NOTE: This is a reconstructed document created from a scanned copy of the report using optical character recognition (OCR). Although many OCR conversion errors have been corrected, many OCR conversion errors remain in this document. Since later issues of the report are used as a template, artifacts from later reports may be present in this document. The content is presented in essentially the same order as the original document, but the formatting, page layout, pagination are different.

THE 1966 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

L E T T E R

FROM

THE BOARD OF TRUSTEES FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

TRANSMITTING

THE 1966 ANNUAL REPORT OF THE BOARD OF TRUSTEES, PURSUANT TO THE PROVISIONS OF SECTION 1841(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE FEDERAL
SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Washington, D.C., February 28, 1966.

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

SIR: We have the honor to transmit to you the 1966 annual report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, in compliance with the provisions of Section 1841(b) of the Social Security Act, as amended which is the first such report.

Respectfully,

HENRY H. FOWLER,
Secretary of the Treasury and
Managing Trustee of the Trust Fund.

W. WILLARD WIRTZ,
Secretary of Labor.

JOHN W. GARDNER,
Secretary of Health, Education, and Welfare.

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

CONTENTS

TABLES

1966 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

THE BOARD OF TRUSTEES

The Federal supplementary medical insurance trust fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1841(b) of the Social Security Act, as amended. The Board is comprised of three members who serve in an ex officio capacity. The members of the Board are the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Secretary of the Treasury is designated by law as the managing trustee. The Commissioner of Social Security is secretary of the Board.

FISCAL YEAR HIGHLIGHTS

The supplementary medical insurance program was not enacted until after the close of the fiscal year covered by this report so that there are no activities about it to report on for fiscal year 1965.

SOCIAL SECURITY AMENDMENTS IN 1965

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

I. COVERAGE PROVISIONS (FOR CONTRIBUTION AND BENEFIT PURPOSES)

(*a*) Persons aged 65 and over on December 31, 1965: Voluntary individual election of coverage during period up to March 31, 1966, by any individual eligible for hospital insurance benefits or by any other citizen or any other alien lawfully admitted for permanent residence who has at least 5 consecutive years of residence (except with respect to persons convicted of certain specified offenses such as treason, espionage, etc.), to be effective July 1, 1966; if such an individual fails to enroll for good cause, within the time limit, he can nevertheless enroll before October 1, 1966, to be effective for the sixth month after enrollment.

(*b*) Persons attaining age 65 after 1965: Similar election in the 7-month period centering around the month of attainment of age 65 (or first subsequent month when eligibility requirements are met), to be effective for month of attaining age 65 if elected in advance (otherwise, effective for first to third month following election).

(*c*) Persons failing to enroll in initial period can enroll in next general enrollment period (October to December of each odd-numbered year), to be effective the next July; only one opportunity to enroll in this way.

(*d*) Termination of enrollment: Either by failure to pay premiums (for premiums not deducted from benefits) or by election to do so during a general enrollment period; individual who terminates coverage may

reenroll within 3 years if he does so in a general enrollment period, with reenrollment permitted only once.

II. BENEFITS PROVIDED

(*a*) Types of benefits: Physician and surgeon services (including anesthesiologist, pathologist, radiologist, and physical medicine in hospital), home health services (as in the hospital insurance program but without requirement that they be furnished after hospitalization), and certain other medical services, such as various diagnostic tests, limited ambulance services, prosthetic devices, rental of hospital equipment used at home, and supplies used for fractures.

(*b*) Amount of reimbursement: Plan pays 80 percent of reasonable charge (or cost, as case may be) after participant has paid a calendar-year deductible of $50; special limits on out-of-hospital, mental-care costs (50-percent coinsurance and $250 maximum annual reimbursement), and on home health services (100 visits per calendar year).

