	44	273		11	61	3,902	3,736	79	3,815	88	1,431
1969	4,423	54	749		22	96	5,344	4,654	104	4,758	586	2,017
1970	4,785	64	617		11	137	5,614	4,804	149	4,953	661	2,677
1971	4,898	66	863		11	180	6,018	5,442	150	5,592	426	3,103
1972	5,226	66	503		48	188	6,031	6,108	167	6,276	−245	2,859
1973	7,663	63	381		48	196	8,352	6,648	194	6,842	1,510	4,369
1974	10,602	99	451	$4	48	405	11,610	7,806	259	8,065	3,545	7,914
1975	11,291	132	481	6	48	609	12,568	10,353	259	10,612	1,956	9,870
Projection:												
1976	12,096	138	610	8	48	738	13,638	12,184	333	12,517	1,121	10,991
Transition	3,292	139	0[3]	2	0	200	3,633	3,329	87	3,416	217	11,208
1977	13,998	0[4]	803[3]	10	141	800	15,752	15,150	325	15,475	277	11,485
1978	18,115	205[4]	674	13	141	886	20,034	17,721	389	18,110	1,924	13,409

[1]For 1967 through 1976, fiscal years cover the interval from July 1 through June 30; the 3-mo interval from July 1, 1976, through Sept. 30, 1976, is labeled the "transition" quarter; fiscal years 1977 and 1978 cover the interval from Oct. 1 through Sept. 30.

[2]Includes costs of experiments and demonstration projects

[3]The 1977 transfer is for benefits and administrative expenses during the five-quarter period covering the “transition” quarter and fiscal year 1977

[4]The 1978 transfer is for contributions during the 5-quarter period covering the “transition” quarter and fiscal year 1977.

TABLE 6.—OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1966-78
[In millions of dollars]

	Income							Disbursements			Trust Fund	
Calendar year[1]	Payroll taxes	Transfers from Railroad retirement account	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Reimbursement for military wage credits	Interest on investments	Total income	Benefits payments	Administrative expenses[2]	Total disbursements	Net increase in fund	Fund at end of year
Historical Data:												
1966	$1,858	$16	$26		$11	$32	$1,943	$891	$108	$999	$944	$944
1967	3,152	44	301		11	51	3,559	3,353	77	3,430	129	1,073
1968	4,116	54	1,022		22	74	5,287	4,179	99	4,277	1,010	2,083
1969	4,473	64	617		11	113	5,279	4,739	118	4,857	422	2,505
1970	4,881	66	863		11	158	5,979	5,124	157	5,281	698	3,202
1971	4,921	66	503		48	193	5,732	5,751	150	5,900	−168	3,034
1972	5,731	63	381		48	180	6,403	6,318	185	6,503	−99	2,935
1973	9,944	99	451	$2	48	278	10,821	7,057	232	7,289	3,532	6,467
1974	10,844	132	471	5	48	523	12,024	9,099	272	9,372	2,652	9,119
1975	11,502	138	621	7	48	664	12,980	11,315	266	11,581	1,399	10,517
Projection:												
1976	12,727	139	0[2]	9	141	561	13,577	13,235	349	13,584	−7	10,510
1977	14,304	205[3]	803[2]	11	141	754	16,218	15,750	338	16,088	130	10,640
1978	19,200	211	674	13	141	797	21,036	18,397	398	18,795	2,241	12,881

[1]Includes costs of experiments and demonstration projects

[2]No transfer is made in 1976 because of the change in transfer dates from December to March. The 1977 transfer is for benefits and administrative expenses during the 15-month period beginning July 1976 and ending September 1977.

[3]The 1977 transfer is for contributions during the 15-month period beginning July 1976 and ending September 1977.

TABLE 7.—RATIO OF THE FUND AT THE BEGINNING OF THE YEAR TO DISBURSEMENTS DURING THE YEAR FOR THE HOSPITAL INSURANCE TRUST FUND

Calendar Year	Percent
Historical Data:	
1967	28
1968	25
1969	43
1970	47
1971	54
1972	47
1973	40
1974	69
1975	79
Projection:	
1976	77
1977	65
1978	57

ACTUARIAL STATUS OF THE TRUST FUND

Acting on the recommendation of the 1971 Advisory Council, the Board of Trustees has adopted the general principle that the hospital insurance program should be financed in such a way that annual income to the program should be approximately equal to annual outlays of the program plus an amount to maintain a balance in the trust fund approximately equal to one year's expenditures. This principle reflects the view that there is a need for a sizeable fund for the contingency that future income and outgo may differ substantially from projections, but that it is unnecessary and impractical to fully fund the future benefits of workers as they accrue the right to those future benefits.

The projected expenditures under the program, expressed as percentages of taxable payroll, are summarized for selected years over the next 25-year period in table 8. The ratio of expenditures to taxable payroll has increased from 0.95 percent in 1967 to an estimated 1.73 percent in 1975, reflecting both the higher rate of increase in hospital costs than in earnings subject to hospital insurance taxes and the extension of hospital insurance benefits to disabled beneficiaries and persons suffering from chronic renal disease. Further increases in this ratio to 2.26 percent in 1980 and to 4.93 percent in the year 2000 result from the assumed continuation of increases in the cost of institutional health care at a higher rate than increases in taxable earnings (see Appendix A for a description of the methodology and assumptions used in this projection).

The allowances necessary to build the trust fund to the level of a year's disbursements and maintain it at that level, expressed as percentages of taxable payroll, are shown also in table 8. Since the level of the trust fund at the beginning of calendar year 1976 is 77 percent of the projected disbursements during 1976, provision must be made for increasing it to the 100 percent level. This building of the trust fund to the level of a year's disbursements could be accomplished in a single year, in a period of several years, or over the entire 25-year projection period. Because of the many patterns of growth possible, the portion of the allowance necessary to build the trust fund to the level of one years outgo has been spread evenly over the entire 25-year period, for purposes of display in table 8. The remaining portion of the allowance is necessary to maintain the trust fund at that level from year to year. This latter portion of the allowance will be at a relatively high level in the short run, as a result of

the high rate of increase in disbursements projected for this period. In the long run, the magnitude of the trust fund maintenance factor is somewhat smaller.

