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1987 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

COMMUNICATION

From

THE BOARD OF TRUSTEES, FEDERAL HOSPITAL INSURANCE TRUST FUND

Transmitting

THE 1987 ANNUAL REPORT OF THE BOARD, PURSUANT TO SECTION 1817(b) OF THE SOCIAL SECURITY ACT AS AMENDED

Prepared by

THE OFFICE OF THE ACTUARY
HEALTH CARE FINANCING ADMINISTRATION

LETTER OF TRANSMITTAL

Board of Trustees of the
Federal Hospital Insurance Trust Fund
Washington, D.C., March 30, 1987

HONORABLE JAMES C. WRIGHT, JR.
Speaker of the House of Representatives
Washington, D.C.

HONORABLE GEORGE BUSH
President of the Senate
Washington, D.C.

GENTLEMEN:

We have the honor of transmitting to you the 1987 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (the 22nd such report), in compliance with the provisions of section 1817(b) of the Social Security Act.

Respectfully,

JAMES A. BAKER, III,
Secretary of the Treasury, and
Managing Trustee of the Trust Fund

WILLIAM E. BROCK,
Secretary of Labor,
and Trustee

OTIS R. BOWEN, M.D.,
Secretary of Health and
Human Services, and Trustee

MARY FALVEY FULLER,
Trustee

SUZANNE DENBO JAFFE,
Trustee

WILLIAM L. ROPER, M.D.,
Administrator of the Health Care Financing
Administration, and Secretary,
Board of Trustees

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1987 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

THE BOARD OF TRUSTEES

The Federal Hospital Insurance Trust Fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1817(b) of the Social Security Act, as amended. The Board has five members. Three serve in an ex officio capacity. These members are the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services. Two public members, Mary Falvey Fuller and Suzanne Denbo Jaffe, are provided for by the Social Security Amendments of 1983 (Public Law 98-21, enacted into law on April 20, 1983). The two public members were nominated by the President for a term of four years, and were confirmed by the Senate.

By law, the Secretary of the Treasury is designated as the Managing Trustee and the Administrator of the Health Care Financing Administration is designated as Secretary of the Board. The Board of Trustees reports to the Congress each year on the operation and status of the trust fund, in compliance with section 1817(b)(2) of the Social Security Act. This is the 1987 annual report, the twenty-second such report.

EXECUTIVE SUMMARY

The hospital insurance (HI) program pays for inpatient hospital care and other related care of those aged 65 and over and of the long-term disabled. In calendar year 1986, about 28 million people over age 65 and about 3 million disabled people under age 65 were covered under HI, financed primarily by the contributions of 127 million workers through payroll taxes. Payroll taxes during 1986 amounted to $54.6 billion, accounting for 92.1 percent of all HI income. Interest payments to the HI fund amounted to 6.1 percent of all HI income for 1986. The remaining 1.8 percent of calendar year 1986 income consisted primarily of transfers from the Railroad Retirement Account and the general fund of the Treasury (in accordance with provisions for the collection of taxes from railroad workers, the collection of taxes on deemed military service wage credits, and reimbursement to the fund for benefits for certain uninsured persons), and premiums paid by voluntary enrollees. Of the $50.4 billion in HI disbursements, $49.8 billion was for benefit payments while the remaining $0.7 billion was spent for administrative expenses. HI administrative expenses were 1.3 percent of total disbursements. In calendar year 1986, the HI trust fund was credited with an additional $10.6 billion, representing the final repayment of the interfund loan made to the Federal Old-Age and Survivors Insurance Trust Fund in December 1982.

As mentioned above, the HI program is financed primarily by payroll taxes, with the taxes paid by current workers used primarily to pay benefits to current beneficiaries. However, the HI program maintains a trust fund to provide a small reserve against fluctuations in program experience, such as those occurring in hospital admissions or inflation. The HI program should also build a reserve to anticipate changes in the demographic composition of the population. However, the projected reserves are inadequate for this purpose. The trust fund holds all of the income not currently needed to pay benefits and related expenses. The assets of the fund may not be used for any other purpose; however, they are invested in certain interest-bearing obligations of the U.S. Government.