(*c*) Basis of payment: Reimbursement on a "reasonable charge" basis for individual suppliers of services and on a "reasonable cost" basis for institutional suppliers of services. When payment is made directly to individual suppliers (by assignment), the bill to the patient may not exceed the reasonable charge basis; otherwise, payment is made to the participant only upon presentation of a receipted bill.

(*d*) Services not covered: Drugs(only covered under hospital insurance, and then only when the individual is receiving covered hospital or extended care facility services and only when furnished in and by such hospital or facility), private duty nursing, dental services, skilled nursing home and custodial care, routine physical and eye examinations, elective cosmetic surgery, services performed by a relative or household member, services performed by a governmental agency, eyeglasses and hearing aids, and cases eligible under workmen's compensation.

(*e*) Administration: By Department of Health, Education, and Welfare, through carriers (such as Blue Shield and insurance companies) who are selected by the Department, who have had experience in this field, and who will determine the reasonable costs and charges applicable and will assist in controlling utilization. Carriers are paid their reasonable costs of administration.

(*f*) Effective date: July 1, 1966.

III. FINANCING

(*a*) Participant premiums: Flat monthly premium at a standard rate determined by the Secretary of Health, Education, and Welfare. The rate is applicable for a 2-year period and is intended to be adequate, along with other income of the system, to support the cost of the benefits and administration, plus a margin for contingencies. The initial standard rate is $3, applicable for July 1966 through December 1967. A higher rate than the standard one is to be paid by those enrolling late or reenrolling after terminating enrollment (10 percent additional for each full year of nonparticipation).

(*b*) Government contributions: Amount equal to total premiums of participants. An amount equal to 6 months' Government contributions

for all eligible to participate on July 1, 1966, is to be made available as a contingency reserve on a non-interest-bearing loan basis until December 31, 1967.

(*c*) Payment of premiums: By automatic deduction from old-age, survivors, and disability insurance, railroad retirement, or civil service retirement benefits when possible. Otherwise, for persons affected by earnings test and for persons not eligible for such benefits, by direct payment (not necessarily on a monthly basis), with a grace period determined by the Secretary of Health, Education, and Welfare of up to 90 days. Public assistance agencies may enroll, and pay premiums for, public assistance recipients who receive money payments and who are not beneficiaries under the old-age, survivors, and disability insurance program or the railroad retirement program.

(*d*) Supplementary medical insurance trust fund: Established on same basis as old-age and survivors insurance, disability insurance, and hospital insurance trust funds, with separate board of trustees (same membership) and with same investment procedures.

NATURE OF THE TRUST FUND

The Federal supplementary medical insurance trust fund was established on July 30, 1965, as a separate account in the U.S. Treasury to hold the amounts accumulated under the supplementary medical insurance program.

The major sources of receipts of the trust fund are (1) amounts deposited in or transferred to it with respect to the premiums paid by persons aged 65 or over who elect to participate in the program and (2) the matching contributions of the Federal Government that are authorized to be appropriated and transferred to it from the general fund of the Treasury.

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

The managing trustee invests that portion of the trust fund which, in his judgment, is not required to meet current expenditures for benefits and administration. The Social Security Act restricts permissible investments of the trust funds to interest-bearing obligations of the U.S. Government or to obligations guaranteed as to both principal and interest by the United States. Obligations of these types may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price. In addition, the Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall have maturities fixed with due regard for the needs of the trust fund and shall bear interest at a rate based on the average market yield (computed by the managing trustee on the basis of market quotations as of the end of the calendar month next preceding

the date of such issue) on all marketable interest-bearing obligations of the United States forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month. Where such average market yield is a multiple of one-eighth of 1 percent, this is taken as the rate of interest on such special obligations; otherwise, such rate is the multiple of one-eighth of 1 percent nearest such market yield.

Interest on public issues held by the trust fund is received by the fund at the time the interest is paid on the particular issues held. Interest on special public-debt obligations issued specifically for purchase by the trust fund is payable semiannually or at redemption.

