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THE 1968 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

L E T T E R

FROM

BOARD OF TRUSTEES FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

TRANSMITTING

THE 1968 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE FEDERAL
SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND
Washington, D.C., March 25, 1968.

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

SIR: We have the honor to transmit to you the 1968 annual report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the 3d such report), in compliance with the provisions of Section 201(c) of the Social Security Act, as amended.

Respectfully,

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

W. WILLARD WIRTZ,
Secretary of Labor.

WILBUR J. COHEN,
Acting Secretary of Health,
Education, and Welfare.

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

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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 fiscal year 1967 was the first full year of operation of the supplementary medical insurance program insofar as both premiums and benefit payments are concerned (since benefits were first available on July 1, 1966, premium collections started then).

Premiums collected in fiscal year 1967 amounted to $647 million, while the matching contributions from the general fund of the Treasury amounted to $623 million. The deficiency of $24 million in Government matching funds will be made up in fiscal year 1968.

Total receipts of the trust fund amounted to $1,284 million in fiscal year 1967. In addition to contributions, receipts consisted of $14 million in interest on investments.

Total disbursements from the trust fund in fiscal year 1967 amounted to $798 million. Of this amount, $664 million was paid out for benefits (this amount is based on Treasury statements; an additional $5 million has been identified by carriers as benefit withdrawals in fiscal year 1967 that did not clear through the Treasury before July 1, 1967). The remaining $134 million was for administrative expenses, which were relatively high as compared with benefit disbursements because the former were relatively high due to the initial expenses in establishing the program and because the latter were relatively low due to the inherent lags in making the benefit payments. The actual outgo for benefits in this first year of operation was 13 percent lower than the original estimate, which was contained in the 1966 trustees report; this difference resulted primarily from the lag in the actual benefit disbursements being significantly greater than had been originally estimated.

The excess of total Income over total outgo, amounting to $486 million, represented the total assets of the trust fund on June 30, 1967.

After the close of fiscal year 1967, Congress made extensive amendments to the Social Security Act directly affecting the supplementary medical insurance program. These amendments made significant changes in the benefit provisions, insofar as costs are concerned. These provisions are described more fully in another section of this report, and their effects are taken into account in the actuarial cost estimates presented in this report.

The promulgation of the premium rate for the period April 1968 through June 1969; namely, a standard premium rate of $4 per month—also took into account the changes made by the 1967 amendments. Appendix I gives a statement of the actuarial assumptions and bases employed in arriving at the new premium rate.

LEGISLATION IN 1967

Public Law No. 90-97, approved September 30, 1967, extended the general enrollment period for the supplementary medical insurance program that had been scheduled for October through December 1967, so that it would run through March 1968. The initial $3 monthly premium rate was continued through March 1968, instead of through December 1967, and the promulgation by the Secretary of Health, Education, and Welfare of the new standard premium rate (for persons enrolling in the earliest possible enrollment period) was delayed so that it could occur any time before January 1, 1968—to be applicable for the period April 1968 through December 1969 (which period was changed by subsequent legislation).

The Social Security Amendments of 1967 (Public Law 90-248, approved January 2, 1968) affect significantly the future levels of income and disbursements under the supplementary medical insurance program. Benefit protection was expanded. Eligibility requirements for the payment of benefits were liberalized. Some modifications in the coverage provisions were made.

The more important changes, significant from an actuarial standpoint, are presented below:

1. Effective April 1, 1968, the outpatient diagnostic services which were previously covered under hospital insurance will be covered for benefit purposes under the supplementary medical insurance program.
2. Effective April 1, 1968, the deductible and coinsurance provisions formerly applicable to the professional component of pathology and radiology services furnished to inpatients in hospitals are no longer applicable.
3. Effective July 1, 1968, broader coverage of outpatient physical therapy services is provided, primarily in instances where the individual is not homebound.
4. Effective April 1, 1968, the supplementary medical insurance program covers the costs of ancillary services furnished in hospitals that are not covered under the hospital insurance program (e.g. because the individual had exhausted his hospital benefits under that program or was not covered thereunder).
5. Claims now have to be filed no later than the end of the calendar year following the year when the services were rendered except that the limit for services furnished in October through December of any year is the end of the second calendar year following such year.
6. The standard premium rate is to be determined on an annual basis for periods beginning with each July (instead of a biennial

calendar-year basis), except that the premium rate promulgated for the period beginning April 1968 is to be applicable through June 1969.

7. The general enrollment periods will be January through March of each year (instead of October through December of odd-numbered years). Enrollees will be permitted to disenroll at any time (effective at the end of the following quarter), instead of only during general enrollment periods.

8. Whenever the transfer of matching funds from the general fund of the Treasury is not made simultaneously with the enrollee contributions, an appropriate interest adjustment is to be made (applicable only to transactions after June 30, 1967).

9. The availability of the contingency reserve based on appropriations from the general fund of the Treasury, with any amounts used being repayable, was extended for 2 years (i.e. until December 31, 1969).

The effect of the foregoing benefit changes is to increase the cost of the program by about 6 percent relatively.

Appendix II gives a summary of the provisions of the supplementary medical insurance program as it is constituted following the enactment of the 1967 amendments.

SUMMARY OF THE OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1968

A statement of the income and disbursements of the Federal supplementary medical insurance trust fund during fiscal year 1967 and of the assets of the fund at the beginning and end of the fiscal year is presented in table 1.

TABLE 1.—STATEMENT OF OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1967

Receipts, fiscal year 1967:		
Premiums from participants:		
Deducted from monthly benefits [1]	$527,901,607.14	
Deposited by States	32,135,900.00	
Collected by Social Security Administration [2]	86,644,135.41	
Total premiums		$646,681,642.55
Contributions from general fund of the Treasury:		623,000,000.00
Interest:		
On Investments	$15,041,275.05	
Less interest on amounts of transferred to the old-age and survivors insurance trust fund for administrative expenses	989,000.00	
Net interest		14,052,275.05
Total receipts		1,283,733,917.60
Disbursements, fiscal year 1968:		
Benefit payments		664,260,684.06
Administrative expenses:		
Department of Health, Education and Welfare [3]	$107,969,999.30	
Treasury Department	9,745.00	
Civil Service Commission	41,830.00	
Reimbursement to old-age and survivors insurance trust fund—		
For expenses in fiscal year 1966 [4]	24,136,504.00	
For expenses in fiscal year 1967 [5]	1,405,000.00	
For construction of facilities for Social Security Administration	129,889.00	
Gross administrative expenses	133,692,967.30	
Less receipts from sale of surplus supplies, materials, etc.	10,879.22	
Net administrative expenses		133,682,088.08
Total disbursements		797,942,772.14
Net addition to the trust fund		485,791,145.46
Total assets of the trust fund, June 30, 1967		485,791,145.46

[1] Transferred from the old-age and survivors insurance and disability insurance trust funds, the railroad retirement account, and the civil service retirement and disability fund.
[2] With respect to uninsured persons and insured persons not receiving monthly benefits.
[3] Includes administrative expenses of the carriers.
[4] $24,095,779 for expenses of the Department of Health, Education, and Welfare and $40,725 for expenses of the Civil Service Commission.
[5] For expenses of the Public Health Service.