The HI contribution rates applicable to taxable earnings in each of the calendar years 1983 and later are shown in Table I. The maximum taxable amounts of annual earnings are shown for 1983 through 1987. After 1987, the automatic increase provisions in section 230 of the Social Security Act determine the maximum taxable amount.

TABLE I.--CONTRIBUTION RATES AND MAXIMUM TAXABLE AMOUNT ON ANNUAL EARNINGS

Calendar year	Maximum taxable amount of annual earnings	Contribution Rate (Percent of taxable earnings) Employees and employers, each	Self-Employed
1983	$35,700	1.30	1.30
1984	37,800	1.30	2.60
1985	39,600	1.35	2.70
1986	42,000	1.45	2.90
1987	43,800	1.45	2.90
Changes scheduled in present law:			
1988 & later	Subject to automatic increase	1.45	2.90

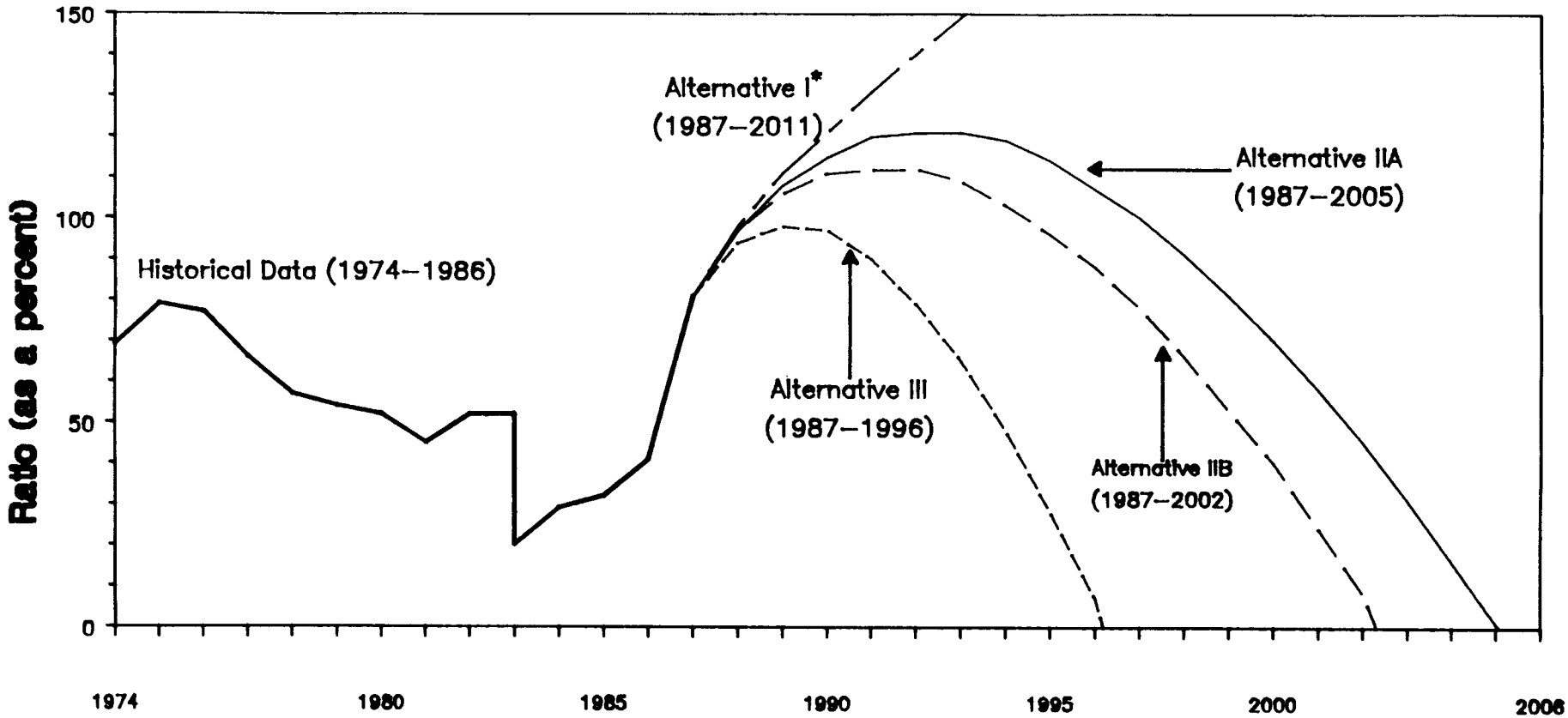
Actuarial Status of the Trust Fund

The Board of Trustees has adopted the general financing principle that annual income to the hospital insurance program should be at least equal to annual outlays of the program plus an amount to maintain a balance in the trust fund equal to a minimum of one-half year's disbursements. At the beginning of 1987, the trust fund was above the minimum desired level.

Projections were made under four alternative sets of assumptions: optimistic, two intermediate sets (alternatives II-A and II-B), and pessimistic. Under both sets of intermediate assumptions, the trust fund ratio, defined as the ratio of assets at the beginning of the year to disbursements during the year, is projected to increase until about 1992 and then decline steadily until the fund is completely exhausted just after the turn of the century. Under the more optimistic set of assumptions (alternative I), the trust fund is projected to remain solvent throughout the first two 25-year projection periods. Under the more pessimistic set of assumptions (alternative III), the trust fund is projected to increase to a level of about 98 percent in 1989 and then decrease rapidly until the fund is exhausted in 1996.

Table 11 in this report summarizes the estimated operations of the HI trust fund under the four alternative sets of assumptions. Figure I shows historical trust fund ratios for recent years and projected ratios under the four sets of assumptions.