Public issues acquired by the fund may be sold at any time by the managing trustee at their market price. Special public-debt obligations issued for purchase by the trust fund may be redeemed at par plus accrued interest. Interest receipts and proceeds from the sale or redemption of obligations held in the trust fund are available for investment in the same manner as other receipts of the fund. Interest earned by the invested assets of the trust fund will provide income to meet a portion of future benefit disbursements. The role of interest in meeting future benefit payments is indicated in tables 1 and 2.

In addition, the assets of the trust fund assure the continued payment of benefits without sharp changes in premium rates during periods of shortrun fluctuations in total income and expenditures.

EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND DURING THE PERIOD JULY 1, 1965 TO JUNE 30, 1968

In the following statement of the expected operations and status of the supplementary medical insurance trust fund during the period July 1, 1965, to June 30, 1968, it is assumed that present statutory provisions affecting the supplementary medical insurance program remain unchanged throughout the period. The disbursements of the program are affected by medical and economic factors as well as by legislative provisions. Because it is difficult to foresee economic and social developments, the assumptions and the resulting estimates presented here are subject to some uncertainty.

Also of importance is the previously indicated fact that the standard premium rate for participants, and thus the matching contribution from the general fund of the Treasury, is subject to revision for the 2-year period January 1968 through December 1969. Since the estimates presented here carry through June 1968, it has been necessary to make some assumption as to the premium rate for this period. This assumption has simply been that the initial standard premium rate of $3 per month would be continued. This procedure was followed so as to show the effect thereof on the financing of the program, although there is, of course, no certainty that the standard premium rate will not have to be increased in 1968.

The cost estimate presented here is based on the assumption that 80 percent of those eligible to participate in the supplementary medical insurance program will actually do so. Insofar as participation differs from this assumption, the experience will vary from the cost estimate. As to the proportion of eligible persons electing to participate, the ex-

perience through mid-February 1966 is not conclusive-and could not be expected to be conclusive, because the initial enrollment period for those who attained age 65 before 1966 does not close until March 31, 1966. This limited experience indicates that about 75 percent of the persons eligible to make an election as to whether or not to participate in the supplementary medical insurance program have already done so and that 90 percent of this group has elected to participate. If the remaining 25 percent of the eligible population who have not yet responded make elections in the same proportion as those who have responded, then the participation rate will, of course, be 90 percent. At the extreme, the absolute minimum participation rate would be that which would prevail if none of those 25 percent who had not responded elect to come under the program, in which case the participation rate would be almost 70 percent. It is certain, however, that in the remaining period there will be many elections to participate from among those who had not previously signified the1r intentions (and, also, some changes from those who had originally not desired the protection), so that the eventual percentage of participation will be well beyond 70 percent, and quite possibly above the 80 percent assumption on which the estimates contained in this section are based.

The following statement of the expected operations of the trust fund should, therefore, be read with full recognition of (a) the limited amount of data available for making cost estimates for this new program, (b) the difficulties of estimating future trust fund disbursements under changing economic conditions, (c) the assumption of the $3 standard premium rate being effective for the last 6 months of the period considered, and (d) the uncertainty as to the rate of participation in the program by those eligible to do so.

Estimates are presented in table 1 to show the expected operations of the trust fund in fiscal years 1967-68 (no figures being shown for fiscal year 1966, because the system does not go into operation as to benefit payments or income receipts until July 1, 1966). The estimates are based on the assumption that economic activity will expand throughout the period and that medical-care costs will increase steadily at the same rate as in the immediate past.

TABLE 1.—*Estimated future operations of the supplementary medical insurance trust fund, fiscal years 1967-68*

[In millions]

Item	1967	1968
Income:		
Premiums from participants	$550	$562
Contributions from general fund of Treasury	550	562
Interest on investments [1]	2	9
Disbursements:		
Benefit payments	765	995
Administrative expenses [2]	[3] 132	85
Net increase in fund	205	53
Fund at end of year	205	258

[1] Includes net profit on marketable investments.
[2] Receipts from sales of surplus materials, services, etc., are deducted from gross administrative expenses.
[3] Includes administrative expenses incurred in fiscal year 1966, which were paid from the old-age and survivors insurance trust fund and reimbursed thereto (with interest) in fiscal year 1967.