The total assets of the trust fund amounted to $486 million on June 30, 1967. Since the operations of the trust fund began on July 1, 1966, it had no assets at the beginning of the fiscal year 1967.

Net receipts of the fund amounted to $1,284 million. Of this total, $647 million represented premium payments by the enrollees, and $623 million represented the matching contributions from the general fund of the Treasury (the deficiency of $24 million will be made up, along with appropriate interest after June 30, 1967, in fiscal year 1968). The remaining $14 million of receipts consisted of net interest on the investments of the fund.

Disbursements from the fund during the fiscal year 1967 totaled $798 million. Of this total, $664 million was for benefit payments.

The remaining disbursements amounted to $134 million for net administrative expenses.

The assets of this fund at the end of fiscal year 1967 totaled $486 million, consisting of $479 million in the form of obligations of the U.S. Government and $7 million in undisbursed balances. Table 2a shows the distribution of the total assets of the fund at the end of fiscal year 1967

TABLE 2-a.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, BY TYPE, AT THE END OF FISCAL YEAR 1967

	Par value	Book Value[1]
Investments in public-debt obligations sold only to this fund (special Issues):		
Certificates of indebtedness: 4¾ percent, 1968	31,923,000	31,923,000.00
Notes:		
4¾ percent, 1969	31,923,000	31,923,000.00
4¾ percent, 1970	31,923,000	31,923,000.00
4¾ percent, 1971	31,923,000	31,923,000.00
4¾ percent, 1972	31,923,000	31,923,000.00
4¾ percent, 1973	31,923,000	31,923,000.00
4¾ percent, 1974	287,311,000	287,311,000.00
Total investments in public-debt obligations	478,849,000	478,849,000.00
Undisbursed balance		6,942,145.46
Total assets		485,791,145.46

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

The 1965 amendments provided that the public-debt obligations issued for purchase by the supplementary medical insurance trust fund shall have maturities fixed with due regard for the needs of the trust fund. In implementing the similar provision for the old-age and survivors insurance and disability insurance trust funds, the maturity dates for the holdings of special issues are spread as nearly as practicable in equal amounts over a 15-year period.

On June 30, 1967, special issues held by the supplementary medical insurance trust fund were distributed in equal amounts of $31,923,000 maturing in each of the 7 years, 1968-74. In addition, $255,388,000 (representing 8 years' annual amounts at the foregoing $31,923,000 rate) was invested in 7-year notes bearing 4¾-percent interest and maturing on June 30, 1974.

The 7-year notes amounting to $255,388,000 were acquired on June 30, 1967, under the following circumstances: If, on June 30, 1967, the trust fund holdings of special issues had been spread equally over a 15-year period, it would have been necessary for the Treasury to issue, for purch88e by the trust fund, approximately $31,923,000 of bonds maturing in each of the 8 years, 1975-82. Such bonds-with more than 7 years of maturity-would have been required, under present law (31 U.S.C. 753(a)), to bear an interest rate no higher than 4¼ percent. On the other hand, the application of section 1841(c) of the Social Security Act resulted in a rate of 4¾ percent. Accordingly, the sum of $255,388,000 that would have been invested in bonds maturing during the period 1975-82 was, instead, invested in notes that had the longest possible duration to maturity—that is, in 4¾-percent notes maturing June 30, 1974 (which were m addition to the $31,923,000 of notes that had the same maturity date, which were issued as part of the normal 15-year spread, as mentioned previously).

New securities at a total par value of $1,739 million were acquired during the fiscal year through the investment of receipts of the fund and the reinvestment of funds made available from the maturity of securities. The par value of securities redeemed during the year was $1,260 million. A summary of transactions for the fiscal year, by type of security, is presented in table 2b.

TABLE 2-b.— STATEMENT OF TRANSACTIONS IN PUBLIC-DEBT SECURITIES FOR THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1967

[All amounts represent par values]

	Acquisitions	Dispositions
Obligations sold only to this fund (special Issues)		
Certificates of indebtedness:		
4⅜ percent, 1967	$58,919,000	$58,919,000
4½ percent, 1967	110,218,000	110,218,000
4⅝ percent, 1967	424,476,000	424,476,000
4¾ percent, 1967	354,380,000	354,380,000
4¾ percent, 1967	31,923,000	0
5 percent, 1967	145,966,000	145,966,000
5⅛ percent, 1967	104,665,000	104,665,000
5⅜ percent, 1967	61,210,000	61,210,000
Notes:		
4¾ percent, 1969	31,923,000	0
4¾ percent, 1970	31,923,000	0
4¾ percent, 1971	31,923,000	0
4¾ percent, 1972	31,923,000	0
4¾ percent, 1973	31,923,000	0
4¾ percent, 1974	287,311,000	0
Total transactions	1,738,683,000	1,259,834,000

Table 3 compares the actual experience in the fiscal year with the estimates presented in the previous two reports. The actual premium collections have been somewhat higher than the estimates, due to greater participation than had been estimated (the estimates in the 1966 report, based on the data contained in the Budget Document of the United States for the fiscal year 1967, assumed only 80-percent participation—although the original actuarial cost estimates assumed a range of 80 to 95 percent, averaging 87½ percent—whereas the actual participation has been about 92 percent). The actual benefit payments were significantly lower than estimated; this was caused by the fact that the timelag involved in the payment of benefits was much longer than had been estimated. On an incurred basis, rather than on a cash basis, it is estimated that benefit payments in the period July 1966 through December 1967 were about 7 percent higher than the allowance therefor in the premium-rate determination. Since the actual benefit payments were so much lower than in the estimates, the actual balance in the trust fund at the end of the year considerably exceeded the estimated amount.