Figure 1
Short Term HI Trust Fund Ratios



*The trust fund remains solvent under alternative I during this 25–year projection period.

Note: The trust fund ratio is defined as the ratio of assets at the beginning of the year to disbursements during the year.

The adequacy of the financing of the HI program on a long-range basis is measured by comparing on a year-by-year basis the actual tax rates specified by law with the corresponding total costs of the program, expressed as percentages of taxable payroll. The actuarial balance is defined to be the excess of the average tax rate for the valuation period over the average cost of the program expressed as a percent of taxable payroll. Table II compares the actuarial balance under each of the four sets of assumptions for the 75-year projection period 1987-2061. Figure 2 shows the year-by-year costs as a percent of taxable payroll for each of the four sets of assumptions, as well as the scheduled tax rates. The cost figures in Table II and Figure 2 include amounts for maintaining the trust fund at the level of at least a half-year's disbursements as recommended by the Board of Trustees. Under alternative I, maintenance amounts are included only in the last 25-year projection period.

Figure 2 emphasizes the inadequacy of the financing of the HI program by illustrating the divergence of the program costs and scheduled tax rates under each set of assumptions.

Table III presents a comparison of the projected experience in the 1986 and 1987 reports. As Table III indicates, the projections in the 1987 report show that the fund will be depleted several years later than in the 1986 report under all alternative projections. This change is primarily due to legislation passed since the 1986 report was issued and to the more optimistic economic assumptions underlying the projections in the 1987 report. Table IV shows the major reasons for the change in the 75-year actuarial balance of the HI program from the 1986 report. The section of the report entitled "Actuarial Status of the Trust Fund" discusses more completely the reasons for the change in the actuarial balance.

