APPENDIXES

Appendix I. Assumptions and Methodology for Long-Range Cost Estimates

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

(1) Methodology

As stated previously, when the Hospital Insurance program was being enacted in 1965, a certain procedure for developing the cost estimates and determining the actuarial balance of the program was established by the Congress, after considering different possible approaches recommended by actuaries. Such procedure has continued to be followed and will be described in this appendix.

The long-term actuarial cost estimates for the HI program are made over a future period of 25 years. It is believed that a 25-year projection period for this program is as far ahead as should be considered, because of the uncertainty as to future institutional care practices and as to changes in the costs of these institutional services. On the other hand, the program is a long-term social insurance program; thus, it is necessary to look ahead for a period in the future to have some idea as to the rising costs that can possibly ensue, even with the uncertainties stated above.

The actuarial balance is determined by first calculating the present value of the estimated future benefit payments and administrative expenses over the next 25 years, plus the discounted value of estimated outgo in the 26th year. Then, the level-cost of the disbursements is calculated by dividing the present value of the total cost by the present value of the estimated future taxable payroll for the 25-year period. This is compared to the level-equivalent of the estimated future contributions and the level-equivalent value of the existing trust fund. The level-equivalent of the estimated future contributions is calculated by taking the present value of the estimated contributions over the next 25 years as a percentage of the present value of the estimated future taxable payroll for the same period. The estimates covering a 25-year future period can, therefore, indicate the extent to which the cost will increase and whether the scheduled tax rates are adequate to maintain the system on an actuarially sound basis over this period.

The actuarial balance of the system only considers the costs of insured persons who are covered by the HI program. Costs for uninsured persons covered under the program are borne by the general fund of the Treasury.

The cost estimate for the HI program assumes that earnings in covered employment will rise in the future. This is a different approach from the assumptions used in the cost estimates for the old-age, survivors, and disability insurance system. Under the latter program, a level-earnings assumption is used, because the benefit structure of the present law is assumed to remain unchanged in the future and it can be said to be based on the current general level of earnings. The reason for using the rising-earnings assumption for the cost estimate for the HI program is that service-type benefits are provided and that it is assumed that the cost of institutional services will increase in the future. One major cause for these increases is due to the trend of wages. Since this trend is reflected in the benefit costs, then it is only realistic to take it into account also in the assumptions as to earnings in covered employment.

The cost estimates as shown in this report are prepared on an accrued basis. The income items are allocated to the fiscal-year period that they are earned, while benefit payments and administrative expenses are allocated to the fiscal-year period that they are incurred. Analysis and cost estimates on an accrued basis are more meaningful than those on a cash basis.

(2) Trend in hospital costs

A major consideration in making cost estimates for hospital benefits 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 "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 technology and procedures, which result in more highly skilled hospital personnel and a larger average number of personnel per patient.

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.

Table A presents a summary comparison of the annual increases in daily hospital costs and the corresponding increases in wages that have occurred since 1956 and up through 1969.

The annual increases in earnings 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 1965, although there were some deviations from the average annual rate of 3.6 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 6.8 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]
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
1964	3.1	6.9
1965	1.6	7.0
Average for 1956–65	3.6	6.8
1966	4.4	8.3
1967	6.3	12.3
1968	7.0	13.5
1969	6.0	[3] 14.0
Average for 1960–69	4.2	8.8

[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. Data are from American Hospital Association, and "hospitalization costs" represents total hospital expense per patient day.
[3] Preliminary estimate made by Social Security Administration.

Since 1957, hospital costs increased at a faster rate than earnings. The differential between these two rates of increase fluctuated widely, being as high as about 6 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 latest 10-year period (1960–69), the differential of the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 4.6 percent. In the last 4 years, this differential was about 6 percent.

(3) *Assumptions as to future trends of hospitalization costs per day and earnings underlying cost estimates*

The data on the 1968 interim reimbursements to hospitals from the HI program are virtually complete. After making adjustments for the possible difference between the interim reimbursement rates and the final audited costs, the experience shows that, for 1968, the average daily reimbursement is about $48.55 for insured persons and $42.86 for uninsured persons. The average daily reimbursement excludes the amounts paid by the beneficiaries under the cost-sharing provisions. These provisions reduce the average daily cost of hospitalization by approximately 6.3 percent for insured persons and 7.0 percent for uninsured persons.

Table B summarizes the assumptions used for future increases in the average daily reimbursement amounts to hospitals, as well as the future increases of general earnings levels. It is assumed that the annual rate of increase in hospital costs has peaked in 1969 and that it will gradually decrease thereafter and finally will merge with the annual rate of increase in general wages by 1978. Thereafter, both are assumed to have the same annual increases.

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

The experience from the HI program has shown that there seems to be a long-term increasing trend in hospital utilization rates. This is corroborated by other national statistics, which have observed that there have been such trends over the past three decades.

