Actuarial Status of the Trust Fund

Hospital insurance benefit payments will increase for many years—not only in terms of dollars, but also as a percentage of taxable payroll. Estimates covering a 25-year future period are needed, therefore, to indicate the extent to which the cost will increase and to indicate whether the scheduled tax rates are adequate to maintain the system, on an actuarially-sound basis over this period.

The benefit cost will rise for somewhat the same reasons that are applicable to the cash benefits under the old-age, survivors, and disability insurance program and, in addition, because of the likely increase in hospitalization costs per unit of service. The cost for the cash benefits increases primarily because the U.S. population will, in the long run, almost certainly become relatively much older. Hospitalization costs have increased in the past significantly more rapidly than general earnings levels, and it is likely that this trend will continue for some years. Even in the long run, it is likely that hospitalization costs will continue to rise since somewhat over 60 percent of hospital costs are wage costs and since the general earnings level has a similar trend (although the current differential between the rates of increase of these two factors will very probably be eliminated or may even be reversed).

The long-range actuarial cost estimates for the hospital insurance program are made over a future period of 25 years, whereas the long-range actuarial cost estimates for the old-age, survivors, and disability insurance program are made over a 75-year future period. It is believed that a 25-year projection period for the hospital insurance program is as far ahead as should be considered because of the uncertainties as to future hospital practices. Even so, it is necessary to look ahead for a period such as this so as to have some idea of the rising cost that can possibly ensue.

Another difference between the cost estimates for the two programs is that for old-age, survivors, and disability insurance, the cost estimates assume level earnings trends in the future, whereas under the hospital insurance program, rising earnings are assumed; this different approach is used so as to provide a margin of safety in each case. Under the former program, the level-earnings assumption is a conservative one and provides a margin of safety, since increases in earnings, with no changes in the program, result in lower costs relative to taxable payroll; or, to put it another way, this assumption provides a margin that can be used, when earnings rise, to increase benefits without changing the contribution rates. Such increases would, in all probability, be somewhat more than enough to keep up with price changes, so long as the maximum taxable earnings base is also increased from time to time.

On the other hand, under the hospital insurance program, if the maximum taxable earnings base is not increased so as to keep up to date, increases in the general earnings level, when accompanied by parallel (or greater) increases in hospital costs, result in higher costs relative to taxable payroll. The reason for this is that, under these conditions, hospital costs rise more rapidly than covered earnings, whose increase is "dampened" by the effect of the earnings base. Thus, the use of the rising-earnings assumption for the hospital insurance program, coupled with a rising hospital-cost assumption and with the assumption of no change in the earnings base, is of a conservative nature and provides a margin of safety.

Since the cost estimates assume that the earnings base will not be changed in the 25-year period under consideration, but do assume that earnings and hospitalization costs will rise steadily, the cost estimates are on a conservative basis, because it seems unlikely that, in the face of rising earnings, the taxable earnings base would not be changed for 25 years. It is for this reason that steadily increasing contribution rates over the 25-year period were adopted to finance the hospital insurance program. Correspondingly, if the earnings base is kept up to date, and if the experience follows the various assumptions, then the several increases in contribution rates scheduled for 1973 and after will not be necessary; in essence, then, this means that under these conditions, and with the existing contribution schedule, there would be about a 15-percent safety margin in the financing.

Table 5 shows the estimated progress of the hospital insurance trust fund according to the intermediate-cost estimate. This estimate is that which was derived at the time the 1967 amendments were enacted.

TABLE 5.—ESTIMATED PROGRESS OF HOSPITAL INSURANCE TRUST FUND, INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions [1]	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
Actual data: [2]					
1966	$1,911	$891	[3]$107	$31	$944
1967	3,508	3,353	77	51	1,073
Estimated data: [4]					
1968	3,972	3,190	112	64	2,066
1969	4,223	3,636	127	90	2,616
1970	4,391	3,982	139	108	2,994
1971	4,564	4,292	150	117	3,233
1972	4,732	4,602	161	121	3,323
1973	5,274	4,912	172	125	3,638
1974	5,503	5,216	183	132	3,874
1975	5,695	5,522	193	135	3,989
1980	8,087	6,940	243	203	6,454
1985	9,241	8,690	304	373	10,731
1990	11,627	10,843	380	553	15,711

[1] Includes transfers from railroad retirement account under financial interchange provisions. These transfers are essentially the contribution collections for the hospital insurance program less the administrative expenses of the Railroad Retirement Board in connection with such collection and certain other aspects of the program. Also includes reimbursement for noncontributory military service wage credits.