TABLE II.--SEVENTY-FIVE YEAR ACTUARIAL BALANCE OF THE HOSPITAL INSURANCE PROGRAM UNDER ALTERNATIVE SETS OF ASSUMPTIONS

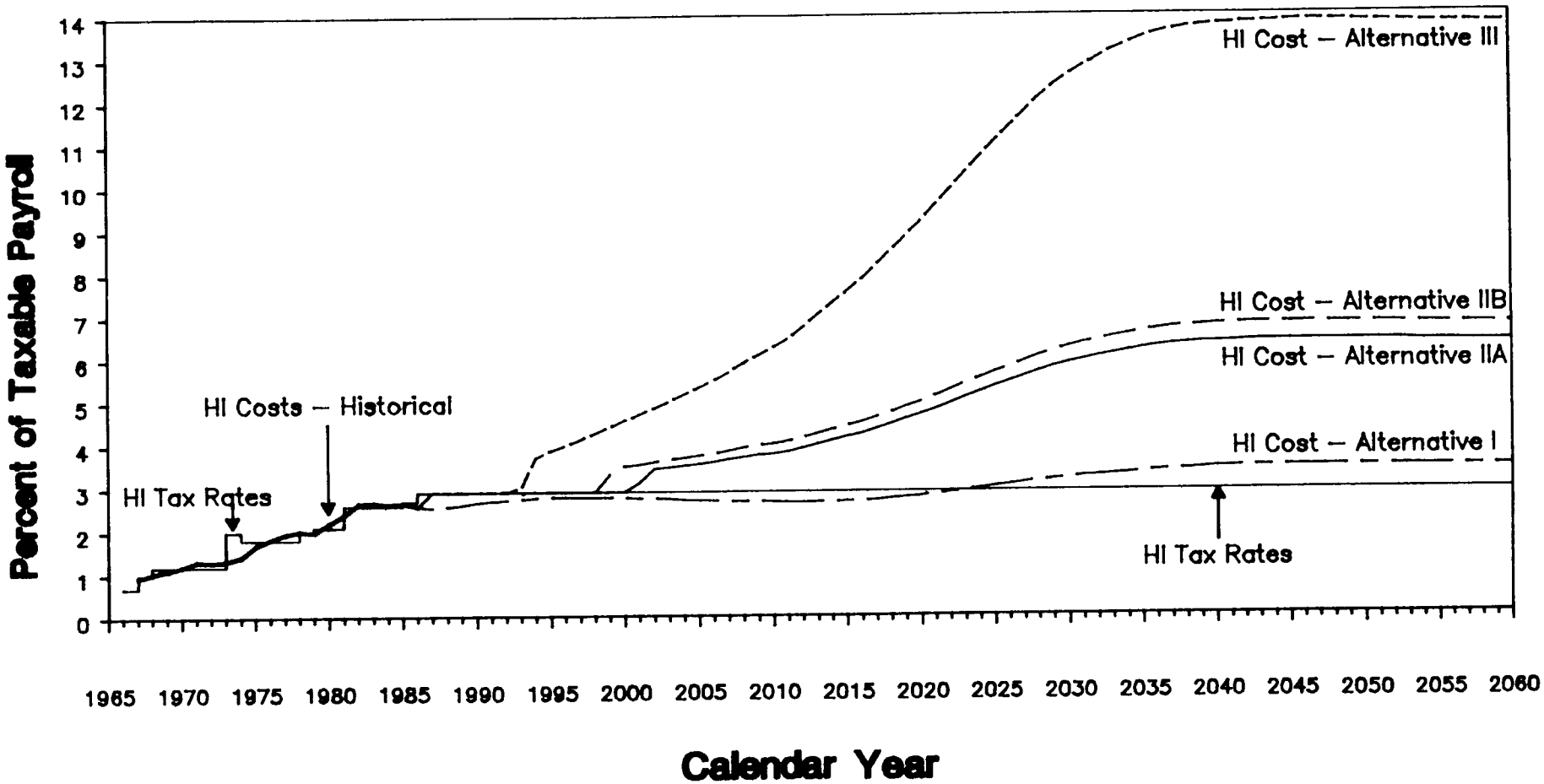
	Alternative			
	I	II-A	II-B	III
1987-2011:				
Average contribution rate 1/	2.90%	2.90%	2.90%	2.90%
Average cost of the program 2/	2.71	3.21	3.34	4.41
Actuarial balance	+0.19	-0.31	-0.44	-1.51
2012-2036:				
Average contribution rate 1/	2.90	2.90	2.90	2.90
Average cost of the program 2/	2.97	5.16	5.49	10.47
Actuarial balance	-0.07	-2.26	-2.59	-7.57
2037-2061:				
Average contribution rate 1/	2.90	2.90	2.90	2.90
Average cost of the program 2/	3.43	6.36	6.77	13.78
Actuarial balance	-0.53	-3.46	-3.87	-10.88
1987-2061:				
Average contribution rate 1/	2.90	2.90	2.90	2.90
Average cost of the program 2/	3.04	4.91	5.20	9.55
Actuarial balance	-0.14	-2.01	-2.30	-6.65