TABLE B.—ASSUMPTIONS AS TO FUTURE RATES OF INCREASE IN HOSPITAL COSTS AND EARNINGS IN COVERED EMPLOYMENT

[In percent]

Calendar year	Increase over previous year	
	Average daily reimbursement amount	Average earnings in covered employment
1969	15	6.6
1970	14	5.9
1971	13	5.4
1972	11½	5.0
1973	10	4.6
1974	8½	4.3
1975	7	4.1
1976	6	4.0
1977	5	4.0
1978 and after	4	4.0

The hospital utilization assumptions are based on the hypothesis that the current practices in this field will not change drastically in the near future. On the other hand, the optimistic assumption is made that the annual rate of increase in the utilization of hospital services will gradually decrease over the next decade. After 1978, the hospital utilization rates by age and sex are assumed to remain unchanged.

The cost estimates shown in this report use the assumptions shown in table C. The hospital utilization rates are based on the actual experience in 1968. The aggregate hospital utilization rate in 1968 for the insured population was 3.89 days per person per year and 4.78 days for uninsured persons. The utilization rates for males and females were derived separately. For each sex, the utilization rate for each quinquennial age group was established up to age 85. The population aged 85 and over is considered as one group.

TABLE C.—*Assumptions as to future rates of increases in utilization rates of hospitals*

[In percent]

Calendar year:	*Increase over previous year*
1969	2
1970	2
1971	2
1972	1. 5
1973	1. 5
1974	1. 5
1975	1
1976	1
1977	. 5
1978	. 5
1979 and after	0

Since the average age of the insured population will increase in the future, the aggregate rate will also increase over the long-range future, even without the assumption that there is a long-term increasing trend in the utilization rates.

(*5*) *Assumptions as to cost per day of extended care facilities*

In 1968, the average reimbursement amount per day to extended care facilities from the HI program was $16.98 for insured persons and $15.71 for uninsured persons (as in the case of hospitalization costs, after taking into account the cost-sharing payments made by the beneficiaries). This average daily reimbursement amount is 20 percent higher than in 1967. The projected increases for future years are based on this actual experience. It is assumed that the annual rate of increase peaked in 1968 and that it will decrease gradually thereafter and will merge with the annual rate of increase in general wages by 1978; thereafter, both will have the same annual increases. Table D shows the assumptions used as to the future annual rates of increase in the average daily reimbursement amounts for extended care facilities.

(*6*) *Assumptions as to utilization rates of extended care facilities*

The utilization rates of extended care facilities have remained relatively level in 1967–69. This experience emerged in spite of the fact that the total number of facilities and beds certified under the HI program had increased. The most likely explanation might be that the administrative actions taken by the Social Security Administration to prevent the use of extended care facility benefits for domiciliary care are offsetting the increases in utilization due to medical reasons.

The utilization rate in 1968 was 0.95 days of care per year per capita for insured persons and 1.76 days for uninsured persons. It is assumed that utilization rates will be stabilized at the 1969 level, except for increasing in proportion to the number of additional new beds available. The average number of extended care facility beds per capita of population aged 65 and over was calculated for the 7 States which had the highest number of beds per capita in July 1969. The assumption was made that the average number of beds per capita for the entire United States will reach this level in 1977 and that the utilization rates of extended care facilities will increase in proportion to the beds available up through 1977 and then will remain level thereafter (see table D).

TABLE D.—ASSUMPTIONS AS TO FUTURE INCREASES IN UTILIZATION RATE AND AVERAGE DAILY REIMBURSEMENT AMOUNT OF EXTENDED CARE FACILITIES

[In percent]

Calendar year	Increase over previous year	
	Utilization rate	Average daily reimbursement amount
1969	0	17
1970	8	16
1971	10	14
1972	10	12
1973	8	10
1974	6	8½
1975	4	7
1976	3	6
1977	2	5
1978 and after	0	4

(7) Assumptions as to Home Health Service Benefits

The unit cost of home health services is based on the actual experience from the HI program in 1968, for which the average reimbursement amount per visit was $9.75 with virtually no difference as between insured and uninsured persons. The annual rate of increase in cost per visit has been about 10 percent. It is assumed that this rate of increase will decline gradually and will merge with the annual rate of increase in general wages by 1978 (see table E).

The utilization rates of home health services have increased sharply since the HI program began. This trend can be explained by the facts that a greater number of home health agencies are in operation and that there is greater public awareness and use of these facilities. This trend will most likely continue, due to the efforts of Federal and State governments in promoting the expansion of these services, as well as the efforts to make the public more aware of the availability of these services and of the desirability of using them. Table E shows the assumptions used as to future trends in the utilization rates of home health services.

TABLE E.—ASSUMPTIONS AS TO FUTURE INCREASES IN COST ELEMENTS, HOME HEALTH SERVICE BENEFITS

Calendar year	Insured		Uninsured	
	Utilization rate [1]	Average reimbursement per visit	Utilization rate [1]	Average reimbursement per visit
	Initial values			
1968	0.20	$9.75	0.26	$9.75
	Percentage increase over previous year			
1969	33	10	30	10
1970	30	10	30	18
1971	26	9	27	0
1972	22	8	24	8
1973	18	8	20	9
1974	14	7	16	7
1975	10	7	12	7
1976	6	6	8	6
1977	4	5	6	5
1978	2	4	4	4
1979 and after	0	4	0	4

[1] Average number of visits per year per capita.