[2] Including transactions with respect to uninsured persons. The payments therefor from the general fund of the Treasury are included in the contributions column (actually, $37,000,000 in 1966 and $301,000,000 in 1967).

[3] Including administrative expenses incurred in 1965.

[4] Excluding transactions with respect to uninsured persons. The progress of the trust fund is based on a figure of $1,332,000,000 at the end of 1967, which differs from the actual figure largely because of the fact that reimbursements from the general fund of the Treasury with respect to uninsured persons were not up to date (but such amounts will be paid in the future).

The estimated future progress of the trust fund shown in table 5 does not include the transactions relating to the uninsured persons who are covered for the benefits of this program, the cost for whom is borne out of the general fund of the Treasury. The early-year figures for the progress of the trust fund on a long-range, calendar-year basis shown in table 5, which were prepared in mid-1966 while the legislation was in course of enactment, are not fully consistent with the short-range estimates on a fiscal-year basis, shown in the preceding section, which were prepared in December 1967, but the differences are relatively small. The benefit-payment figures are fully consistent between the two sets of estimates, but the contribution income figures are somewhat lower in the long-range cost estimates.

The estimated level-cost of the benefits under the hospital insurance program is 1.38 percent of taxable payroll. The level-equivalent of the contribution schedule is estimated at 1.41 percent of taxable payroll. Accordingly, this estimate indicates that the program has a small positive actuarial balance of 0.03 percent of taxable payroll under the assumptions made.

The benefits with respect to the uninsured group, and the accompanying administrative expenses, are paid from the hospital insurance trust fund, with the intention being that there will be current reimbursement therefor from the general fund of the Treasury. These benefit payments will decrease slowly in the future because the effect of mortality on this closed group more than offsets the rising trend of hospitalization costs and the increasing hospital utilization per capita for this group, as the average age becomes higher. The estimated benefit payments and administrative expenses for this category for 1968 and the following 4 calendar years are as follows (in millions):

Calendar year:	*Outgo*
1968	$465
1969	471
1970	459
1971	432
1972	403

A discussion of the assumptions under which these estimates have been made appears in appendix I.

Table 5 also shows data on the actual operation of the hospital insurance trust fund in calendar years 1966 and 1967, including the effect of the benefit payments for uninsured persons and the corresponding reimbursements from the general fund of the Treasury.

Conclusion

The current long-range actuarial cost estimates for the hospital insurance system indicate that the system has a favorable actuarial balance. According to the intermediate-cost estimate, the program has a favorable actuarial balance of 0.03 percent of taxable payroll on a level-cost basis computed over the next 25 years. These long-range cost estimates show that the system, as modified by the 1967 amendments and according to the cost estimates made at the time of enactment of that legislation, continues to be financed on an actuarially-sound basis.

It is recognized that, in a new program such as this, the actuarial cost estimates are subject to a range of variation. Nonetheless, the intermediate-cost estimate indicates that a sizable fund will be accumulated, which, after some years, will reach a magnitude of 1 year's benefit payments. In the initial years of operation, the balance in this fund, according to this estimate, should be sufficient to meet any adverse fluctuations of benefit payments as compared with contribution income.

APPENDIXES

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

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

(1) *Past increases in hospital costs and in earnings*

Table A presents a summary comparison of the annual increases in daily hospital costs and the corresponding increases in wages that have occurred since 1954 and up through 1966.

The annual increases in earinings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first-quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The data on increases in hospital costs are based on a series of average daily expense per patient day (including not only room and board but also other inpatient charges and other expenditures of hospitals) prepared by the American Hospital Association.

The annual increases in earnings fluctuated somewhat over the 10-year period up through 1963, although there were not very large deviations from the average annual rate of 4.0 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise fluctuated from year to year during this period, around the average annual rate of 6.7 percent.

TABLE A.—COMPARISON OF ANNUAL INCREASE IN HOSPITAL COSTS AND IN WAGES

[In percent]

Year	Increase over previous year	
	Average wages in covered employment [1]	Average daily hospitalization costs [2]
1955	3.8	6.3
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
Average for 1955–63 [3]	4.0	6.7
1964	3.1	6.9
1965	1.6	7.0
1966	4.4	8.3

[1] Data are for calendar years (based on experience in 1st quarter of year).