TABLE 3.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1967

[Amounts in millions]

		1966 report		1967 report	
	Actual amount	Estimated amount	Estimate as percentage of Actual	Estimated amount	Estimate as percentage of Actual
Premiums from enrollees	$647	$550	85	$623	96
Government contributions	623	550	88	623	100
Benefit payments	664	765	115	861	130
Assets, end of year	486	205	42	260	53

Note: In interpreting the figures in the above table, reference should be made to the accompanying text.

ACTUARIAL STATUS OF THE TRUST FUND

In discussing the actuarial status of the supplementary medical insurance program, it is first necessary to consider the experience on an accrual basis and the limitations on the accuracy of the estimates before presenting and discussing the results of these estimates.

(1) Actuarial status of program dependent on accrued experience

The actuarial status of the program, and of the trust fund, can appropriately be measured only on an accrual basis; that is, the solvency of the trust fund depends on the services performed, on the basis of which benefits must be paid. Cash disbursements for benefits and administrative expenses by themselves are misleading, due to the relatively large liabilities outstanding at any time for benefits and processing costs that must be paid for services already performed. These liabilities result from the timelag between the time that services are performed and the time that benefits for them are paid. This lag is due to the $50 deductible which must be accumulated before any benefits are payable, the tendency of enrollees to accumulate bills and submit them together (especially at the end of the year), and the time required by carriers to process and adjudicate the bills received.

This liability outstanding at any time for benefits for services performed for which no payment has been made may be referred to as "benefits incurred but unpaid." Estimates of the amount of such benefits incurred but unpaid as of the end of each calendar year according to the "expected" estimates, and of the administrative expenses related to processing these benefits, appear in table 4. Also included in table 4 are estimates of the excess of premiums collected in advance over premiums due and uncollected, and of Government matching contributions due but not yet transferred to the trust fund.

The actuarial status of the program and the financial status of the trust fund at any time can be found by adjusting the balance in the trust fund account by the net of these asset and liability items on that date (as in item C of table 4). The actuarial experience of the program during any period can be obtained by adjusting the cash flow of premiums, matching Government contributions, benefit payments, and administrative expenses to an accrual basis by adding the net increase in each asset or liability item during the period to the corresponding item on a "cash" basis for that period.

TABLE 4.—SUMMARY OF PROJECTED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, ACCORDING TO "EXPECTED" ESTIMATE, AT THE END OF CALENDAR YEARS 1966-68

[In millions of dollars]

	As of Dec. 31—		
	1966	1967	1968
A. Assets:			
Premiums due and uncollected, less premiums collected in advance	−$7	−$11	−$11
Government matching contributions due and unpaid, less such contributions with respect to premiums paid in advance	315	18	−7
Actual balance in trust fund	122	412	337
Total assets	430	419	319
B. Liabilities outstanding:			
Benefits incurred but unpaid	363	439	339
Administrative cost for processing that are related to benefits incurred but unpaid	32	43	31
Total liabilities	395	482	370
C. Net actuarial surplus	35	−63	−51

The dependence of the actuarial status of the program on the accrued experience is recognized in section 1839(b)(2), in which it is stated that the premium rate "shall be such amount as the Secretary estimates to be necessary so that the aggregate premiums for such 12-month period will equal one-half of the total for the benefits and administrative costs which he estimates will be *payable* from the Federal supplementary medical insurance trust fund *for* such 12-month period." [Italic supplied.] Similarly, an assessment of the actuarial status of the program and of the financial status of the trust fund for any period must be made on the basis of estimates of the benefits and administrative expenses "payable * * * for" (i.e., accrued in such period).

(2) Necessary limitations on accuracy of estimates of past and future experience

There are many difficulties in projecting the cost of a service benefit program that are not encountered in projecting the cost of cash benefit programs, due to the many economic and social factors involved. This is especially so as. to the rate at which physicians may increase their fees and as to the increase in utilization of services that will gradually result from placing physician services within the financial means of over 92 percent of those aged 65 or older. Further difficulties result from the absence of firm estimates of the present and immediate past experience of the program, on which projections of future experience can be based (as discussed in appendix IV); and any errors in the former are necessarily incorporated into the latter. The "expected" estimates of the 1966 experience could vary as much as 10 percent from the actual experience, and estimates for later years could vary further from the actual experience.

Final conclusions as to the accrued experience of the program for 1966-67 will not be possible until the deadline for filing claims based on services performed during 1966-67 has passed, all claims have been adjudicated and decided by carriers, payment records covering all benefit payments have been prepared by carriers and forwarded to Social Security Administration, and the payment records pertaining to benefits paid through the deadline for filing claims based on services received during 1967 have been reconciled with the benefits actually paid from the trust fund for this period.

(3) "Expected" estimates

The financing of this program is essentially different from that for the cash benefit programs in that the premium is only set for a 1-year period (except for the period from April 1968 through June 1969); consequently, estimates are needed on y for 1½ years into the future. Thus, there is not the same need for estimates of the highest cost and lowest cost experience that might be reasonably expected over many years into the future, so that the financing of the system can be set at the middle of the range between what would be necessary to finance the highest cost experience thought reasonably possible and the lowest cost experience thought reasonably possible. Further, the premium rate is required by law to be based on the best estimate possible of the benefits and administrative expenses that can be expected to accrue for services performed during the period to which such rate is to be applicable. Such an estimate can be referred to as an "expected" estimate.

The "expected" estimates of the cost per capita of benefits and administrative expenses that was accrued during calendar years 1966-67, and that anticipated for calendar years 1968-70, appear in table A in appendix IV. Since the $50 deductible applies to each calendar year, these costs can be developed only for calendar year periods; however, the premium rate is to be determined for fiscal year periods (except for the initial period July 1966 through March 1968 and the period from April 1968 through June 1969). The prorated average monthly rate of these costs for the periods to which a particular premium rate is applicable are as follows:

Period	Applicable premium rate	Benefit payments	Administrative costs	Total disbursements
July 1966–March 1968	$3	$5.00	$0.72	$6.42
April 1968–June 1969	4	7.22	.66	7.88

The premium rate for the period from July 1966 through March 1968 was about 7 percent lower than the combined benefits and administrative expenses accrued during this period. The slightly unfavorable experience during this period resulted primarily from an increase of approximately 15 percent in the average fees charged by physicians between July 1965 (when the premium rate was determined) and July 1967 (the approximate mid-point of the period in which the benefits were paid), as compared with the 6-percent increase assumed for this period. Further, the administrative expenses were higher than originally estimated (on a continuing basis)—the actual ratio of administrative expenses to benefit payments on an accrual basis was 10 percent in 1967, as against the estimate of 8½ percent.