The adequacy of the financing of the hospital insurance program under current law is measured by comparing on a year to year basis the actual tax rates specified by law with the corresponding total costs of the program, expressed as percentages of taxable payroll. If these two items are exactly equal in each year of the 25-year projection period and all projection assumptions are realized, tax revenues along with interest income will be sufficient to provide for benefit and administrative expenses for insured persons and to gradually build the trust fund to the level of a year's outgo by the end of the period. In practice, however, tax rate schedules generally are designed with rate changes occurring only at several-year intervals, rather than with continual year by year increases to match exactly with projected cost increases. To the extent that small differences between the yearly costs of the program and the corresponding tax rates for short periods of time are offset by subsequent differences in the reverse direction, the financing objectives will be approximately met.

The projected total costs of the program, expressed as percentages of taxable payroll, and the tax rates scheduled under current law are shown in table 8 for selected years over the 25-year period 1976-2000. The total cost of the program, including expenditures plus trust fund building and maintenance, exceeds the tax rate in nearly every year of the projection. In addition, expenditures for benefits and administrative expenses alone exceed the corresponding tax rates for all future years, beginning in the late 1980's. The trust fund as a percent of a year's disbursements is projected to remain relatively level in the range of 55-60 percent through 1980, to increase somewhat during the early 1980's to a level of approximately 75 percent at the beginning of 1985, and to decline thereafter until the trust fund is completely exhausted in the early 1990's.

The actuarial balance of the hospital insurance program is defined to be the excess of the average tax rate for the 25-year valuation period over the average cost of the program, expressed as a percent of taxable payroll, for the same period. The average tax rate for the 25-year period 1976-2000 is 2.75 percent; the average cost of the program is 3.39 percent of taxable payroll, composed of 3.31 percent for program expenditures and 0.08 percent for the building and maintenance of the trust fund. The resulting actuarial balance, as shown in Table 9, is a deficit of 0.64 percent of taxable payroll.

Cost estimates for the hospital insurance program are of necessity based on a number of assumptions. These include (1) the behavior of the economy in general, (2) changes in the level of usage of health care services, (3) increases in the cost of health care, relative to increases in wages and prices in the general economy, and (4) demographic factors. While an accurate prediction of the future is not possible, short and long range estimates can be made, based on reasonable assumptions, which will indicate the trend and general range of future costs.

Since future economic, health care usage and cost, and demographic experience may differ considerably from any single set of assumptions on which cost estimates are based, projections also have been prepared on the basis of two additional sets of assumptions. The estimated operations of the hospital insurance trust fund during calendar years 1975-80 are

summarized in table 10 for all three alternatives, and table 11 compares the actuarial balance among the three. The assumptions underlying alternative II, the intermediate projection, are presented in substantial detail in Appendix A. The assumptions used in preparing alternative projections I and III are also summarized in Appendix A. Alternative II underlies the projections shown in the statement of expected operations of the trust fund through December 31, 1978 of this report.

The three alternative sets of assumptions were selected in order to indicate the general range in which the cost estimates might reasonably be expected to fall. The alternative I assumptions are somewhat more optimistic than those of alternative II, resulting in a stronger trust fund development and a lower average cost over the 25-year period. Conversely, alternative III assumptions are somewhat more pessimistic and result in a weaker trust fund development and a higher average cost. Alternatives I and III provide for a fairly wide range of possible experience, and actual experience reasonably may be expected to fall within the range. However, there can be no assurance that this will be the case, particularly in light of the wide variations in experience that have occurred since the beginning of the program.

Under alternative II, the trust fund as a percent of a year's disbursements is projected to remain relatively level in the range of 55-60 percent through 1980, to increase somewhat during the early 1980's to a level of approximately 75 percent at the beginning of 1985, and to decline thereafter until it is completely exhausted in the early 1990's. Under alternative I, the trust fund is projected to reach nearly 70 percent of a year's disbursements by the beginning of 1980 and to grow steadily over the remainder of the 25-year valuation period, ultimately reaching a level which is well in excess of a year's outgo. Under alternative III, the trust fund as a percent of a year's disbursements is projected to decrease steadily over the next 10 years, with complete exhaustion of the fund in the mid-1980's.

The divergence in experience among the three alternatives is reflected both m the estimated operations of the trust fund and in the 25-year average costs. The variations in the underlying assumptions, as shown in Appendix A, can be characterized as (1) moderate in terms of the magnitude of the differences on a year by year basis and (2) persistent over the duration of the 25-year period. Under alternative II, program costs are projected to grow approximately 5 percent more rapidly than taxable payroll in the short range, gradually declining to an ultimate level of 3 percent more rapidly in the long run. Under alternative I, program costs are projected to grow approximately 3 percent more rapidly than taxable payroll in the short run, gradually declining to an ultimate difference of 1 percent. Similarly, alternative III follows a pattern whereby program costs increase about 7 percent more rapidly than taxable payroll in the early years, gradually declining to an ultimate difference of about 5 percent. Recent experience has indicated that assumptions such as those producing alternative III are not unreasonable. In view of this and because of the wide ran e of possible experience, the maintenance of a substantial balance m the hospital insurance trust fund is particularly important.

TABLE 8.—COST AND TAX RATES OF THE HOSPITAL INSURANCE PROGRAM, EXPRESSED AS A PERCENT OF TAXABLE PAYROLL [1]

Calendar year	Expenditures under the program [1]	Trust fund building and maintenance [2]	Total cost of the program	Tax rate scheduled in the law
Historical Data:				
1967	0.95			
1968	1.03			
1969	1.09			
1970	1.17			
1971	1.30			
1972	1.26			
1973	1.37			
1974	1.50			
1975	1.73			
Projection:				
1976	1.87	0.13	2.00	1.80
1977	1.97	.12	2.09	1.80
1978	2.07	.12	2.19	2.20
1979	2.17	.11	2.28	2.20
1980	2.26	.10	2.36	2.20
1985	2.82	.07	2.89	2.70
1990	3.54	.07	3.61	3.00
1995	4.27	.07	4.34	3.00
2000	4.93	.07	5.00	3.00
Average [3]	3.31	.08	3.39	2.75

[1] Benefits and administrative expenses for insured beneficiaries.
[2] Allowance for building the trust fund balance to the level of a year's outgo and maintaining it at that level.
[3] Average for the 25-year period 1976-2000.