Note.—Program starts operation as to benefit payments and income receipts at beginning of fiscal year 1967. It is assumed that the $3 monthly premium rate applies throughout the entire period, although it is subject to change effective with January 1968 (i.e., for the second half of fiscal year 1968 and thereafter). Not included above is the advance appropriation from the general fund of the Treasury that is to provide a contingency reserve during the period July 1966 through December 1967 (to be used only if needed and to be repayable). In interpreting the estimates, reference should be made to the accompanying text which describes the underlying assumptions. Estimates were prepared in January 1966.

The small increase in estimated premium income from participants in fiscal year 1968, as compared with fiscal year 1967, reflects the increasing number of persons aged 65 and over who are eligible to participate in the program. Benefit disbursements increase sharply from fiscal year 1967 to 1968, because of the lag in the former year that results from the effects of the $50 deductible (which is applicable on a calendar year basis, and thus applies not only to the first half of fiscal year 1967, but also again in the second half of the fiscal year) and because of the assumed delay in payment of claims as between the date the services are performed and the date when payment is made from the trust fund. In regard to the latter point, it is assumed that payment from the trust fund with respect to a particular claim will be made at the time that it is approved by the carrier. Also contributing to the increase in benefit disbursements from fiscal year 1967 to 1968 are several other factors—a larger number of persons being covered and the assumed long-range upward trend in the cost of medical care.

Income of the trust fund is expected to exceed outgo in each of the 2 fiscal years 1967-68. During this period, there is an estimated net increase in the trust fund of $258 million, of which $205 million occurs in the first year. The foregoing figures are on a cash basis, rather than on an accrual basis. An essential difference between the financing of the supplementary medical insurance program and social insurance systems (such as the hospital insurance program) is its voluntary character. It is possible that large numbers of persons could terminate enrollment during an enrollment period. Consequently, the premium rate charged must cover the cost of all services received during the premium-payment period, before the termination of eligibility, even though the claims for the cost of such services furnished during the last few months before termination will generally not be paid until after the date of termination. Thus, the premium rate for a 2-year period must cover the costs of all

services and administrative expenses pertaining to that period—i.e., it must be determined on an accrual or incurred basis.

A further problem is presented by the grace period (of up to 90 days) that is available for persons who are not receiving monthly benefits under the old-age, survivors, and disability insurance system, the railroad retirement system, or the civil service retirement system. Such persons who terminate coverage due to failure to pay a premium will be covered for a certain period without paying any premiums with respect thereto. The premium rate for all persons allows for the cost of this free coverage.

If the actual experience follows the estimate presented in table 1, the standard premium rate for the period January 1968 through December 1969 will not have to be increased above the initial standard rate of $3 per month. On the other hand, if the actual experience is somewhat higher than that of the estimate presented in table 1, the standard premium rate will have to be increased.

The trust fund balances shown in table 1 do not include the contingency reserve that is to be established by an appropriation from the general fund of the Treasury and is to be available until December 31, 1967. The size of this reserve is to be $18 times the estimated number of persons eligible to participate in the program on July 1, 1966, if they had so elected. Any amounts used from this contingency reserve are to be repayable, without interest, to the general fund of the Treasury. Based on 19.0 million eligibles, the size of this contingency reserve will be $342 million; the authorization for this amount is provided for in the budget of the U.S. Government for the fiscal year 1967. Under the estimates presented in table 1, it will not be necessary to draw upon this contingency reserve.