(4) Expected estimates of the accrued experience

The expected estimates for the accrued experience of the supplemental medical insurance program for calendar years 1966-68 appear in table 5. Premiums and Government matching contributions were assumed to be paid for the estimated actual enrollment during 1966-67; in later years, 92 percent participation was assumed. As of July 1967, it is estimated that approximately 92 percent of persons aged 65 or over in the United States were enrolled.

The standard premium rate for periods after June 1969 will be determined for each fiscal year before the beginning of the calendar year in which such fiscal year begins.

TABLE 5.—ESTIMATED INCOME AND DISBURSEMENTS PAYABLE (ACCRUAL BASIS) UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, CALENDAR YEARS 1966-68

[In millions]

Calendar Year	Premiums from participants	Government contributions	Benefit payments [1]	Administrative expenses [1]	Interest on fund	Net operations in year	Accumulated surplus at end of year
1966	$315	$315	$491	[1] $107	$3	$35	$35
1967	636	636	1,272	121	23	−98	−63
1968	832	832	1,525	147	20	+12	−51

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

Note.—Experience on accrued basis for period from Apr. 1, 1968 through June 30, 1969, is estimated to be as follows (in millions of dollars):

Premiums	Government contribution	Benefits	Administrative expenses	Interest	Net in period	Accumulated surplus at end of period
1,117	1,117	2,002	199	30	63	−60

Benefit payments have been projected from the expected estimates of per capita costs that are shown in table A of appendix IV assuming the same average enrollment as for premium income. Administrative expenses as projected on a cash basis, and adjusted to an accrual basis by assuming that processing costs relating to benefits incurred but unpaid at the end of any calendar year are 9 percent of such benefit payments.

The trust fund balances shown in the various tables presented in this report do not include the contingency reserve that is authorized to be available until December 31, 1969. The size of this reserve is to be $18 times the estimated number of persons who were eligible to participate in the program on July 1, 1966, if they had so elected. Any amount appropriated and drawn would be repayable without interest from future income of the program.

As can be seen by examination of table 4, the program netted an estimated surplus of $35 million on an accrual basis during calendar year 1966, an abnormal period due to the application of the full $50 deductible in a 6-month period and due to considerable nonrecurring startup expenses. Due to the inadequacy of the $3 premium rate (by about 7 percent), benefit payments and administrative expenses incurred exceeded accrued income during calendar year 1967 by an estimated $98 million, leaving an estimated deficit of $63 million on an accrual basis for the initial 1½-year period. The estimated accrued deficit increased during the first quarter of 1968 by $60 million to reach approximately $123 million by March 31, 1968.

The increased premium rate for April 1968 through June 1969 results in an estimated net accrued surplus for the last 9 months of 1968 amounting to $72 million, which reduces the estimated net accrued deficit to $51 million as of December 31, 1968.

Interest earnings of $30 million are estimated to be earned during this 18-month period at an interest rate of 5 percent per year on the average balance in the trust fund. As explained previously, the large positive balance in the trust fund is a result of the natural delay between the date that services are performed and benefits accrued and the date on which benefit payments made on the basis of the services are paid. The balance in the fund during 1966-67, and in the beginning of 1968, was unusually large due to the newness of the program and the lack of familiarity of many enrollees with reimbursement insurance. The interest earned on these unusually large balances will contribute about half of the decrease expected in the net accrued deficit during the period from April 1968 through March 1969. Thus, income derived from those enrolled during 1966-67 will contribute substantially toward reducing the deficit incurred in that period.

(5) Expected estimates of the experience on a. cash basis

The income and disbursements of the trust fund on a cash basis for calendar years 1966-67 and projected for calendar years 1968-69 according to the expected estimates appear in table 6. Cash income exceeded cash disbursements during 1966-67 by a large margin, resulting in a large cash balance in the trust fund at the end of 1967 of $412 million, although the program actually had an estimated net deficit of $63 million on that date, due to the large liabilities outstanding on account of incurred but unpaid claims. Cash disbursements are expected to exceed cash income during calendar year 1968 due to the inadequacy of the $3 premium rate during the first quarter of the year and due to an assumed reduction of $112 million in the liabilities for incurred but unpaid benefits and for the cost of processing such benefits.

TABLE 6.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND CALENDAR YEARS 1968-69 AND ACTUAL DATA 1966-67

[In millions]

Calendar year	Premiums from participants	Government contributions[1]	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
Actual experience:						
1966	$322		$128	[1] $75	$3	$122
1967	640	$933	1,196	110	23	412
Expected estimate:						
1968	832	857	1,625	159	20	337
1969 [2]	903	903	1,707	173	17	280
High-cost estimate:						
1968	832	857	1,780	163	14	172
1969 [2]	903	903	2,081	187	[3] 2	([3])

[1] Administrative expenses shown include those paid in fiscal 1966 and 1967.
[2] Experience that would result if the premium rate remained at $4.00 after June 1969.
[3] Would require use of contingency fund that is authorized to be available from the general fund of the Treasury (maximum of $342,000,000).

(6) High-cost estimates

Although the premium is set, and the actuarial status of the program and the trust fund is determined, by the "expected" estimate of the future experience of the program, there is the question of the adequacy of cash resources should the developing experience follow the highest cost assumptions that appear reasonable in the immediate future. Accordingly, it seems desirable to test out this matter using such high-cost assumptions, as contrasted with those that are expected. Such estimates were prepared using the high portion of the range thought reasonably likely for each assumption that is required m estimating the current and future experience. These estimates are appropriate only for measuring the adequacy of the cash balance in the trust fund if the experience turns out to be as high as can reasonably be anticipated.

Comparisons of the cash resources of the trust fund with the disbursements that would result if the experience that developed produced as high a cost as might reasonably be expected appear in tables 6 and 7. As can be seen from table 7, under these conditions, there would be a slight cash deficit in the trust fund by the end of fiscal 1968, a circumstance that would require a transfer from the authorized contingency reserve. Under these adverse conditions (which are not anticipated based on current information available), the premium rate would presumably be increased, effective July 1969, which would solve the cash problem of the program. An additional margin would, however, have to be incorporated into future premium rates—both to insure adequate cash to pay benefits and to rebuild the balance in the trust fund to a reasonable level.