TABLE 9.— ACTUARIAL BALANCE OF THE HOSPITAL INSURANCE PROGRAM, EXPRESSED AS A PERCENT OF TAXABLE PAYROLL

	Percent
Average contribution rate, scheduled under present law[1]	2.75
Average cost of the program:[1]	
Expenditures, for benefit payments and administrative costs for insured beneficiaries	3.31
Building and Maintaining the trust fund, at the level of 1 year's expenditures	0.08
Total cost of the program	3.39
Actuarial balance	−0.64

[1] Average for the 25-year period 1976-2000.

TABLE 10.—ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1975-80, UNDER ALTERNTIVE SETS OF ASSUMPTIONS

[Dollar amounts in billions]

Calendar Years	Total Income	Total disburse-ments	Net Increase In fund	Fund at end of year	Ratio of assets to disburse-ments[1] (percent)
Alternative I:					
1975 [2]	$13.0	$11.6	$1.4	$10.5	79
1976	13.6	13.6	0	10.5	77
1977	16.2	16.0	.2	10.7	66
1978	21.2	18.5	2.7	13.4	58
1979	24.1	21.2	2.9	16.3	63
1980	26.7	24.0	2.7	18.9	68
Alternative II:					
1975 [2]	13.0	11.6	1.4	10.5	79
1976	13.6	13.6	0	10.5	77
1977	16.2	16.1	.1	10.6	65
1978	21.0	18.8	2.2	12.9	57
1979	23.6	21.7	1.9	14.8	59
1980	26.0	25.0	1.0	15.8	59
Alternative III:					
1975 [2]	13.0	11.6	1.4	10.5	79
1976	13.6	13.6	0	10.5	77
1977	16.0	16.2	−.1	10.4	65
1978	20.6	19.0	1.6	12.0	55
1979	22.9	22.2	.7	12.7	54
1980	24.9	25.8	−.8	11.9	49

[1] Ratio of the fund at the beginning of the year to disbursements during the year.
[2] Figures for 1975 represent actual experience.

TABLE 11.—ACTUARIAL BALANCE OF THE HOSPITAL INSURANCE PROGRAM, UNDER ALTERNATIVE SETS OF ASSUMPTIONS
[In percent]

	Alternative		
	I	II	III
Average contribution rate scheduled under present law[1]	2.75	2.75	2.75
Average cost of the program, for expenditures and for trust fund building and maintenance[2]	2.59	3.39	4.39
Actuarial balance	+.16	−.64	−1.64

[1]Average for the 25-year period 1976-2000.
[2]Average for the 25-year period 1976-2000, expressed as a percent of taxable payroll.

CONCLUSION

The present financing schedule for the hospital insurance program is not adequate to provide the expenditures anticipated over the entire 25-year valuation period, if the assumptions underlying the estimates prove to be realistic. The tax schedule is sufficient to provide for program expenditures over the next 10 years. However, it is not sufficient, under current assumptions, to provide for any growth in the trust fund-relative to annual disbursements-toward the level of a full year's disbursements recommended by the 1971 Advisory Council. The financing for the last half of the 25-year period is not sufficient even to provide for projected benefits and administrative expenses.

The trust fund balance at the beginning of 1976 is 77 percent of the projected disbursements for 1976, somewhat below the level of a full year's disbursements. The ratio of fund to disbursements is projected to drop slightly during the next 5 years and then to return to a level of approximately 75 percent during the early 1980's. After 1985, the trust fund is projected to decline steadily, until it is completely exhausted in the early 1990's.

The Board recommends that the financing of the hospital insurance program be strengthened to remove the average 25-year deficit of 0.64 percent of taxable payroll. Most of the increased financing is required after 1985.

APPENDICES

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

The basic methodology and assumptions used in the estimates for the hospital insurance program are described in this appendix. In addition, sensitivity testing of program costs under alternative sets of assumptions is presented.

A. PROGRAM COSTS

The principal steps involved in projecting the future costs of the hospital insurance program are (1) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base; (2) projecting increases in the cost of inpatient hospital services covered under the program; (3) projecting increases in the cost of skilled nursing facility and home health agency services covered under the program; and (4) projecting increases in administrative costs. The major emphasis will be directed toward the cost of inpatient hospital services, which accounts for approximately 95 percent of benefit expenditures.

1. Projection base

The hospital insurance program is obligated, by law, to reimburse institutional providers for the actual reasonable cost of providing covered services to beneficiaries. In order to establish a suitable base from which to project the future costs of the program, the incurred cost of services provided must be reconstructed for the most recent period of time for which a reliable determination can be made. To do this, payments to providers must be attributed to the dates of service, rather than to payment dates. In addition, the nonrecurring effects of any changes in regulations or administration of the program and of any items affecting only the timing and flow of payments to providers must be eliminated. As a result, the rates of increase in the incurred cost of the program differ from the increases in cash disbursements shown in Tables 5 and 6.

The actual reasonable costs of covered services to beneficiaries are determined on the basis of provider cost reports. Payments to a provider initially are made on an "interim" basis; to adjust interim payments to the level of retroactively determined costs, a series of payments or recoveries is effected through the course of cost settlement with the provider. The net amounts paid to date to providers in the form of cost settlements are known; however, the incomplete data available do not permit a precise determination of the exact amounts incurred during specific periods of time. Due to the time required to obtain cost reports from providers, to verify these reports, and to perform audits (where appropriate), final settlements have lagged behind the liability for such payments by as much as several years for some providers. Hence, the final cost of the program has not been completely determined for the most recent years of the program, and some degree of uncertainty remains even for the early years.

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

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

Allocating the various payments to the proper incurred period—using incomplete data and estimates of the impact of administrative actions—presents difficult problems, the solution of which can be only 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 increases the error of projection directly, by incorporating any error in estimating the base year into all future years.