[2] Data are for fiscal years ending in September of year shown. When the data are adjusted on a calendar-year basis, the increase from 1965 to 1966 was determined to be 11.0 percent.

[3] Rate of increase compounded annually that is equivalent to total relative increase from 1955 to 1963.

TABLE B.—ASSUMPTIONS AS TO FUTURE RATES OF INCREASE IN HOSPITAL COSTS

[In percent]

Calendar year	Low-cost	Intermediate-cost	High-cost
1967	12.0	15.0	15.0
1968	10.0	15.0	15.0
1969	8.0	10.0	15.0
1970	6.0	6.0	15.0
1971	5.2	5.2	15.0
1972	4.6	4.6	10.0
1973	4.1	4.1	4.1
1974	3.6	3.6	3.6
1975 and after	3.0	3.0	3.0

Note: It is also assumed in the cost estimates that the general wage level increases at an average rate of 3 percent per year over the 25-year period considered in the estimates (the year-by-year increases will be somewhat more than this in the early years and thus are assumed to be somewhat less in subsequent years).

During the period 1954–63, hospital costs increased at a faster rate than earnings. The differential between these two rates of increase fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential of the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 2.7 percent.

In 1964–66, the increases in hospital costs as compared to the increase in wages resulted in differentials that are in excess of the 2.7 percent applicable in 1954–63. The 1967 experience to date shows a slightly higher rate of increase in hospital costs than did 1966, but it seems likely that wages also increased more in 1967 than in 1966.

Over the next 25 years, earnings are assumed to increase at an average rate of about 3 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be.

(2) Effect on cost estimates of rising hospital costs

A major consideration in making cost estimates for hospital benefits, then, is how long and to what extent the tendency of hospital costs to rise more rapidly than the general earnings level will continue in the future, and whether or not it may, in the long run, be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly catching up with the general level of wages and obviously may be expected to catch up completely at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased unit expense (which could possibly decrease overall costs of an illness).

There are, however, several possible counterbalancing factors. The higher costs involved for more refined and extensive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making actuarial cost estimates for hospital benefits is that—unlike the situation in regard to cost estimates for the monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base is concerned). The reason for this result is that it is asssumed that hospital costs rise at least at the same rate over the long run as the total earnings level, whereas the contribution income rises less rapidly than the total earnings level, unless the earnings base is kept up to date.

For these reasons, the cost estimates are based on the assumption that both hospital costs and earnings will increase in the future for the entire 25-year period considered, while at the same time the earnings base will not change. The fact that the cost-sharing provisions (the initial hospital deductible and coinsurance features) are on a dynamic basis, which automatically varies after 1968 in accordance with changes in hospital costs, results in lower estimated costs than if these provisions were on a static, unchanging basis.

(3) Assumptions as to relative trends of hospital costs and earnings underlying cost estimates

As indicated previously, the financing basis of the hospital insurance program should be developed on a conservative basis. For the reasons brought out, the cost estimates should not be developed on a level-earnings basis, but rather they should assume dynamic conditions as to both earnings levels and hospitalization costs. Accordingly, it seems appropriate to make cost projections for only 25 years in the future and to develop the financing necessary for only this period (but with a resulting trust fund balance at the end of the period equal to about 1 year's disbursements).

Several estimates of the short-term future trend of average daily hospital costs have recently been made by persons with experience in this field. All of these are well above the rate of 5.7 percent per year until 1970 that was assumed in the initial cost estimates for the program made when it was enacted in 1965. The American Hospital Association has estimated an annual rate of increase of as much as 15 percent for the next 3 to 5 years. The Blue Cross Association has made a corresponding estimate of 9 percent per year in the period up to 1970.

Three sets of assumptions as to the short-term trend of average daily hospital costs have been made. (See table B.) In the cost estimate presented here, only the intermediate-cost assumption is used. In each case, the annual rates of increase are assumed to merge with those used in the initial cost estimates for the program for 1971 for the low-cost and intermediate-cost assumptions and 1973 for the high-cost assumptions; namely, increases slightly above the increases in the earnings level from these dates until about 1975, and then the same increases. The low-cost set of assumptions yields about the same result as the Blue Cross prediction, while the high-cost set corresponds to the highest American Hospital Association prediction. The intermediate-cost set is used to develop the financing provisions of the legislation.