The very small cash deficit that would result if the experience followed the highest cost assumptions that appear reasonable provides assurance that there will be enough funds to pay benefits-in effect, by borrowing from the reserves for incurred but unpaid claims.

(7) Summary of actuarial status of program

The actuarial status of the program and the financial status of the trust fund depend on the determination and measurement of the accrued income and benefit payments and administrative expenses accrued under the program. Due to the small inadequacy of the initial $3 rate, there was an estimated net deficit in the operations of the program from July 1966 through March 1967 of about 7 percent and hence in the estimated accrued balance at the end of this period. However, due to the normal delay between the time that services were furnished and the time at which benefits were claimed on the basis of these services, there was an adequate cash balance in the trust fund, and the cash balance will continue to be adequate through fiscal year 1969, considering the availability of the contingency fund, even if the experience follows high-cost assumptions.

The premium rate of $4 that is set for the period April 1968 through June 1969 will, according to the expected estimate, result in an estimated net surplus to the program that will reduce the estimated net deficit to about $60 million, about half of the estimated net deficit at the beginning of this period.

EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND DURING THE PERIOD JULY 1, 1967 TO JUNE 30, 1970

The estimated progress of the supplementary medical insurance trust fund on a cash basis during fiscal years 1968-70 according to the expected estimates appears in table 7. Cash income during fiscal year 1967 exceeded cash disbursements by $486 million, leaving a balance in the trust fund of this amount as of June 30, 1967. This amount exceeded by a small margin the benefit payments and processing costs related thereto based on services furnished prior to June 30, 1967, that would subsequently be claimed, adjudicated, and paid. Such liabilities outstanding as of June 30, 1967, for benefit payments and administrative expenses incurred but unpaid were unusually large due to the newness of the program and the lack of familiarity of many enrollees with reimbursement insurance.

According to the expected estimate of the benefits that will be paid during fiscal year 1968, benefit payments will exceed benefits accrued, thus reducing the liability outstanding- at the end of the period for benefits incurred but unreported. This is equivalent to the assumption that the average delay from the time that services are performed and the time at which benefits based on these services are paid will decrease, as the enrollees become familiar with the program and claim benefits more promptly, as the administrative system becomes routine, and as a result of provision in the 1967 amendments for payment on the basis of an itemized bill when there is no assignment, rather than requiring a receipted bill. Consequently, cash disbursements during fiscal year 1968 are estimated to exceed cash income by a relatively large amount as compared to the estimated net deficit on an accrued basis, due to this reduction anticipated in liabilities outstanding. As a result, the balance in the trust fund is estimated to be reduced to $348 million at the end of fiscal year 1968.

TABLE 7.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND FISCAL YEARS 1968-70 AND ACTUAL DATA FOR 1967

[In millions]

Fiscal year	Premiums from participants	Government contributions	Benefit payments	Administrative expenses	Interest on fund[1]	Balance in fund at end of year
Actual experience:						
1967	$647	$623	$664	[1] $134	$14	$486
Expected estimate:						
1968	714	739	1,473	139	21	348
1969	895	895	1,656	167	19	334
1970 [2]	909	909	1,766	179	14	221
High-cost estimate:						
1968	714	739	1,502	139	20	318
1969	895	895	1,947	176	8	−7

[1] Administrative expenses shown include those paid in fiscal 1966 and 1967.

[2] Experience that would result if the premium rate remained at $4.00 per after June 1969.

For fiscal years 1969 and 1970, the liability outstanding for benefits incurred but unreported are assumed to remain a constant amount. This assumption implies that the delay between the accrued date and the payment date of benefits will be reduced slightly (the benefit payments accrued that are assumed to be incurred but unpaid are hen a lower percentage of the total benefit payments, which gradually increase). As a result, cash benefit payments in fiscal years 1969-70 are assumed to be equal to those accrued.

According to the "expected" estimates—that is, the best estimates that can be made based on information currently available of the experience most likely to occur—there will be an estimated net gain (that is, an excess of accrued income over benefit payments and administrative expenses accrued) during fiscal year 1968. This results from the fact that the $4 premium rate for this period is estimated to be adequate to finance the program on an accrual basis. Due to the assumed reduction during this period in the liabilities outstanding for benefits and administrative expenses incurred but unpaid, however, cash disbursements are expected to exceed cash income in this period, with the result that the balance in the trust fund is estimated to decrease slightly, to $334 million at the end of fiscal year 1969.

If the experience that develops should follow the highest cost assumptions that appear reasonable—that is, substantially more adverse than expected—the balance in the trust fund would decline to $318 million at the end of fiscal year 1968 and would be exhausted at the end of fiscal year 1969, a situation that would require the appropriation and use of some of the contingency fund that is authorized for use through the end of calendar year 1969. The fact that there would be adequate assets in the trust fund to pay benefits throughout the period for which the $4 premium rate has been set (and considering the availability of the $342 million contingency reserve) shows that this premium rate will provide adequate revenue to meet benefit obligations until the premium rate can be increased, even under very unfavorable experience—substantially more adverse than expected.

CONCLUSION

According to the best estimates that can be made based on information currently available as to the actual experience that will develop in the immediate future, the premium rate promulgated for the period April 1968 through June 1969 is slightly more than sufficient to finance the cost of benefit payments and administrative expenses that will accrue in this period. Further, the estimated net deficit of the program, as measured on an accrual basis, that resulted from the slight inadequacy of the initial premium rate (applicable for July 1966 through March 1968), amounted to $123 million on March 31, 1968, but will be reduced to $60 million on June 30, 1969.

Due to the absence of conclusive data as to the accrued cost of the program during 1966-67 upon which to base projections of future experience, a variation of more than 10 percent from the best, or “expected,” estimate of future experience is quite possible. But there will be an adequate cash flow under the program from which to pay benefits and administrative expenses throughout this period, even if experience should produce the highest cost that appears reasonably possible based on information currently available. The availability of sufficient funds to pay benefits is further guaranteed by the availability of the authorized contingency reserve of $342 million until the end of 1969. Thus, the financing of the supplementary medical insurance program can be considered to be on a financially sound basis throughout the period from April 1968 through June 1969.