2. Hospital costs

The hospital insurance program reimburses participating hospitals for the actual reasonable cost of providing covered services to beneficiaries. Because of its cost reimbursement nature, the program, in essence, pays for the share of aggregate inpatient hospital costs which are allocated to beneficiaries. Hence, for analysis and projection purposes, trends in program costs can be separated conceptually into (a) increases in aggregate expenditures by hospitals for all patients in producing services of the types covered by the program and (b) changes in the share of these expenditures that are for hospital insurance beneficiaries and hence will be paid by the hospital insurance program.

Increases in aggregate inpatient hospital costs can be analyzed into three broad categories:

(a) Economic factors.-The increase in unit costs that would result if hospitals' input cost increases (wage increases for hospital employees and price increases for goods and services purchased by hospitals) were the same as those for the general economy;

(b) Volume of services.-The increase in total output of units of service (as measured by hospital admissions) ; and

(c) Unit input intensity.-The increase in total costs due to increased labor and non-labor input intensity (wage and price increases for hospital inputs which are more rapid than for workers and products in the general economy plus increases in the number of hospital employees and amount of supplies and equipment used to produce a unit of service).

It has been possible to isolate some of these elements and to identify their roles in previous hospital cost increases. Table A1 shows the values of the principal components of the increases for historical periods for which data are available and the projected trends used in the estimates.

Increases in economic factors can be divided into those for payroll and those for nonpayroll expenditures. Slightly more than half of hospital costs are for direct payroll expenses. This proportion has declined over the years, and a modest continuation in the decline is projected. The weighted averages of the economic factors in Table A1 reflect these year by year proportions. Increases in average wages remained relatively uniform in the period 1966-71, ranging from 5½ to 6½ percent per year; slightly higher rates, varying between 6 and 7 percent, occurred during 1972-75. Changes in the CPI rose from a rate of nearly 3 percent per year in 1966 to slightly more than 6 percent in 1974 and was followed by a 9 percent increase in 1975. The increases in both average wages and

CPI beyond 1975 are based on assumptions used in projecting experience under the OASDI program.

Volume of services increases are separated into a part due to population growth and a part due to changes in the average number of admissions per capita. The population projection used in this report is based on assumptions used in projecting experience under the OASDI program. Admission incidence rates increased on average 1.7 percent during the 10-year pre-Medicare period 1956-65; the trend since then has been relatively consistent, with most recent years exhibiting increases in excess of 2 percent per year. A continuation of this basic trend is projected for the next 5 years, with a gradual tapering thereafter.

Unit input intensity changes can be analyzed and projected in terms of payroll and nonpayroll components in a manner similar to that for economic factors. The payroll component can be further divided between unit input intensity increases related to wage level increases for hospital employees and to employee intensity increases.

For several years preceding the beginning of the hospital insurance program, average hospital wages and salaries (as reported by the American Hospital Association) increased at a rate of about one percent per year more rapidly than the rate of increase in earnings in OASDI-covered employment. During the 1967-71 period, this differential ranged between 3 and 4H percent. Several factors contributing to this sizable differential can be identified, including (a) the fact that hospital employees historically have earned less than similarly skilled workers in other industries; (b) the growth in third party reimbursement of hospitals–through Medicare, Medicaid, and comprehensive private plans–is likely to have weakened hospital resistance to wage demands; (c) increased proportions of highly trained and more highly paid personnel; and (d) an increased degree of labor organization and activity. The wage increase differential was substantially decreased during the period 1972-74 when hospital costs were subject to the Economic Stabilization Program.

Over the short term, a differential level generally consistent with experience over the last 10 years (excluding years subject to Economic Stabilization Program controls) is assumed. Especially high wage increases might well be expected in the immediate future, reflecting a readjustment for the relatively low increases during 1972-74. Eventually the majority of this difference should disappear, when hospital workers' wages are at least comparable to those for similarly skilled personnel in other industries and when the proportion of highly trained personnel grows relatively large. The projection assumes a modest continuation of the wage level intensity factor over the long run, based on the fact that the hospital industry is a highly technological one and one with limited restraints on costs due to the high degree of third party reimbursement.

The number of hospital employees has increased somewhat more rapidly than the number of admissions over the past 20 years. Increases in employee intensity averaged 2 percent per year during the 10 years preceding Medicare. The early years of the program were marked by a substantial surge in employees per admission, followed by a period of virtually no change during the imposition of Economic Stabilization Program controls. Many of the same factors which have impacted on hospital wage level differentials can be identified also as contributing factors to the increase in employee intensity; in addition, the increased number and complexity of services provided within a given admission

have been significant factors. The projection assumes, in general, a continuation of the pre-Medicare trend, dampened slightly to reflect a lower rate of industry growth than during the earlier period.

Non-labor unit input intensity is a composite of several heterogeneous components. These include (a) price increases for goods and services that hospitals purchase which do not parallel increases in the CPI, (b) increases in volume of medical and other supplies purchased and used per admission, and (c) increases in medical equipment and other capital assets employed in the provision of a hospital admission. Due to a lack of data, the non-labor intensity factor cannot be separated into its component parts and must be treated as a residual. Historically, this factor has increased at a high rate and in an erratic fashion. Increases during the 1956-65 period averaged nearly 5½ percent; these were followed by an irregular series of increases during the period 1966-71 ranging between 6 and 18 percent. The second and third years of the controlled-period 1972-74 produced increases of only 2 to 3 percent, substantially below even the increases for the 10-year pre-Medicare period. The projection assumes a gradual tapering of the non-labor intensity factor, from a level consistent with experience during recent years (excluding years subject to Economic Stabilization Program controls) to a level consistent with experience during the decade preceding Medicare.

Aggregate inpatient hospital cost increases-reflecting the composite of economic factors, volume of services, and unit input intensity-have exhibited a very rapid rate and irregular pattern of increases. Although the pre-Medicare period produced an average rate of increase of approximately 10% percent, typical rates in subsequent years have tended to vary between 13 and 18 percent.