ACTUARIAL STATUS OF THE TRUST FUND

The supplementary medical insurance program does not contain long-range financing provisions. Rather, the standard premium rate is to be varied at 2-year intervals, according to determinations made by the Secretary of Health, Education, and Welfare, so that the disbursements from the system will be met on a short-range basis by its income. This financing basis is quite proper from an actuarial standpoint for a voluntary insurance program which is financed in part by Government contributions, although it differs significantly from the long-range financing basis of social insurance systems, such as the hospital insurance program.

Several different estimates of the progress of the supplementary medical insurance trust fund for the calendar years 1966-67 is shown in table 2. Four sets of estimates are presented, under different assumptions as to low-cost and high-cost estimates and as to low and high participation. These estimates were those that were derived at the time that the 1965 amendments were enacted. The low-participation assumption is 80 percent, while the high-participation assumption is 95 percent.

It may be noted that the short-range estimates on a fiscal-year basis shown in the preceding section (which were prepared in January 1966 and, for fiscal year 1967, are taken from the budget of the U.S. Gov-

ernment for the fiscal year 1967) are completely consistent with an intermediate-cost estimate that would be derived from the 80-percent participation estimates in table 2 by a simple averaging of the low-cost and high-cost estimates.

TABLE 2.—*Estimated progress of supplementary medical insurance trust fund, calendar years 1966-67*

[In millions]

Calendar year	Premium from participants	Government contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
Low-cost estimate, 80-percent participation:						
1966 [1]	$275	$275	$220	$65	$5	$270
1967	560	560	895	75	15	435
Low-cost estimate, 95-percent participation:						
1966 [1]	325	325	260	80	5	315
1967	665	665	1,060	90	15	510
High-cost estimate, 80-percent participation:						
1966 [1]	275	275	345	85	5	125
1967	560	560	1,065	95	5	90
High-cost estimate, 95-percent participation:						
1966 [1]	325	325	410	100	5	145
1967	665	665	1,260	110	5	110

[1] Administrative expenses shown include those paid in fiscal 1965 and 1966.

Note.—Not included above is the advance appropriation from the general fund of the Treasury that is to provide a contingency reserve during 1966-67 (to be used only if needed and to be repayable).

A significant balance develops in the trust fund in 1966, due to (1) the necessity of the beneficiaries first accumulating the deductible, which must be met before any benefits are payable, (2) the lag in benefit payments that results from the delay in presenting claims, and (3) administrative processing. In this respect, it will be noted that the income from premium payments by individuals will go into the trust fund beginning in the early part of July 1966; the matching Government contributions are assumed to go into the trust fund simultaneously.

Under the low-cost estimates, the trust fund is estimated to have a balance of $270 to $315 million at the end of 1966, and between $435 to $510 million at the end of 1967. On the other hand, under the high-cost estimates, the balance in the trust fund at the end of 1966 is between $125 and $145 million and is about $35 million lower at the end of 1967; such balances, however, will have developed on a "cash disbursements" basis, rather than on an "accrual" basis, and will be smaller than the then existing liability for incurred but unpaid claims. Not included in the foregoing figures is the $342 million that is established as a potential contingency reserve, on the basis of an advance, repayable appropriation from the general funds of the Treasury.

If the actual experience follows the low-cost estimates presented in table 2, the standard premium rate for the period January 1968 through December 1969 will not have to be increased above the initial standard rate of $3 per month. On the other hand, if the actual experience follows the high-cost estimates, the standard premium rate will have to be increased.

CONCLUSION

The current actuarial cost estimates for the supplementary medical insurance program indicate that its premium rate is adequate to meet

the benefit payments and administrative expenses for at least the first 1½ years of operation, July 1966 through December 1967. The premium rate for subsequent years can be adjusted by the Secretary of Health, Education, and Welfare in accordance with the developing experience.

The actuarial cost estimates indicate that if the experience is relatively favorable, the initial monthly premium rate of $3 from covered individuals enrolling promptly can be retained for the calendar years 1968-69. Extremely favorable experience could even result in a reduction of this premium rate. On the other hand, if the experience is not quite so favorable, then the premium rate for 1968-69 will have to be higher than $3.