(4) Assumptions as to hospital utilization rates underlying cost estimates

The hospital utilization assumptions for the cost estimates in this report are founded on the hypothesis that current practices in this field will not change relatively more in the future than past experience has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates are the same as those used in the initial cost estimates for the program that were prepared when it was enacted in 1965. Analysis of the available actual experience for the first year of operation seems to indicate that it is somewhat higher than the original assumptions, but the evidence is not yet conclusive and there are other cost factors in the assumptions whose experience is in the opposite direction.

(5) Assumptions as to hospital per diem rates underlying cost estimates

The average daily cost of hospitalization that is used in these cost estimates is computed in the same manner as the corresponding figures in the initial cost estimates that were prepared when the legislation was enacted in 1965. Specifically, an average of about $38.50 per day was used for 1966 (as developed under the reimbursement principles prevailing under previous law) and was projected for future years in the manner described previously. Analysis of the experience for interim reimbursements for 1966, for which data as to the adjustments between the interim and final payments are not yet available, indicates that this assumption was somewhat higher than the experience (before taking into account the effect of such adjustments).

(6) Assumptions as to extended care facility benefits underlying cost estimates

The limited experience that is available to date in regard to the extended care facility benefits indicates that their cost will be considerably in excess of the initial estimates. It now appears that these benefits will amount to about $250 to $300 million in the first year of operation (calendar year 1967) as against the estimate of $25 to $50 million. The apparent major reason for this difference is the much larger number of facilities that qualified than had been expected according to the estimate. It should also be recognized that the original estimate was made on the basis of relatively little data, since this type of benefit had not been widely provided previously, which is a favorable factor in the cost estimates.

Accordingly, the cost estimates have been modified by increasing the estimated benefit outgo in 1967, as presented in previous cost estimates, by $250 million with respect to insured persons (and a proportionate amount for noninsured persons). This figure is increased each future year up through 1975 by the assumed increases in hospitalization costs. After 1975, the same assumption as to hospitalization-cost increases is continued, but the resulting figure is gradually scaled down until it is taken as zero for 1990 (since the estimate for that year already includes the ultimate costs for extended care facility benefits). Appropriate corresponding assumptions are made for the noninsured group, taking into account its decreasing size and its increasing average age, which results in greater relative use of the extended care facility benefits.

(*7*) *Assumptions as to home health service benefits underlying cost estimates*

The cost estimates for the posthospital home health service benefits are based on rather limited data. These benefits are estimated to have a relatively low cost in the early years of operation (about $10 million in the initial estimate for the first full year). The initial estimated first-year cost was low primarily because of the small number of qualifying facilities that had been estimated to be available; the number that have qualified has been several times larger than anticipated in the cost estimates for the first year of the program and more in line with what had been anticipated in the long run. Allowance has been made in the cost estimates for the likely future expansion of facilities providing such services. The actual experience in the first full year of operation (fiscal year 1967) showed expenditures of about $16 million (on an accrual basis), or somewhat more than the estimate of $10 million.

(*8*) *Administrative expenses*

It has been assumed that the administrative expenses in connection with the hospital insurance program, including those of the fiscal intermediaries that are reimbursable under the program, will amount to 3.5 percent of the benefit payments, which is consistent with the actual experience in fiscal year 1967. It appears, however, that this ratio will be somewhat lower in the future (especially as hospital costs increase more rapidly than other prices) so that this assumption somewhat overstates the cost of the program.

(*9*) *Interest rate*

An interest rate of 3.75 percent is used in determining the level-costs of the benefit payments and administrative expenses and the level-equivalent of the contributions. However, in developing the progress of the trust fund, a higher rate is used in the first 10 years; namely, 5 percent initially, gradually declining to a level of 4 percent after 1975. As of December 31, 1967, the average yield of the invested assets of the trust fund was 4.94 percent. The 3.75 percent rate used for the level-cost calculations thus is on the low side, so that this assumption somewhat overstates the cost of the program.

(*10*) *Timing of benefit payments*

The estimates of benefit payments on a year-by-year basis are made on the assumption that the suppliers of services will be reimbursed from the trust fund concurrently as the services are furnished to the insured individual (in long-duration cases, periodically)—and not by advance payments. In other words, the year-by-year cost estimates for the benefit payments are on an accrual basis. Any short advance or deferment of benefit payments would have some effect on the year-by-year estimates (especially for the first year of operation), but would have no significant effect on the long-range costs or financing basis.