Changes in the program's share of aggregate hospital costs result from (a) changes in the proportion of the population covered, including changes due to legislation; (b) changes in the relative number and value of services received by beneficiaries; and (c) the effect of administrative actions defining the services eligible for reimbursement and affecting the level of program payments. Historical and projected changes in the hospital insurance program's share of aggregate inpatient hospital costs appear in table A1, with changes in the proportion of the population covered netted from the other sources. As indicated in the table, the share of hospital costs allocated to beneficiaries has fluctuated somewhat in recent years.

The increases experienced in the proportion of the population covered reflect the more rapid rate of increase in the number of persons age 65 and over than in the total population of the United States and, beginning in mid-1973, coverage of certain disabled beneficiaries and persons with chronic renal disease. Increases in the prop0rtion of the population covered are projected to continue, reflecting a continuation of the demographic shift into categories of the population which are eligible for hospital insurance protection.

Other sources which contribute to changes in the program's share of hospital costs include changes in the relative number and value of services received by beneficiaries and the effect of administrative actions defining covered services and affecting payment levels. Data are not available which would enable a quantitative separation between the two components for historical years. The projection assumes, over the long range, changes in these other sources only due to the effects of

demographic shifts on the relative number of services received by beneficiaries compared with the number of services received by persons not covered under the program. Increases in the average age of beneficiaries and of persons not covered lead to higher expected levels of usage of hospital services by both groups, the net effect of which is reflected as changes in other sources.

Regulations promulgated under the Economic Stabilization Program restricted several of the components of hospital cost increases. The Social Security Administration adopted a policy of withholding reimbursements which reflected increases in costs of more than 9 percent per year (adjusted for volume) for accounting periods beginning after the announcement of controls in August 1971, unless the hospital obtained certification of compliance from the Internal Revenue Service.

This reimbursement policy establishing presumptive compliance levels had a substantial impact on reimbursable hospital cost increases: during 1972 and 1973, program cost increases (excluding the effects of new beneficiary groups) were at a substantially lower rate than in previous years. Data for 1974 and preliminary indications for 1975, however, show a strong reversal in the pattern of cost increases for services covered under the hospital insurance program relative to aggregate inpatient hospital cost increases. These share increases reflect both (a) a significant increase in relative number of services used by beneficiaries and (b) a readjustment of reimbursement levels under the program, from the restricted levels under the presumptive compliance limits to levels reflecting actual costs attributable to beneficiaries. A very modest continuation in the effect of these influences is projected for 1976, representing a leveling and stabilizing of these temporary factors.

3. Skilled nursing facility and home health agency costs

Historical experience with the number of days of care covered in skilled nursing facilities under the hospital insurance program has been characterized by wide swings. The number of covered days dropped very sharply in 1970 and continued to decline through 1972. This was the result of strict enforcement of regulations separating skilled nursing from custodial care. Because of the small fraction of nursing home care covered under the program, this reduction primarily reflected the determination that Medicare was not liable for payment rather than reduced usage of services.

The 1972 amendments extended benefits to persons who require skilled rehabilitative services regardless of their need for skilled nursing services (the former prerequisite for benefits). This change has resulted in significant increases in services covered in 1973 (the first effective year of the provision) and in 1974. Some continuation of this pattern is assumed for the next 5 years, with only modest increases projected thereafter.

Increases in the average cost per day in skilled nursing facilities under the program are caused principally by increasing payroll costs for nurses and other skilled labor required. Projected rates of increase are assumed to be comparable to the increases in general wages throughout the 25-year projection period. The resulting increases in the cost of skilled nursing facility services ate shown in Table A2.

Program experience with home health agency costs has shown a generally upward trend. The number of days of care has fluctuated somewhat from year to year, with very sharp increases appearing in the last two years. Relatively large increases are assumed for the next two

years, followed by a projected pattern of increases similar to that for skilled nursing facilities. Cost per service is assumed to increase at a rate comparable to increases in general wages. The resulting home health agency cost increases are shown in table A2.

4. Administrative expenses

The costs of administering the hospital insurance program have remained relatively small, in comparison with benefit amounts, throughout the history of the program. The ratio of administrative expenses to benefit payments has generally fallen within the range of 2½ to 3 percent. The short range projections of administrative costs are based on estimates of workloads and approved budgets for intermediaries and the Social Security Administration. In the long range, administrative cost increases are based on an increasing volume of services covered, primarily due to population growth, and on assumed unit cost increases of 5 percent per year (¾ percent less than the increase in general wages).

B. FINANCING

In order to analyze costs and to evaluate the financing of a payroll tax supported program, program costs must be compared on a year by year basis with the taxable payroll which supports these costs. Since the vast majority of total program costs relates to insured beneficiaries and since general revenue appropriations and premium payments are available to support the smaller uninsured segments, the remainder of this report will focus on the financing for insured beneficiaries.

1. Taxable payroll

Taxable payroll increases can be separated into a part due to wage increases in covered employment and a part due to increases in the number of covered workers. The taxable payroll projection used in this report is based on assumptions used in projecting experience under the OASDI program; increases in taxable payroll are shown in table A2. The average wage increase component of this projection is the same as that shown in table Al.

2. Relationship between program costs and taxable payroll

The single most meaningful measure of program cost increases, with reference to the financing of the system, is the relationship between program cost increases and taxable payroll increases. If the rates of increase in both series are the same, a level tax rate over time will be adequate to support the program. However, to the extent that program costs increase more rapidly than taxable payroll, a schedule of increasing tax rates will be required to finance the system over time. Table A2 shows the resulting increases in program costs relative to taxable payroll over the 25-year projection period. These relative increases are projected to be in excess of 5 percent during the 1976-78 period, with gradual reductions thereafter to an ultimate level of approximately 3 percent per year. The result of these increases over the duration of the projection period is the series of expenditure ratios shown in table A3, which increase from 1.87 percent of taxable payroll in 1976 to 4.93 percent in the year 2000.