1/ As scheduled under present law.

2/ Expressed as a percent of taxable payroll. Includes amounts for trust fund maintenance. Under alternative I, maintenance amounts are included only in the last 25-year projection period.

NOTE: Taxable payroll is adjusted to take into account the lower contribution rates on tips and on multiple-employer "excess wages," as compared with the combined employer-employee rate.

Figure 2
Estimated HI Cost and Tax Rates



Note: HI projected cost includes an allowance for maintaining the trust fund balance at the level of at least a half–year's outgo after accounting for the offsetting effect of interest earnings. Under alternative I, maintenance amounts are included only in the last 25–year projection period.

TABLE III.--STATUS OF THE HOSPITAL INSURANCE TRUST FUND

Alternative Assumptions	Year in which the trust fund is exhausted as published in the		75-year actuarial balance 1/ of the HI program as published in the	
	1986 Report	1987 Report	1986 Report	1987 Report
I (Optimistic)	2/	3/	-0.52%	-0.14%
II-A (Intermediate)	1998	2005	-2.65	-2.01
II-B (Intermediate)	1996	2002	-3.02	-2.30
III (Pessimistic)	1993	1996	-8.03	-6.65

1/ The actuarial balance of the hospital insurance program is defined to be the excess of the average tax rate for the valuation period over the average cost of the program, expressed as a percent of taxable payroll, for the same period.

2/ The trust fund is solvent at least through the end of the first 25-year projection period.

3/ The trust fund is solvent at least through the end of the second 25-year projection period.

Table IV.--CHANGE IN THE 75-YEAR ACTUARIAL BALANCE SINCE THE 1986 TRUSTEES REPORT

1. Actuarial Balance, Alternative II-B, 1986 Report	-3.02%
2. Changes:	
a Valuation period	-0.07
b. Base estimate	+0.05
c. Legislation since the 1986 Report	
1. Consolidated Omnibus Budget Reconciliation Act	+0.30
2. Omnibus Budget Reconciliation Act of 1986	-0.06
d. Economic and demographic assumptions	+0.34
e. Hospital assumptions	+0.16
f. Net effect, all changes	+0.72
3. Actuarial Balance, Alternative II-B, 1987 Report	-2.30

Conclusion of the Board of Trustees

The present financing schedule for the hospital insurance program is sufficient to ensure the payment of benefits and maintain the fund at a level of at least one-half year's disbursements over the next 12 to 14 years if the assumptions underlying the estimates are realized. The trust fund is exhausted just after the turn of the century under both alternatives II-A and II-B. Under the more pessimistic alternative III, the fund is exhausted in 1996. Under the more optimistic alternative I, the trust fund is solvent at least through the first two 25-year projection periods.