APPENDIXES

APPENDIX I. STATEMENT OF ACTUARIAL ASSUMPTIONS AND BASES EMPLOYED IN ARRIVING AT AMOUNT OF STANDARD PREMIUM RATE OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM BEGINNING APRIL 1968

There follows a statement of actuarial assumptions and bases employed in arriving at the amount of the standard premium rate for the supplementary medical insurance program beginning April 1968. The standard premium rate is that rate which is payable by those who enroll in their initial enrollment period and by those who enroll in a general enrollment period that terminates less than 12 months after the close of their initial enrollment period.

The actuarial determination has been made on the basis of both the actual operating experience under the program and the results of a current continuing sample survey of beneficiaries (which gives certain information more promptly than do the aggregate operations of the program). Because of the timelag in the submission of bills in this program, complete figures for the 6 months of 1966 are not yet available, and the processed data for the first 10 months of 1967 are rather incomplete.

There are current figures for cash expenditures under the program, but these figures taken alone are misleading because they do not take into account the liabilities arising from the natural delay in benefit payments until well after the date that services were received. Such delay is due to the tendency of enrollees to accumulate a number of bills before submitting a claim, the inherent delays by physicians and enrollees in making requests for payment, and the time required by the carriers to adjudicate and pay claims. There was a balance of $394 million in the supplementary medical insurance trust fund at the end of October 1967 (a decline from a peak of $570 million at the end of March 1967), but there were at that time substantial outstanding liabilities incurred for services rendered during the first 16 months of the program.

On the basis of claims and administrative expenses paid (cash basis), the average monthly per capita expenditures of the program for the 6 months of 1966 were $1.93; for the first 10 months of 1967, the average was $6.06. However, these figures need to be adjusted for the estimated increase in liability that took place during the period for benefits that will be paid for services rendered during the period but had not been paid at the end of the period; that is, the premium rate must be set on an accrual basis, rather than a cash basis.

Figures on an accrual basis for the 6 months of 1966 are, of course, much more complete than for 1967. On the basis of the 1966 accrual figures, it is now estimated that, for this 6-month period, benefits and administrative expenses per capita exceeded the income from premiums and matching Government contributions by 30 cents per month (i.e., 15 cents each). It is further estimated that the liability of the system for the entire 1½-year period, July 1966-December 1967, will be about 7 percent higher than the income from the premiums and the matching Government contribution. In other words, it is expected that the $3 premium for the entire period will be lower than half the cost for benefits and administrative expenses by about 20 cents. About 12 cents of this 20 cents is accounted for by the fact that apparently physicians' fees were higher during this period than had been assumed in setting the premium; the remaining 8 cents arises from the fact that there has apparently been a somewhat greater utilization of services under the program than had been anticipated. Projecting costs of the program for the 15-month period following March 1968 at the level of operation in 1966-67 thus would require an additional 20 cents in the premium rate. These estimates are based upon incomplete data for past periods and upon projections thereof and may be somewhat more or less when the final accounts are in.

In estimating the cost of the program for April 1968 through June 1969, it is necessary to provide for the long-term trend toward greater utilization of medical services (including the effects of the discovery and more frequent use of new, highly expensive medical techniques) and the long-range upward trend of the general earnings levels, which will be reflected in higher physicians' fees and administrative expenses.

It is assumed that, in 1968-69, physicians' fees will increase at an annual rate of 5 percent and utilization of medical services by enrollees will increase at an annual rate of 2 percent. Administrative expenses are assumed to represent 9½ percent of the benefit payments; this figure is based on the actual operating results in 1967, when the average per capita administrative expenses of $.56 per month represented 9.5 percent of the average per capita benefit costs on an incurred basis. (The administrative expenses, on a paid basis, represented and average monthly per capita amount of $0.70 for the 6 months of 1966. The 1966 average was relatively high because of the necessary one-time start-up costs.) The average interest rate on the invested assets of the trust is assumed to be 4¾ percent (the rate applicable to virtually the entire portfolio as of October 31, 1967).

It is estimated that the monthly per capita cost on a calendar year basis would be $7.61 for 1968 and $8.28 for 1969 if the provisions of the 1967 amendments were in effect for this entire period. The cost for the 15-month period beginning April 1968 would average out at $7.89 a month (half of which is $3.95). Thus, a standard premium rate of $4 per month for the period April 1968 through June 1969 would allow a margin for contingencies, as required by law.

In addition, the interest earnings of the trust fund are available as a margin for contingencies and, if not needed to pay benefits and administrative expenses in the current period, will reduce the unfunded liability for the past deficiency in the premium rate. Interest earnings are the equivalent of another 10 cents per capita in available income.

The explanation of the $1 increase in the monthly premium rate for the new premium period can be summarized in the following manner:

(a) The cost of the protection under the program as in effect in 1966-67 is estimated to have exceeded the income from premiums and Government matching contribution by about 7 percent—an increase of about 20 cents.

(b) The cost of the program in 1966-67 was abnormally low as a result of the fact that in the 6 months of operation in 1966 the full $50 deductible was applicable, and it had a much stronger effect in reducing benefit costs than will be the case in later years; in other words, with all other things being the same, the program cost is higher for future years, in which the $50 deductible is usually applicable for 12-month periods, than for the initial period—an increase of about 3 cents.

(c) The $50 deductible represents a smaller proportion of the total covered medical charges when these increase as a result of either higher physician fees or higher utilization—an increase of about 11 cents.

(d) The utilization of medical services is assumed to be higher in the new premium period than in 1966-67, and so the program cost is higher—an increase of about 11 cents.

(e) The level of physicians' fees is assumed to be higher in the new premium period than in 1966-67, and so the program cost is higher—an increase of about 27 cents.

(f) The increased benefit protection arising from the provisions of the 1967 amendments must be taken into account—an increase of about 23 cents.

(g) The promulgated rate includes an amount to provide a margin for contingencies—an increase of 5 cents.

As indicated previously, the program has more than ample funds, on a cash basis, to meet its expected obligations for benefit payments and administrative expenses now and in the period to which the promulgated premium rate applies.

APPENDIX II. SUMMARY OF PRINCIPAL PROVISIONS

Public Law 89-97, approved July 30, 1965, amended the Social Security Act by establishing the supplementary medical insurance program. A summary of its principal provisions, as amended by subsequent legislation up to and including Public Law 90-248, approved January 2, 1968, 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 through May 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 immediately preceding enrollment (except with respect to persons convicted of certain specified offenses such as treason, espionage, etc.), effective July 1, 1966.