(*11*) *Other changes in assumptions from those in initial cost estimates*

In the cost estimate of this report there has been used the new population projection that was used in the cost estimates made for the old-age, survivors, and disability insurance system in late 1966 (and used in the 1967 report of the Board of Trustees for this program).

In the cost estimates for this report, benefit disbursements were increased by 2 percent to allow for the provision in the reimbursement principles for providers of services that, in general, gives an increase of 2 percent of operating costs as an allowance for costs not readily measurable (1.5 percent for proprietary institutions) and by 0.2 percent as an allowance for the accelerated-depreciation methods provided in the reimbursement principles for providers of services (the original estimates had assumed only the straight-line depreciation method).

Appendix II. Legislative History Affecting the Trust Fund

Board of Trustees.—Beginning with July 30, 1965, when the Federal hospital insurance trust fund was established, the three members of the Board of Trustees, who serve in an ex officio capacity, have been the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. Since the establishment of the fund, the Secretary of the Treasury has been managing trustee. The Commissioner of Social Security has been secretary of the Board of Trustees. The Board of Trustees meets not less frequently than once each calendar year.

Contribution rates.—The Social Security Amendments of 1965, which established the hospital insurance program, fixed the contribution rates for employees and their employers and for self-employed persons at 0.35 percent for 1966 and 0.50 percent for 1967–72, with rates increasing thereafter to 0.80 percent beginning in 1987. The maximum amount of earnings to which these rates are applicable, first established at $6,600 per year, was increased to $7,800 by the 1967 amendments, which also increased the contribution rates, as shown previously in the main text.

Special refunds of employee contributions.—With respect to wages, refunds to employees who work for more than one employer during the course of a year and pay contributions on such wages in excess of the statutory maximum are paid from the Treasury account for refunding Internal Revenue collections. Beginning in 1968, railroad compensation may be included with wages in determining whether a refund is due, but only with respect to hospital insurance contributions. The managing trustee pays, from time to time, from the hospital insurance trust fund into the Treasury, as repayments to the account for refunding internal revenue collections, the amount of contributions which are subject to refund.

Credits for military service.—The Social Security Act Amendments of 1946 provided survivor-insurance protection to certain World War II veterans for a period of 3 years following their discharge from the Armed Forces. The 1950 amendments provided noncontributory $160 monthly wage credits to persons who served in the Armed Forces during World War II, and amendments in 1952–56 provided similar noncontributory credits on account of active military or naval service from July 25, 1947, through December 31, 1956. The 1956 amendments provided contributory coverage for military personnel beginning January 1, 1957. The 1967 amendments provide noncontributory credits of $100 a month (generally) as an allowance for the value of living expenses provided.

The trust fund is to 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 from September 16, 1940, through December 31, 1956, and from the provisions enacted in 1946 and 1967. The statutory provisions that provide for the financing of these noncontributory credits for military service are set forth in appendix III.

Coordination of hospital insurance and railroad retirement program.—Public Law 234, approved October 30, 1951, amended the Railroad Retirement Act to provide a basis of coordinating the railroad retirement program with the old-age and survivors insurance system, and this is also applicable to the hospital insurance system as a result of Public Law 89–97. The 1951 legislation provides that the railroad wage credits of workers who die or retire with less than 10 years of railroad employment shall be transferred to the old-age and survivors insurance system. These amendments did not affect workers who acquire 10 years or more of railroad service. That is, the survivors of over-10-year railroad workers will, as under the 1946 amendments to the Railroad Retirement Act, receive benefits under one program or the other based on combined wage records, while retirement benefits will be payable under both systems to individuals with 10 or more years of railroad service who also qualify under old-age and survivors insurance.

With respect to the financial relationships with the railroad retirement system, when it has a different maximum earnings base than the hospital insurance program, the latter program will cover railroad employees directly in the same manner as other covered workers, their contributions will go directly into the hospital insurance trust fund, and their benefit payments will be paid directly from this trust fund. When the two bases are the same, the hospital insurance taxes will be collected by the railroad retirement system, along with the railroad retirement taxes, and will be transferred to the hospital insurance trust fund through the financial interchange provisions. Under either case, the hospital and related benefits with respect to railroad workers will be paid from the hospital insurance trust fund, and the administrative expenses in connection with the hospital insurance program that are paid by the railroad retirement system but would otherwise have been paid by the hospital insurance trust fund are reimbursed to the railroad retirement account through the financial interchange provisions.