(8) Administrative expenses

The administrative expenses per capita in connection with the HI program, including those of fiscal intermediaries, were calculated on the basis of the budgeted administrative expenses for fiscal year 1970. This cost per capita was projected to increase in the future at the same rate of increase as general wages.

(9) Interest rate

A discount rate of 5 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, higher rates are used in the first few years—namely, 6.25 percent in 1970, gradually declining to a level of 5 percent by 1983 and thereafter.

(10) Other changes in assumptions

The new population projection that was used in the cost estimates made for the old-age, survivors, and disability insurance system in late 1969 (and used in the 1970 report of the Board of Trustees for this program), was also used in the cost estimate of this report.

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 DECEMBER 31, 1969, 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 percent, the rate of interest on such obligations shall be the multiple of one-eighth of 1 percent 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 to 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 Fund 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. * * *

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(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 of December 31, 1969, 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 PURCHASES)

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

(*b*) 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

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

person was hospitalized, up to 100 days of such care in a spell of illness, with coinsurance of $5 per day for all days after the 20th one; after 1968, the $5 coinsurance will be automatically adjusted to reflect changes in hospital costs after 1966.

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

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

(e) Administration—by Department of Health, Education, and Welfare. Each provider of services can nominate a fiscal intermediary (such 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 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.

APPENDIX V. INPATIENT HOSPITAL DEDUCTIBLE FOR 1969 [1]

Notice of inpatient hospital deductible for 1969 under part A of title XVIII of the Social Security Act.

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 $44 in the case of any spell of illness beginning during 1969.

There follows a statement of the actuarial bases employed in arriving at the amount of $44 for the inpatient hospital deductible for the calendar year 1969 (as contrasted with the figure of $40 applicable for the period from July 1966 through December 1968). Certain other cost-sharing provisions under the hospital insurance program are also affected by changes in the amount of the inpatient hospital deductible.

The law provides that, for calendar years after 1968, the inpatient hospital deductible shall be equal to $40 multiplied by the ratio of (1) the current average per diem rate for inpatient hospital services for the calendar year preceding the year in which the promulgation is made (in this case, 1967) 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 1967 are derived from individual inpatient-hospital bills that are recorded on a 100 percent basis in the records of the program. These records show, for each bill, the total inpatient days of care, the interim reimbursement amount, and the total cost (the sum of interim reimbursement, deductible, and coinsurance). With respect to reimbursements to the hospitals by the program, no allowance is made for adjustments with the providers of services that may be made after their fiscal years are ended. There is currently no significant information available to modify the data for the effect of such adjustments, but it is believed that, since a relative comparison is made of one year with another, this factor is largely self-compensating and would have no appreciable effect on the final results.

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 $37.95, while the corresponding figure for calendar year 1967 is $43.03. It may be noted that these averages are based on about 29 million days of hospitalization in 1966 and 59 million days of hospitalization in 1967. Accordingly, the ratio of the 1967 rate to the 1966 rate is 1.134. When this ratio is multiplied by $40, it produces an amount of $45.36, which must be rounded down to $44. Accordingly, the inpatient hospital deductible for spells of illness beginning during calendar year 1969 is $44.

Dated: September 18, 1968.

WILBUR J. COHEN, *Secretary.*

[SEAL]

[1] This notice was published in the Federal Register for September 24, 1968 (33 F.R. 186).

APPENDIX VI. NOTICE OF INPATIENT HOSPITAL DEDUCTIBLE FOR 1970 UNDER PART A OF TITLE XVIII OF SOCIAL SECURITY ACT[1]

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 $52 in the case of any spell of illness beginning during 1970.

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

The law provides that, for calendar years after 1968, the inpatient hospital deductible shall be equal to $40 multiplied by the ratio of (1) the current average per diem rate for inpatient hospital services for the calendar year preceding the year in which the promulgation is made (in this case, 1968) 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 1968 are derived from individual inpatient-hospital bills that are recorded on a 100-percent basis in the records of the program. These records show, for each bill, the total inpatient days of care, the interim reimbursement amount and the total cost (the sum of interim reimbursement, deductible, and coinsurance). With respect to reimbursements to the hospitals by the program, no allowance is made for adjustments with the providers of services that may be made after their fiscal years are ended. There is currently no significant information available to modify the data for the effect of such adjustments, but it is believed that, since a relative comparison is made of one year with another, this factor is largely self-compensating and would have no appreciable effect on the final results.

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 $37.95, while the corresponding figure for calendar year 1968 is $49.34. It may be noted that these averages are based on about 30 million days of hospitalization in 1966 and 65 million days of hospitalization in 1968. Accordingly, the ratio of the 1968 rate to the 1966 rate is 1.300. When this ratio is multiplied by $40, it produces an amount of $52, which need not be rounded. Accordingly, the inpatient hospital deductible for spells of illness beginning during calendar year 1970 is $52.

Dated: September 26, 1969.

ROBERT H. FINCH, *Secretary.*

[1] This notice was published in the Federal Register for September 30, 1969 (34 F.R. 187).