(*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 an initial period can enroll in any general enrollment period (January to March of each year), that begins within 3 years after the close of his initial enrollment period, to be effective the next July.

(*d*) Termination of enrollment: either by failure to pay premiums (for premiums not deducted from benefits) or by election to do so at any time (to be effective at the end of the following calendar quarter). An individual who terminates coverage may reenroll if he does so in a general enrollment period that begins within 3 years after such termination, 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), hospital outpatient services (prior to April 1, 1968, such services that were of a diagnostic nature and were furnished by a particular hospital in an amount in excess of $20 during a 20-day period were excluded from this program because they were included in the hospital insurance program; currently, all these outpatient services are consolidated in the supplementary medical insurance program), 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 limited ambulance services, prosthetic devices, rental of hospital equipment used at home (or purchase thereof if not more expensive, after December 31, 1967), and surgical dressings.

(*b*) Amount of reimbursement: plan pays—

(*i*) in the case of the professional component of inpatient radiology and pathology, 100 percent of reasonable charges, and

(*ii*) for all other services, 80 percent of reasonable charge (or, in the case of institutional services, 80 percent of reasonable cost) after the 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 to the enrollee or to individual suppliers of services on the basis of an assignment from the enrollee, or on a "reasonable cost" basis to the particular institution for institutional suppliers of services. When payment is made on a "reasonable charge" basis directly to individual suppliers (by assignment), the "reasonable charge" determination by the carrier must be accepted as the full charge for the services, and the supplier cannot bill the patient for amounts in excess of the "reasonable charge"; otherwise, payment is made to the enrollee on the basis of an itemized bill, whether or not receipted (prior to January 2, 1968, payment was made to participant only upon presentation of a receipted bill).

(*d*) Services not covered: self-administered drugs (only covered under hospital insurance, and then only when the individual is receiving covered hospital or extended care facility services and only when ordinarily furnished in and by such hospital or facility), private duty nursing, dental services, routine physical and eye examinations, elective cosmetic surgery, services performed by a relative or household member, services performed by a governmental agency (except when it provides services to the public generally as a community institution or 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, according to regulations promulgated by the Secretary of Health, Education, and Welfare. Carriers are paid their reasonable costs of administration.

III. FINANCING

(*a*) Participant premiums: flat monthly premium at a standard rate determined by Secretary of Health, Education, and Welfare. A rate of $4.00 has been promulgated for the period from April 1968 through June 1969. The rate applicable to each fiscal year after June 1969 will be promulgated by the Secretary before the preceding January 1. Such rate for any period is intended to be adequate, along with other income of the system, to support the cost of the benefits and administration for services received by enrollees during the period on an accrual basis, plus a margin for contingencies. A higher rate than the standard one is to be paid by those enrolling late or reenrolling after terminating enrollment (a surcharge of 10 percent of the premium rate for each full year during which an individual enrolling late could have participated but did not).

(*b*) Government contributions: amount equal to total premiums paid by or on the behalf of participants. Further, an amount equal to

6 months' Government contributions for all eligible to participate on July 1, 1966, has been authorized to be made available as a contingency reserve on a non-interest-bearing loan basis until December 31, 1969. A sum of $100 million was appropriated for this purpose in 1966; this appropriation lapsed unused at the end of 1967. No further appropriations have been requested.

(*c*) Payment of premiums: by automatic deduction from old-age, survivors, and disability insurance, railroad retirement, or civil service retirement benefits when possible (except for such persons who are public assistance recipients receiving money payments and whose premiums are paid by State agencies). Otherwise, for persons affected by earnings test, and for persons not eligible for such benefits, by direct payment, with a grace period determined by the Secretary of Health, Education, and Welfare of up to 90 days. State public assistance agencies may enroll, and pay premiums for, public assistance recipients who receive money payments and other persons who are not recipients of money payments but who are eligible under the medical assistance program; at the option of the State, such recipients and other persons who are beneficiaries under the old-age, survivors, and disability insurance program or the railroad retirement program may be included in this group.

(*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. Premiums paid or deducted from benefits on the behalf of enrollees are transferred to this trust fund. In addition, matching funds are appropriated from the general fund of the Treasury and are transferred to the trust fund simultaneously with the premiums (with proper interest adjustment if any difference in timing occurs).

APPENDIX III. 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.

Under a decision of the Comptroller General of the United States (B-4906) dated October 11, 1951, receipts derived from the sale of surplus supplies and materials are credited to and form a part of the trust fund, where the initial outlays therefore were paid from the trust fund.

Under section 1106(b) of the Social Security Act, as amended, the Secretary of Health, Education, and Welfare is authorized to charge outside persons, agencies, and organizations for providing certain services not directly related to the old-age, survivors, and disability insurance program. The Social Security Administration has accumulated a unique body of information in the course of the administration of the program. Situations arise when it is in the public interest to use this information to perform certain services for outside parties, such as the preparation of statistical tabulations for research purposes, when such services can be performed without violating the confidentiality of the records or interfering unduly with the administration of the program. Such services could not properly be provided at the expense of the trust fund. Receipts derived from performance of these services are equal to the cost of providing them; in some instances, the receipts are credited to the trust fund to counterbalance administrative expenses already paid from the trust fund (in which case such amount is netted out of the figures on administrative expenses in the financial statements of the trust fund), while in other instances such receipts are not credited to the trust fund, and the applicable administrative expenses are met directly from them. Accordingly, such administrative expenses, and the offsetting receipts, do not have any effect on the financial statements of the trust fund.

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.

Congress has authorized expenditures from the trust funds for construction of office buildings and related facilities for the Social Security Administration. The costs of such construction are included as part of the administrative expenses in the financial statements of operations of the trust funds as set forth in previous sections of this report. The net worth of the resulting facilities—just as the net worth of all other capital assets—is not carried as an asset in such statements.

That portion of each trust fund which, in the judgment of the managing trustee, is not required to meet current expenditures for benefits and administration is invested in interest-bearing obligations of the U.S. Government, in obligations guaranteed as to both principal and interest by the United States, or in certain federally-sponsored agency obligations that are designated in the laws authorizing their issuance as lawful investments for fiduciary and trust funds under the control and authority of the United States or any officer of the United States. 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, if earlier.

Marketable 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 6 and 7 of the main text.