A contingency reserve (whose amount, in accordance with the provisions of the law, has been determined to be $342 million) is authorized to be appropriated from the general funds of the Treasury (to be available through 1967, with any amounts used to be repayable, without interest). This is to serve as a safeguard that the benefit payments will be made. The actuarial cost estimates indicate that there will be no need to make use of this contingency reserve. Rather, under all cost estimates, a sizable balance in the trust fund will be accumulated; however, under the high-cost estimates, this balance will have developed on a "cash disbursements" basis, rather than on an "accrual" basis, and will be smaller than the liability for incurred but unpaid claims. Accordingly, it may be said that the short-range actuarial status of the program is favorable under the initial premium rate established by the 1965 amendments.

APPENDIXES

APPENDIX I. ASSUMPTIONS, METHODOLOGY, AND DETAILS OF COST ESTIMATES

The basic assumptions in the cost estimates for the supplementary medical insurance system are described in this appendix. [1] Also given are more detailed data in connection with these estimates.

Benefit cost assumptions

Only a relatively small amount of data is available in regard to insurance experience with respect to the physicians' services and other medical services that would be covered by the supplementary medical insurance system. The cost estimates used in determining the premium rate to be charged to individuals, along with the matching Government contribution, have utilized data from the experience under the Federal Employees Health Benefits Act of 1959 for persons aged 65 and over, the experience under the Connecticut 65 program, and various information obtained from the National Health Survey conducted on a periodic basis by the Public Health Service of the Department of Health, Education, and Welfare.

The results from the foregoing data were modified appropriately to take into account the specific provisions of the supplementary medical insurance program, such as the crediting of the outpatient diagnostic deductible under the hospital insurance program as an incurred expense for this program, the special limitations on expenses involved in connection with the treatment of mental, psychoneurotic, and personality disorders for those not outpatients of a hospital, etc.

The monthly per capita benefit costs were estimated to be $4.72 for 1966 and $4.81 for 1967 in the low-cost estimate and to be $5.60 and $5.71, respectively, in the high-cost estimate. All of the foregoing figures are on an "incurred cost" basis, rather than on a "cash outgo" basis. Due to the lag in claims presentation and payment and the lag for the accumulation of the deductible that are inherent in a program of this type, some of the disbursements for services incurred during a given period will be made after the end of that period. Therefore, the incurred cost for an initial period is higher than the cash cost for that period.

The same per capita costs have been used for the two participation assumptions. It could be argued that with participation substantially lower than the 80-percent assumption, there would be antiselection against the program and that thus a higher per capita cost should be used. However, it seems more likely that those who do not participate will consist, to a considerable extent, of uninformed persons with low incomes who will not see the need or have the foresight to participate.

[1] For more details as to the procedures followed in making these cost estimates, see "Actuarial Cost Estimates and Summary of Provisions of the Old-Age, Survivors, and Disability Insurance System as Modified by the Social Security Amendments of 1965 and Actuarial Cost Estimates and Summary of Provisions of the Hospital Insurance and Supplementary Medical Insurance Systems as Established by Such Act," Committee on Ways and Means, House of Representatives, July 30, 1965.

The per capita cost for this category will not be significantly lower than the average, and, therefore, their nonparticipation could not be regarded as antiselection. The experience under private group health insurance indicates that 75-percent participation is adequate protection against antiselection.

It is recognized that there could be a very considerable element of antiselection in an individual voluntary program such as this, if the insured person were required to pay the full cost. However, since half of the premium is paid from general revenues, the amount paid by the individual is low enough to be very attractive to even the lowest cost groups.

Relative future trends of medical costs

The cost estimates assume that the medical costs covered by the program will increase at a rate of about 4 percent per year. The experience during the first calendar year of operation, 1966, will be rather atypical in several respects. Benefit coverage will be available only beginning with July 1, 1966. On the one hand, some medical services may well be deferred until after the program becomes effective, rather than being incurred in the first 6 months of the year. On the other hand, the $50 deductible applies only for the second half of the year-i.e., for covered expenses incurred on and after July 1, 1966-whereas in future years, it is applicable against a full calendar year's medical expenses.