C. SENSITIVITY TESTING OF COSTS UNDER ALTERNATIVE ASSUMPTIONS

Over the past 20 years, aggregate inpatient hospital costs for all patients have increased substantially faster than increases in average wages and prices in the general economy. As indicated in table A1, the 10-year period preceding Medicare was characterized by an average 10.4 percent increase in hospital costs, nearly 7½ percent higher than the increases attributable to economic factors in the general economy. The 1965-70 period experienced substantially higher increases in total hospital costs, averaging nearly 16½ percent. Of this increase, general economic factors accounted for only 5½ percent; the remaining 11 percent reflected increases in the volume of services provided and in unit input intensity. Even during the 1972-73 period of Economic Stabilization Program controls, hospital costs increased at an average rate of nearly 12 percent, almost 6 percent higher than the amount attributable to increases in average wages and in the CPI. Preliminary indications for the fully decontrolled year 1975 show an average hospital cost increase of nearly 17 percent, of which 8½ percent is in excess of increases in general economic factors.

The sustained, high rates of hospital cost increases in the past raise serious questions concerning future cost increases which might be anticipated. Under conventional economic wisdom, the hospital industry would not be expected to sustain growth relative to the general economy, of the order of magnitude experienced during the last 20 years, indefinitely into the future. However, the growth pattern has persisted for a long period of time and shows no indication of subsiding. The most reasonable pattern of cost increase assumptions for the future, then, would fall between the two extremes of (1) an indefinite continuation of the past levels of excess of hospital cost increases over general economic factors and (2) a decline in the near term to hospital cost increase levels approaching those for the economy as a whole.

In view of the uncertainty of future cost trends, projected costs for the hospital insurance program have been prepared under three alternative sets of assumptions. A summary of the assumptions and results is shown in table A3. The set of assumptions labelled "Alternative II" forms the basis for the detailed discussion of hospital cost trends and resulting program costs presented throughout this report. It represents an intermediate set of cost increase assumptions, compared with the lower cost and more optimistic alternative I and the higher cost and more pessimistic alternative III. Increases in the economic factors (average wages and CPI) for the three alternatives are consistent with those underlying the OASDI report.

As noted earlier, the single most meaningful measure of hospital insurance program cost increases, with reference to the financing of the system, is the relationship between program cost increases and taxable payroll increases. The extent to which program cost increases exceed increases in taxable payroll will determine how steeply tax rates must increase to finance the system over time.

Under alternative II, program costs in the short run are projected to increase approximately 5 percent faster than increases in taxable payroll, gradually decreasing to an ultimate difference in increases of 3 percent. Program expenditures, which are currently about 2 percent of taxable payroll, increase to a level of nearly 5 percent by the year 2000

under alternative II assumptions. Hence, if all of the projection assumptions are realized over time, hospital insurance tax rates by the end of the 25-year period will have to be substantially higher than those provided in the present financing schedule (3 percent of taxable payroll, for 1986 and later).

Alternatives I and III contain assumptions which result in program costs increasing, relative to taxable payroll increases, 2 percent less and 2 percent more rapidly, respectively, than the results under alternative II.

Under alternative I, program costs ultimately increase 1 percent more rapidly than increases in taxable payroll. By the year 2000, program expenditures under this alternative would be slightly greater than 3 percent of taxable payroll. Hence, hospital insurance tax rates required by the end of the valuation period would be close to those currently scheduled. Under alternative III, program costs ultimately increase 5 percent more rapidly than increases in taxable payroll. The result of this differential is a level of program expenditures in the year 2000 which is 7½ percent of taxable payroll, 4½ percent higher than the 3 percent tax rate currently scheduled.

TABLE A1.—COMPONENTS OF HISTORICAL AND PROJECTED INCREASES HOSPITAL COSTS[1]

[Percent]

Calendar year	Economic Factors			Volume of Services[2]		Unit Input Intensity[2]				Aggregate inpatient hospital costs[4]	HI Share		HI inpatient hospital costs
	Average wages	CPI	Weighted average[3]	Total population	Admission incidence	Wage level	Employee intensity	Nonlabor intensity	Weighted average[3]		Proportion of population	Other sources	
Historical Data:													
1956-65	3.7	1.6	3.0	1.6	1.7	1.0	2.0	5.3	4.1	10.4			
1966	5.5	3.0	4.6	1.1	0.5	−4.7	8.2	8.4	5.5	11.7			
1967	5.7	2.8	4.7	1.1	−0.7	3.4	6.2	18.4	13.5	18.6			
1968	6.4	4.2	5.7	1.0	.1	3.3	4.4	11.6	9.7	16.5	0.6	7.5	24.6
1969	6.6	5.4	6.5	1.0	2.6	2.7	3.5	9.9	8.3	18.4	.5	−3.7	15.2
1970	5.3	5.9	6.0	1.1	2.4	4.5	1.3	8.3	7.3	16.8	.5	−5.3	12.0
1971	5.4	4.3	5.2	1.0	2.0	4.6	−.1	6.1	5.5	13.7	.6	−.3	14.0
1972	6.9	3.3	5.5	.9	1.2	1.2	.2	11.3	5.9	13.5	.7	4.5	9.7
1973	6.3	6.2	6.5	.7	2.4	−1.6	.0	3.1	.5	10.1	5.3	−.9	14.5
1974	7.0	11.0	9.2	.7	3.0	−1.2	2.3	2.0	1.6	14.5	6.0	3.4	23.9
Projection													
1975	6.8	9.1	8.3	.7	1.0	2.5	2.8	8.0	6.9	16.9	2.2	6.4	25.5
1976	7.7	6.3	7.4	.7	1.5	3.1	1.5	7.5	6.3	15.9	1.5	1.6	19.0
1977	8.5	6.0	7.7	.7	1.5	2.3	1.5	7.5	5.9	15.8	1.4	.2	17.4
1978	9.4	6.0	8.1	.7	1.5	1.0	1.5	7.0	4.9	15.2	1.3	.1	16.6
1979	8.5	5.5	7.4	.7	1.5	1.4	1.5	7.0	5.1	14.7	1.2	−.2	15.7
1980	7.7	5.0	6.7	.7	1.5	1.7	1.5	7.0	5.2	14.1	1.2	−.3	15.0
1985	5.8	4.0	5.0	.7	.9	.7	1.5	5.5	4.0	10.6	1.3	−.3	11.6
1990	5.8	4.0	5.0	.6	.3	.7	1.5	5.5	4.0	9.9	.9	−.2	10.6
1995	5.8	4.0	5.0	.5	.3	.2	1.0	5.5	3.6	9.4	.5	−.2	9.7
2000	5.8	4.0	5.0	.4	.4	.2	1.0	5.5	3.6	9.4	.3	−.1	9.6

[1]Percent increase in year indicated over previous year.