There are currently over four covered workers supporting each HI enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of that century, there will be only slightly more than two covered workers supporting each enrollee. Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, but under all but the most optimistic assumptions, the trust fund is projected to become exhausted even before the major demographic shift begins to occur. Exhaustion is projected to occur just after the turn of the century under the intermediate assumptions, and could occur as early as 1996 if the pessimistic assumptions are realized.

The Board notes that promising steps to begin reducing the rate of growth in payments to hospitals have already been taken. Initial experience under the prospective payment system for hospitals suggests that this payment mechanism is an effective means of constraining the growth in hospital payments and improving the efficiency of the hospital industry. Efforts focused on improving the efficiency and reducing the costs of the health care delivery system need to be continued, in

close combination with mechanisms that will assure that the quality of health care is not adversely affected.

Because of the magnitude of the projected actuarial deficit in the HI program and the probability that the HI trust fund will be exhausted shortly after the end of this century, the Board believes that early corrective action is essential in order to avoid the need for later, potentially precipitous changes. The Board, therefore, urges that the Congress take early remedial measures to bring future HI program costs and financing into balance.

SOCIAL SECURITY AMENDMENTS SINCE THE 1986 TRUSTEES REPORT

Public Law 99-272, the "Consolidated Omnibus Budget Reconciliation Act of 1985," was enacted April 7, 1986 and contained several provisions that have an impact on the Federal Hospital Insurance Trust Fund. The major changes include:

(1) The Secretary of Health and Human Services (HHS) is required to provide an increase of 1/2 percent in the prospective payment rates during the last 5 months of fiscal year 1986 for the Federal portion of the prospective payment and the last 5 months of the cost reporting period beginning in fiscal year 1986 for the hospital-specific portion of the prospective payment. The applicable percentage increase for hospitals exempt from prospective payment will be 5/24 of one percent for cost reporting periods beginning in fiscal year 1986. In fiscal years 1987 and 1988, the applicable percentage increase can be no greater than the increase in the hospital market basket. The effective date is May 1, 1986, for hospitals with cost reporting years beginning October 1. For all other hospitals, the effective date is the eighth month of their cost reporting periods.

(2) The indirect teaching adjustment factor in the hospital prospective payment formula is reduced from 11.59 percent to 8.1 percent for hospital discharges occurring during the period May 1, 1986 to September 30, 1988, and to 8.7 percent for discharges occurring after September 30, 1988. The statute includes a specific mathematical formula so that the adjustment is applied on a curvilinear rather than a linear basis. The effective date is May 1, 1986.

(3) For inpatient hospital services, return on equity capital payments are phased out over three years, eliminating all payments by fiscal year 1990. The rate of return for skilled nursing and other facilities is reduced to the interest rate paid on the HI trust fund. For inpatient hospital services, the modification applies to cost reporting periods beginning on or after October 1, 1986. For skilled nursing and other facilities, the change applies to cost reporting periods beginning on or after October 1, 1985.

(4) The sunset provision for hospice care is repealed. In addition, the routine home care daily rate of payment is set at $63.17 per day, and the daily rate of payment for other services is increased by $10.00. The repeal of the sunset provision is effective upon enactment. The daily payment rate for routine home care is effective April 1, 1986; the increase in the daily payment rate for other services is effective July 1, 1985.

(5) Skilled Nursing Facilities (SNFs) providing less than 1500 days of care per year have the option of being paid a prospective rate set at 105 percent of the regional mean for all SNFs in the region. This change is effective for cost reporting periods beginning on or after October 1, 1986.

(6) Medicare coverage is extended to virtually all State and local employees hired after December 31, 1985 on a mandatory basis. Coverage is effective for services performed after December 31, 1985.

(7) Medicare is made secondary payor for all workers age 65 and over and their spouses who elect to be covered by employment-based health insurance through an employer with 20 or more employees. This is effective May 1, 1986.