Administrative expenses

It has been assumed that the administrative expenses in connection with the supplementary medical insurance program, including those of the carriers who are used for the administration of the benefits, will amount to about 8percent of the benefit payments on a continuing basis. In addition, of course, there are administrative expenses arising in the last half of 1965 and the first half of 1966 for establishing the program; these expenses are assumed to be equivalent to about 8½ percent of the benefit costs that would have been incurred for the first 6 months of 1966, if benefits had then been payable.

Interest rate

An interest rate of 4 percent is used in developing the progress of the trust fund during the first few years of operation for which computations are made. A higher or lower rate would not significantly affect the financing of the program, which is on a current cost basis, with a fund being accumulated only for contingencies.

Timing of benefit payments

The estimates of benefit payments under the low-cost estimates are based on the assumption that, because of the effect of the $50 deductible and the lag in the presentation of claims and the approval thereof by the carriers, the net effect is the same as though only 3 months of benefit costs are met during calendar year 1966. This means that the accrued liability at the end of the year is another 3 months of benefit costs. In the high-cost estimate, the same procedure is followed except that the estimated benefit disbursements in calendar year 1966 represent

4 months of benefit costs, with the accrued liability at the end of the year for incurred but unpaid claims amounting to 2 months of benefit costs.

Total per capita costs of benefit payments and administrative expenses

Under the low-cost estimate, the monthly per capita cost of the benefit payments and administrative expenses combined, on an accrual basis, is $5.12 for 1966 and $5.21 for 1967. Under the high-cost estimate, the corresponding figures are $6.10 for 1966 and $6.21 for 1967.

For both cost estimates, it is necessary to keep in mind that the costs for starting up the program which are incurred in the last half of 1965 and in the first half of 1966 have to be met from the financing available through the premiums from the participants and the contributions from the Federal Government. Under the assumptions made, if these startup administrative expenses are averaged into the 1966 per capita costs (which, in essence, are payable only over the second 6 months of the year), then these figures become $5.52 for the low-cost estimate and $6.60 for the high-cost estimate.

The fact that the total per capita costs for 1966 and 1967 under the high-cost estimate are above the $6 figure representing the sum of the premium rate from the participants and the Government contribution does not mean that, on a cash basis, this program would have insufficient funds to meet its current obligations. Rather, the results shown in tables 1 and 2 indicate otherwise. The reason for this is the lag between incurred claims and actual claims payments. (By the same token, although the program is shown as having substantial trust fund balances according to the high-cost estimates at the end of the periods considered in tables 1 and 2, these are really less than the then existing liabilities for incurred but unpaid claims.) Such a lack of actuarial balance in the premium and contribution structure would, of course, have to be made up by subsequent rate adjustments for the 2-year period beginning January 1968.

APPENDIX II. LEGISLATIVE HISTORY AFFECTING THE TRUST FUND

Board of Trustees.—Beginning with July 30, 1965, when the Federal supplementary medical 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 12 months.

Premium rates.—The Social Security Amendments of 1965, which established the supplementary medical insurance program, fixed the premium rate for individuals enrolling under the program at $3 per month for the 18-month period July 1966 to December 1967. Between July 1 and October 1, 1967 (and every 2 years thereafter), the Secretary of Health, Education, and Welfare may adjust this standard premium rate, which applies to persons who enrolled in their initial enrollment period, so that income to the program will be in balance with outgo for benefit payments and administrative expenses (but with inclusion of an appropriate contingency margin in the premium rate). This standard premium rate will apply to persons who enroll in their initial enrollment period. The premium rate for years after 1967 with respect to persons who enroll later than the first period when enrollment was open to them or who reenrolled after their enrollment had been terminated is the standard premium rate increased by 10 percent for each full year during which they could have been enrolled but were not enrolled.