[2]Based on data from the American Hospital Association through 1974.

[3]Weighted average of individual components, with adjustments for the effects of compounding. The weightings are based on the proportions of aggregate inpatient hospital costs which are for payroll and for nonpayroll expenses. The adjustments for the effects of compounding are necessary to compensate for the fact that the various components actually are multiplicative, rather than additive as illustrated in this table.

[4]Includes hospital costs for all patients.

TABLE A2.—RELATIONSHIP BETWEEN INCREASES IN TOTAL HI PROGRAM COSTS AND INCREASES IN TAXABLE PAYROLL [1]

[In percent]

Calendar year	HI benefit costs[2]				HI administrative costs[2]	Total HI program costs[2]	HI taxable payroll	Ratio of costs to payroll[4]
	Inpatient hospital[3]	Skilled nursing facility	Home health agency	Weighted average				
1976	19.9	18.6	34.2	20.0	33.3	20.3	11.7	7.7
1977	18.2	17.7	27.5	18.3	8.0	18.0	12.0	5.4
1978	17.2	17.3	19.2	17.2	9.1	17.0	11.1	5.3
1979	16.2	16.5	16.8	16.2	8.6	16.1	10.9	4.7
1980	15.5	15.8	14.9	15.5	7.7	15.4	10.5	4.4
1985	11.8	8.0	8.0	11.7	7.5	11.6	6.9	4.4
1990	10.7	7.5	7.5	10.6	7.0	10.6	6.4	3.9
1995	9.7	7.0	7.0	9.6	6.5	9.6	6.4	3.0
2000	9.6	6.8	6.8	9.5	6.0	9.5	6.4	2.9

[1]Percent increase in year indicated over previous year.
[2]Costs attributable to insured beneficiaries only. Benefits and administrative costs for noninsured persons are financed through general revenue transfers and premium payments rather than through payroll taxes.
[3]This column differs slightly from the last column of table A1, since table A1 includes all persons eligible for HI protection while this table excludes noninsured persons.

TABLE A3.—SUMMARY OF ALTERNATIVE PROJECTIONS FOR THE HOSPITAL INSURANCE PROGRAM[1]

[In percent]

Calendar Year	Increases in aggregate inpatient hospital costs[2]				Relationship between costs and payroll			
	Average wages	CPI	Volume and intensity	Total	Program costs[3]	Taxable payroll	Ratio of costs to payroll	Expenditures as a percent of taxable payroll
Alternative I:								
1976	7.7	6.3	8.5	15.9	20.3	11.7	7.7	1.87
1977	8.5	6.0	7.5	15.3	17.5	12.0	4.9	1.96
1978	9.6	5.5	6.1	14.0	15.8	12.0	3.4	2.02
1979	9.1	5.0	6.1	13.5	14.9	11.9	2.7	2.08
1980	8.1	4.0	6.1	12.6	13.9	11.2	2.4	2.12
1985	5.3	3.0	3.7	7.9	8.9	6.3	2.4	2.40
1990	5.3	3.0	3.0	7.2	7.9	5.9	1.9	2.71
1995	5.3	3.0	2.5	6.7	7.0	5.9	1.0	2.95
2000	5.3	3.0	2.5	6.7	6.9	5.9	0.9	3.08
Alternative II:								
1976	7.7	6.3	8.5	15.9	20.3	11.7	7.7	1.87
1977	8.5	6.0	8.1	15.8	18.0	12.0	5.4	1.97
1978	9.4	6.0	7.1	15.2	17.0	11.1	5.3	2.07
1979	8.5	5.5	7.3	14.7	16.1	10.9	4.7	2.17
1980	7.7	5.0	7.4	14.1	15.4	10.5	4.4	2.26
1985	5.8	4.0	5.6	10.6	11.6	6.9	4.4	2.82
1990	5.8	4.0	4.9	9.9	10.6	6.4	3.9	3.54
1995	5.8	4.0	4.4	9.4	9.6	6.4	3.0	4.27
2000	5.8	4.0	4.4	9.4	9.5	6.4	2.9	4.93
Alternative III:								
1976	7.7	6.3	8.5	15.9	20.3	11.7	7.7	1.87
1977	8.0	6.0	8.9	16.4	18.5	10.7	7.0	2.00
1978	8.9	6.5	8.1	16.2	18.0	10.3	7.0	2.14
1979	7.9	6.0	8.4	15.7	17.0	9.7	6.7	2.28
1980	7.4	5.5	8.3	15.1	16.6	9.6	6.4	2.42
1985	6.3	5.0	7.4	13.3	14.3	7.4	6.4	3.26
1990	6.3	5.0	6.7	12.5	13.2	6.9	5.9	4.47
1995	6.3	5.0	6.2	12.0	12.2	6.9	5.0	5.91
2000	6.3	5.0	6.2	12.0	12.1	6.9	4.9	7.52

[1] Percent increase in the year Indicated over the previous year.
[2] Includes hospital costs for all patients.
[3] Includes costs attributable to insured beneficiaries only.

APPENDIX B.—DETERMINATION AND ANNOUNCEMENT OF THE 1976 INPATIENT HOSPITAL DEDUCTIBLE[2]

Pursuant to authority contained in 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 $104 in the case of any spell of illness beginning during 1976.

The announced increase in the inpatient deductible will also result in proportionate changes in the other cost-sharing amounts under the hospital insurance program. Thus, for spells of illness beginning in 1976, the daily coinsurance for the 61st through the 90th days of hospitalization (one-fourth of the inpatient hospital deductible) shall be $26; the daily coinsurance for the lifetime reserve days (one-half of the inpatient hospital deductible) shall be $52; and the daily coinsurance for the 21st through the l00th days of extended care services (one-eighth of the inpatient hospital deductible) shall be $13.