(8) Reimbursement for graduate medical education will be based on hospital-specific per resident amounts. Approved full-time equivalent (FTE) amounts will be derived from the first prospective payment system year cost reports and updated to 1985-86 for those hospitals not on a July 1 cost-reporting year. For the first cost-reporting period on or after July 1, 1985, the updated FTE amount is increased by one percent; subsequent periods will be increased by changes in the CPI. This change is effective for cost-reporting periods beginning on or after July 1, 1985.

(9) The Chief Actuary of the Health Care Financing Administration is permitted to comment on the economic assumptions underlying the Annual Report of the Board of Trustees. This change is effective upon enactment.

(10) Other provisions which revised Title XVIII but which did not have a major financial impact on the program include a one year extension of the Prospective Payment System (PPS) transition; payments for hospitals which serve a disproportionate share of low income patients; and limiting the penalty for late enrollment for those uninsured aged who voluntarily enroll in Part A.

Public Law 99-509, the "Omnibus Budget Reconciliation Act of 1986," was enacted October 21, 1986 and contained several provisions that have an impact on the Federal Hospital Insurance Trust Fund. The major changes include:

(1) For calendar year 1987, the inpatient hospital deductible is set at $520. For future years, the deductible will be indexed annually by the applicable percentage increase used for the prospective payment rate, adjusted to reflect changes in real case mix. Regulations to update the inpatient hospital deductible and all coinsurance amounts must be issued between September 1 and September 15 in the year preceding the year they will apply. This change is effective January 1, 1987.

(2) The payment rates for hospitals on prospective payment and the target rate-of-increase limits for hospitals exempt from prospective payment are increased by 1.15 percent for fiscal year 1987 and will be equal to the market basket index minus 2 percent for fiscal year 1988. For fiscal year 1988, the Secretary of Health and Human Services is required to inform the Congress by April 1, 1987 of his initial estimate of the update

factor; thereafter, his estimate is due March 1 of the preceding fiscal year. The rate of increase applies to cost reporting periods beginning October 1, 1986.

(3) There is an aggregate reduction of capital-related payments to hospitals under prospective payment. Payments will be reduced by 3.5 percent for portions of cost reporting periods occurring in fiscal year 1987, followed by 7 percent in fiscal year 1988, and 10 percent in 1989. Sole community hospitals are excluded from the reductions in capital-related costs. This change is effective October 1, 1986.

(4) Periodic Interim Payment (PIP) is eliminated for inpatient services in hospitals under prospective payment with the following exclusions:

- -- a hospital whose intermediary fails to demonstrate compliance with the prompt payment requirements in (5), below;
- -- a hospital that has a disproportionate share adjustment of at least 5.1 percent during fiscal year 1987,
- -- a rural hospital with fewer than 100 beds, paid on a PIP basis as of June 30, 1987, that continues to meet PIP requirements,
- -- hospitals reimbursed under a State hospital reimbursement system if PIP is an intergral part of the system,
- -- extended care services,
- -- home health services, and
- -- hospice care.

The elimination of the Periodic Interim Payment will apply to claims received on or after July 1, 1987.

(5) Prompt payment provisions requiring intermediaries to pay at least 95 percent of all "clean" non-PIP claims by a given number of calendar days after receipt are effective November 1, 1986.

(6) Medicare is made secondary payor for all disabled Medicare beneficiaries who elect to be covered by employment-based health insurance as a current employee (or family member of such employee) of a large employer (at least 100 employees). Coverage is effective from January 1, 1987 through December 31, 1991.

(7) Other provisions which revised Title XVIII but which did not have a major financial impact on the program include the repeal of the 2-for-1 conversion requirement for certain Health Maintenance Organizations (HMOs); clarifying direct costs of graduate medical education; limitation of payment for home health services; standards for organ procurement agencies; payment for nurse anesthetists; and coverage of hospitals in Puerto Rico under a Prospective Payment System (PPS).