Investments.—Since the inception of the program, provision has been made for the investment of funds which are not required to meet current disbursements. As provided in the Social Security Act, the funds may be invested only in interest-bearing obligations of the U.S. Government or in obligations guaranteed as to both principal and interest by the United States; or the funds may be invested 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. In addition, the Social Security Act authorizes the issuance of public-debt obligations for purchase by the trust funds.

Special issues acquired after enactment bear interest at a rate equal to the average market yield (computed on the basis of market quotations as of the end of the calendar month next preceding their issue) on all marketable interest-bearing obligations of the United States forming a part of the public debt which are not due or callable for 4 or more years from the time the special obligations are issued, such average market yield being rounded to the nearest one-eighth of 1 percent.

Appendix III. Statutory Provisions, as of January 2, 1968, Creating the Trust Fund, Defining the Duties of the Board of Trustees, Financing the Cost of Noncontributory Credits for Military Service, Financing the Cost of Benefits for Presently Uninsured Individuals, and Providing for Advisory Councils on Social Security

(Sec. 217(g), sec. 218 (e)(1), (h), and (j), sec. 229(b), sec. 706, and sec. 1817 of the Social Security Act, as amended, and sec. 103(c) of the Social Security Amendments of 1965)

FEDERAL HOSPITAL INSURANCE TRUST FUND

Sec. 1817. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hospital Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"): The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with such reports; and

(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the

Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to 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 then 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; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f)(1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954 with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary of Health, Education, and Welfare shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(g) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(h) The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

FINANCING THE COST OF BENEFITS IN CASE OF VETERANS

SEC. 217. * * *

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(g)(1) In September 1965, and in every fifth September thereafter up to and including September 2010, the Secretary shall determine the amount which, if paid in equal installments at the beginning of each fiscal year in the period beginning—

(A) with July 1, 1965, in the case of the first such determination, and

(B) with the July 1 following the determination in the case of all other such determinations,

and ending with the close of June 30, 2015, would accumulate, with interest compounded annually, to an amount equal to the amount needed to place each of the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position at the close of June 30, 2015, as he estimates they would otherwise be in at the close of that date if section 210 of this Act as in effect prior so the Social Security Act Amendments of 1950, and this section, had not been enacted. The rate of interest to be used in determining such amount shall be the rate determined under section 201(d) for public-debt obligations which were or could have been issued for purchase by the Trust Funds in the June preceding the September in which such determination is made.

(2) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund—

(A) for the fiscal year ending June 30, 1966, an amount equal to the amount determined under paragraph (1) in September 1965, and

(B) for each fiscal year in the period beginning with July 1, 1966, and ending with the close of June 30, 2015, an amount equal to the annual installment for such fiscal year under the most recent determination under paragraph (1) which precedes such fiscal year.

(3) For the fiscal year ending June 30, 2016, there is authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund such sums as the Secretary determines would place the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position in which they would have been at the close of June 30, 2015, if section 210 of this Act as in effect prior to the Social Security Act Amendments of 1950, and this section, had not been enacted.

(4) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust annually, as benefits under this title and part A of title XVIII are paid after June 30, 2015, such sums as the Secretary determines to be necessary to meet the additional costs, resulting from subsections (a), (b), and (e), of such benefits (including lump-sum death payments).

PAYMENTS AND REPORTS BY STATES

SEC. 218. * * *

* * * * * * *

(e)(1) Each agreement under this section shall provide—

(A) that the State will pay to the Secretary of the Treasury, at such time or times as the Secretary of Health, Education, and Welfare may by regulations prescribe, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if the services of employees covered by the agreement constituted employment as defined in section 3121 of such code; and

(B) that the State will comply with such regulations relating to payments and reports as the Secretary of Health, Education, and Welfare may prescribe to carry out the purposes of this section.

DEPOSITS IN TRUST FUNDS; ADJUSTMENTS

SEC. 218. * * *

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(h)(1) All amounts received by the Secretary of the Treasury under an agreement made pursuant to this section shall be deposited in the Trust Funds and the Federal Hospital Insurance Trust Fund in the ratio in which amounts are appropriated to such Funds pursuant to subsection (a) (3) of section 201, subsection (b)(1) of such section, and subsection (a) (1) of section 1817, respectively.