The new inpatient hospital deductible represents a 13 percent increase over the current deductible. It is important for me to point out that this increase is due in large measure to the continued inflation in the health care industry. Since the expiration of the Economic Stabilization Program controls in April 1974, hospital costs have been increasing 50 percent faster than the overall cost-of-living.

There follows a statement of the actuarial bases employed in arriving at the amount of $104 for the inpatient hospital deductible for the calendar year 1976.

The law provides that, for spells of illness beginning in 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, 1974) 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 1974 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 number of inpatient days of care, the interim reimbursement amount, and the interim cost (the sum of interim reimbursement, deductible, and coinsurance).

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[2] This statement was published in the *Federal Register* for October 1, 1975 (Vol. 40, No. 191, pp. 45216–45217).

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.

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 1974 is $97.93. It may be noted that these averages are based on about 30 million days of hospitalization in 1966 (last 6 months of the year) and 80 million days of hospitalization in 1974. Accordingly the ratio of the 1974 rate to the 1966 rate is 2.583.

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 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. 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 best data available indicates that this adjustment does not change the ratio shown above by enough to result in a different deductible for 1976. The values shown in this report do not reflect this adjustment for final cost settlements. When the ratio of 2.583 is multiplied by $40 it produces an amount of $103.32, which must be rounded to $104. Accordingly, the inpatient hospital deductible for spells of illness beginning during calendar year 1976 is $104.

Dated September 29, 1975.

DAVID MATTHEWS, *Secretary.*

APPENDIX C.—DETERMINATION AND ANNOUNCEMENT OF THE HOSPITAL INSURANCE PREMIUM RATE FOR THE UNINSURED AGED, FOR THE 12-MONTH PERIOD BEGINNING JULY 1, 1976 [3]

Pursuant to authority contained in section 1818(d) (2) of the Social Security Act (42 U.S.C. 1395i-2(d) (2)), I hereby determine and promulgate that the monthly hospital insurance premium, applicable for the 12-month period commencing July 1, 1976, is $45.

Section 1818 of the Social Security Act, added by section 202 of the Social Security Amendments of 1972 (Pub. L. 92-603), provides for voluntary enrollment in the hospital insurance program (Part A of Medicare) by certain uninsured persons 65 and older who are otherwise ineligible. Section 1818(d) (2) of the Act requires the Secretary to determine and promulgate, during the final quarter of

1975, the dollar amount which will be the monthly Part A premium for voluntary enrollment, for months occurring in the 12-month period beginning July 1, 1976. As required by statute, this amount must be $33 times the ratio of (l the 1976 inpatient hospital deductible to (2) the 1973 inpatient hospital deductible, rounded to the nearest multiple of $1, or if midway between multiples of $1, to the next higher multiple of $1.

Under section 1813(b) (2) of the Act, the 1976 inpatient hospital deductible was determined to be $104. The 1973 deductible was actuarially determined to be $76. However, the 1973 deductible was actually promulgated to be only $72 to comply with a ruling of the Cost of Living Council. This has created some ambiguity in the use of the statutory formula for calculating the premium. The premiums for fiscal years 1975 and 1976 were both calculated using the actuarially determined deductible of $76 since this appeared to most closely satisfy the intent of the law. Similarly, the premium for the twelve month period ending June 30, 1977 has been calculated using the $76 deductible for 1973. Thus the monthly hospital insurance premium is $33 × (104/76) = $45.16 which is rounded to $45. The purpose of the premium formula is to adjust the original $33 premium for changes in the cost of providing hospital care. The ratio of the inpatient hospital deductibles does this approximately, since the deductible as calculated under section 1813(b) (2), is based on the average daily cost of providing hospital care under the hospital insurance program. However, the deductible is calculated (by law) from data reflecting program experience in an earlier year. The increase in the 1976 deductible (and thus the increase in the premium now being promulgated) results from the increase in hospital per diem costs in calendar year 1974 over 1973. In addition, the premium calculation fails to adjust for changes in the hospital utilization rate and in changes in non-hospital costs under the program. For these reasons, the premium can only be a rough approximation to actual per capita program costs.

In particular, the $45 premium rate is not expected to be adequate to pay for the estimated cost of enrollees in the year ending June 30, 1977. The table below compares the premium rates charged with the estimated cost per enrollee (assuming that the average cost per premium paying enrollee is the same as the average cost for insured aged

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[3] This statement was published in the *Federal Register* for December 24, 1975 (Vol. 40, No. 248, p. 59472).

enrollees). The table also shows, year-by-year, the difference between premium charged and cost per enrollee and the accumulated value of the excess or deficit. Finally, the table shows the actuarially adjusted rate that would be necessary to pay the current year's cost and the accumulated surplus or deficit from prior years. For the year ending June 30, 1977, it is estimated that the cost per enrollee will be $51.50 and that a deficit of $4.10 per enrollee will be carried forward from previous years. Therefore, a rate of $5.5.60 would be required to place the premium paying enrollee group on a fully self-supporting basis by June 30, 1977.

COMPARISON OF PROMULGATED PREMIUM RATES WITH THE ACTUARIALLY ADDJUSTED RATE

Year ending June 30	Promulgated premium rate	Estimated cost per enrollee in the year	Premium less cost	Accumulated value of col. (4) for prior years[1]	Actuarially adjusted rate col. (3) minus col. (5)
(1)	(2)	(3)	(4)	(5)	(6)
1974	$33	$33.50	+$2.50		$30.50
1975	36	37.40	−1.40	+$2.10	35.30
1976	40	44.60	−4.60	+.60	44.00
1977	45	51.50	−6.50	−4.10	55.60

[1] For a given year, this value is the sum of the differences shown in col. (4) for all preceding years, accumulated with interest and changes in size of enrollment.

The deficit in the premium rate must be temporarily, at least, made up from other sources of income to the Part A trust fund. If the voluntary enrollment program is to be self-supporting in the long run, some future premium rates will have to be greater than actual per capita costs in order to pay off the deficit projected for June 30, 1977. This could occur, for example, if the rate of increase in hospital costs were to decline sufficiently between the year used in calculating the premium and the year that the premium was to be effective.

Dated December 18, 1975.

MARJORIE LYNCH,
Acting Secretary.