Government contributions.—The 1965 amendments provide for payments from general funds of the Treasury to be made in amounts equal to the aggregate premiums paid by enrollees.

Contingency reserve.—An appropriation from general funds of the Treasury is authorized by the 1965 amendments to provide an operating fund at the beginning of the program; i.e., a contingency reserve. The amount of the authorization is the product of $18 and the estimated number of individuals who would be covered by the program on July 1, 1966, if all persons eligible to so elect had done so. This authorization remains effective until the end of 1967. Any amounts actually used by the supplementary medical insurance trust fund are repayable (without interest) to the Treasury.

Investment of assets.—The 1965 amendments provided that the assets of the trust fund should be invested in the same manner as the investments of the Federal old-age and survivors insurance trust fund and the Federal disability insurance trust fund (as was also done for the hospital insurance trust fund, established at the same time). Similarly, the interest rate provisions with respect to special issue investments are the same for all four trust funds.

APPENDIX III. STATUTORY PROVISIONS, AS OF JULY 30, 1965, CREATING THE TRUST FUND, DEFINING THE DUTIES OF THE BOARD OF TRUSTEES, AND PROVIDING FOR ADVISORY COUNCILS OF SOCIAL SECURITY

(Sec. 706, sec. 1840, sec. 1841, and sec. 1844 of the Social Security Act as amended)

FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1841. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical 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.

(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 the 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 March 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 of 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) 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.

(g) The Managing Trustee shall 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) (h) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the costs incurred by the Civil Service Commission in making deductions pursuant to section 1840(e). During each fiscal year, or after the close of such fiscal year, the Civil Service Commission shall certify to the Secretary the amount of the costs it incurred in making such deductions, and such

certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

PAYMENT OF PREMIUMS

SEC. 1840. (a) (1) In the case of an individual who is entitled to monthly benefits under section 202, his monthly premiums under this part shall (except as provided in subsection (d)) be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.

(2) The Secretary of the Treasury shall, from time to time transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the 'Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Secretary of Health, Education, and Welfare and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(b) (1) In the case of an individual who is entitled to receive for a month an annuity or pension under the Railroad Retirement Act of 1937, his monthly premiums under this part shall (except as provided in subsection (d)) be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(c) In that case of an individual who is entitled both to monthly benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under this part, subsection (a) shall apply so long as he continues to be entitled both to such benefits and such annuity or pension. In the case of an individual who becomes entitled both to such benefits and such an annuity or pension after he enrolls under this part, subsection (a.) shall apply if the first month for which he was entitled to such benefits was the same as or earlier than the first month for which he was entitled to such annuity or pension, and otherwise subsection (b) shall apply.

(d) If an individual to whom subsection (a.) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

(e)(l) In the case of an individual receiving an annuity under the Civil Service Retirement Act, or other Act administered by the Civil Service Commission providing retirement or survivorship protection, to whom neither subsection (a.) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Civil Service Commission may determine. The Civil Service Commission shall furnish such information as the Secretary of Health, Education, and Welfare may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies.

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other Act administered by the Civil Service Commission, to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Civil Service Commission and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(f) In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect to whom subsection (d) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

(g) Amounts paid to the Secretary under subsection (d) or (f) shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

(h) In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such program terminates.

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund, a Government contribution equal to the aggregate premiums payable under this part.

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain

available through the calendar year 1967 for repayable advances (without interest), to the Trust Fund an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

ADVISORY COUNCIL ON SOCIAL SECURITY FINANCING

SEC. 706. (a) During 1968 and every fifth year thereafter, 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 the Commissioner of Social Security, as Chairman, and 12 other persons, appointed by the Secretary without regard to the civil service laws. 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 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government employed intermittently.

(d) Each such Council shall submit reports 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), 310l(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.