(2) If more or less than the correct amount due under an agreement made pursuant to this section is paid with respect to any payment of remuneration, proper adjustments with respect to the amounts due under such agreement shall be made, without interest, in such manner and at such times as may be prescribed by regulations of the Secretary of Health, Education, and Welfare.

(3) If an overpayment cannot be adjusted under paragraph (2), the amount thereof and the time or times it is to be paid shall be certified by the Secretary of Health, Education, and Welfare to the Managing Trustee, and the Managing Trustee, through the Fiscal Service of the Treasury Department and prior to any action thereon by the General Accounting Office, shall make payment in accordance with such certification. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary of Health, Education, and Welfare.

FAILURE TO MAKE PAYMENTS

SEC. 218. * * *

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(j) In case any State does not make, at the time or times due, the payments provided for under an agreement pursuant to this section, there shall be added, as part of the amounts due, interest at the rate of 6 per centum per annum from the date due until paid, and the Secretary of Health, Education, and Welfare may, in his discretion, deduct such amounts plus interest from any amounts certified by him to the Secretary of the Treasury for payment to such State under any other provision of this Act. Amounts so deducted shall be deemed to have been paid to the State under such other provision of this Act. Amounts equal to the amounts deducted under this subsection are hereby appropriated to the Trust Funds in the ratio in which amounts are deposited in such Funds pursuant to subsection (h)(1).

FINANCING THE COST OF BENEFITS FOR DEEMED MILITARY SERVICE WAGES AFTER 1967

SEC. 229. * * *

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(b) There are authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund annually, as benefits under this title and part A of title XVIII are paid after December 1967, such sums as the Secretary determines to be necessary to meet (1) the additional costs, resulting from subsection (a), of such benefits (including lump-sum death payments), (2) the additional administrative expenses resulting therefrom, and (3) any loss in interest to such trust funds resulting from the payment of such amounts. Such additional costs shall be determined after any increases in such benefits arising from the application of section 217 have been made.

FINANCING THE COST OF BENEFITS FOR PRESENTLY UNINSURED INDIVIDUALS

SEC. 103. * * *

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(c) There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments made or to be made during such fiscal year from such Trust Fund under part A of title XVIII of such Act with respect to individuals who are entitled to hospital insurance benefits under section 226 of such Act solely by reason of this section,

(2) the additional administrative expenses resulting or expected to result therefrom, and

(3) any loss in interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the preceding subsections of this section had not been enacted.

ADVISORY COUNCIL ON SOCIAL SECURITY

SEC. 706. (a) During 1969 (but not before February 1, 1969) and every fourth year thereafter (but not before February 1 of such fourth year) the Secretary shall appoint an Advisory Council on Social Security for the purpose of reviewing the status of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in relation to the, long-term commitments of the old-age, survivors, and disability insurance program and the programs under parts A and B of title XVIII, and of reviewing the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs under this Act.

(b) Each such Council shall consist of a Chairman and 12 other persons, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public.

(c)(1) Any Council appointed hereunder is authorized to engage such technical assistance, including actuarial services, as may be required to carry out its functions, and the Secretary shall, in addition, make available to such Council such secretarial, clerical, and other assistance and such actuarial and other pertinent data prepared by the Department of Health, Education, and Welfare as it may require to carry out such functions.

(2) Appointed members of any such Council, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

(d) Each such Council shall submit reports (including any interim reports such Council may have issued) of its findings and recommendations to the Secretary not later than January 1 of the second year after the year in which it is appointed, and such reports and recommendations shall thereupon be transmitted to the Congress and to the Board of Trustees of each of the Trust Funds. The reports required by this subsection shall include—

(1) a separate report with respect to the old-age, survivors and disability insurance program under title II and of the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954,

(2) a separate report with respect to the hospital insurance program under part A of title XVIII and of the taxes imposed by sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, and

(3) a separate report with respect to the supplementary medical insurance program established by part B of title XVIII and of the financing thereof.

After the date of the transmittal to the Congress of the reports required by this subsection, the Council shall cease to exist.

Appendix IV. 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 amended by Public Law 90–248, approved January 2, 1968, 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 of illness" (a period beginning with the first 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 3 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*) Extended 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

[1] Public Law 89–212, approved Sept. 29, 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.

services and various types of therapy treatment, including outpatient 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 or 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 as 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 of 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, $7,800; 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.