In addition to serving as a source of income, the assets of the trust fund assure the continued payment of benefits without sharp changes in premium rates during periods of short-run adverse fluctuations in total income and expenditures.

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

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

(1) BASIS OF FINANCING OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

The financing of the supplementary medical insurance system is essentially different from that for the cash benefit and hospital insurance programs in several fundamental respects. First, the premium rate for any period is required by law to be set at such an amount that income from premiums and Government matching contributions accrued in the period is estimated to be sufficient to cover the benefit payments and processing costs related to all services furnished during that period. In this way, those enrolled in the program during any period for which a particular premium rate is applicable will, as a group, pay for half the cost of the services that they as a group receive during that period.

Second, the financing of the program is set only for short periods into the future, so that there is no need for long-term projections of the experience of the program. (The premium rate for each fiscal-year period is promulgated before the January 1 that precedes the beginning of such year.) Further, there is no natural accumulation of an excess of income over disbursements as the covered population matures. Consequently, there is greater urgency that the cash income exceed the cash disbursements in the period for which the experience is projected, although the natural lag in the payment of benefits results in a cash surplus which provides some margin to insure enough assets on hand at any time to pay benefits should the premium prove inadequate by a small margin. In addition, a contingency reserve of approximately $342 million was authorized, to be available until December 31, 1969, as further assurance that there would be enough assets available to the program to be able to pay benefits if the premium rate is inadequate.

Because the supplementary medical insurance program is self-supporting, if there were no lag in payments or if there were no contingency fund available, the premium rate would have to contain a substantial margin to insure adequacy. The contingency fund was authorized solely to allow the premium rate to be set at a level consistent with the best estimate that can be made of the actual accrued experience anticipated. Under these circumstances, the enrollees during the period to which a particular premium rate is applicable will, as a group, pay for half the cost of the services received by them during this period, instead of their being required to contribute to building surplus funds for the program.

As a result of the foregoing considerations, the actuarial status of the supplementary medical insurance system and the solvency of its trust fund can be assessed only on an accrual basis—that is, on the basis of all obligations for future payment of benefits, in addition to those already paid. The liability of the system that is outstanding at any time for benefits that will be paid as a result of services already performed is referred to as "benefits incurred but unpaid." This liability results from the delays in the program as between the date on which services are performed and the date benefits based on these services are paid from the trust fund. These delays are due to the tendency of enrollees to accumulate a number of bills before submitting a claim, the time required by physicians and enrollees to complete the claim forms and submit them to the carriers, and the time required by the carriers to adjudicate and process the claims.

Further, the $50 deductible applicable to each calendar year tends to shift the benefits incurred toward the end of the calendar year, and encourages enrollees to wait until they have all bills relating to a calendar year before submitting a claim. Thus, the liability outstanding at the end of a calendar year for benefits incurred but unpaid tends to be especially large.

Since nearly all administrative costs of the program are initiated when a claim is filed, there is also outstanding at any time the liability of processing costs related to the benefits incurred but unpaid. To obtain the operating results of the system for any period, all cash income and disbursements must be adjusted by the increase in the corresponding asset or liability item during the period.

Another fundamental difference that may affect the financing methods is the voluntary enrollment provisions of the supplementary medical insurance program. As long as a large proportion (i.e., over 75 percent) of those eligible to participate do so, the level of average services per capita received by the group will not be significantly affected by the inclusion of a somewhat greater proportion of those in poor health than in the population aged 65 and over. Thus, both income and disbursements vary directly in proportion to the enrollment. Accordingly, the financial basis of the program depends solely on the relationship of the premium rate to the benefit payments and administrative expenses accrued per capita, and not on independent estimates of total income and disbursements (in contrast to the situation under the old-age, survivors, and disability insurance and the hospital insurance programs, under which income is not directly proportioned to disbursements).

It is believed that as long as the participation rate is at least 75 percent, there will be no significant adverse selection against the system by there being an excessive proportion of high-cost enrollees. However, if participation drops below that level, there might well be such antiselection.

Except for a very small group who may receive 3 months of free coverage because of the grace period, before being disenrolled for nonpayment of premiums, the premiums are collected and the Government matching contributions are transferred for each enrollee for each month of enrollment. Thus, the premiums accrued for any period are very close to the product of the premium rate and the average enrollment in that period. Consequently, the premium rate can be based on the estimated benefit payments and administrative expenses expected to be accrued in the period divided by the average enrollment anticipated in that period. Such amounts are referred to as benefit payments and administrative expenses per capita.

(2) INFORTATION AVAILABLE ON WHICH TO BASE ESTIMATES OF ACCRUED EXPERIENCE

The only reliable basis for an accurate assessment of the accrued experience of the program is the actual experience data developed from accounting information from the program (i.e., from the records of payments actually made). Accurate data from the program are available on a cash basis. However, due to the delays mentioned above, increased by the newness of the program and the unfamiliarity of many enrollees with reimbursement insurance, experience data from the program are not yet complete, even for 1966.

In general, the expected estimates were based on data from the current medicare survey through July 1967 and on payment records for services performed in 1966 that were processed to the 0.1-percent actuarial sample before January 1968 (but not as yet reconciled with actual disbursements from the trust fund, to insure reliability). Estimates of the benefit payments accrued that were derived from these different sources were in reasonably close agreement.

The current medicare survey is a survey carried out in cooperation with the Bureau of the Census, in which a sample of 4,000 enrollees is picked for each year; interviewers make repeated visits to each member of the sample to determine the cost of medical services received by them. The actuarial sample consists of payment records for all benefit payments made with respect to members of a 0.1-percent random sample of enrollees and of copies of all bills and supporting documentation submitted with respect to such persons.

The current medicare survey provides an estimate of the total charges for services received by enrollees and the proportion potentially reimbursable; such data are available through July 1967. A number of estimates and assumptions are necessary, however, to derive from these data an estimate of the accrued experience. For example, there are no data as to the proportion of enrollees who would satisfy the deductible in a 12-mont.h period (since the source data available are for 6-month periods), or as to the proportion of enrollees with more than $50 in covered expenses who will not file claims including all covered services received.

As stated above, the many adjustments and assumptions required make these estimates subject to some variation from the actual experience in 1966 (as much as 10 percent), and to more variation in later years, since any errors in estimating the experience that has occurred during 1966-67 are necessarily incorporated into estimates for later years.

Further difficulties were encountered in estimating the effect of the benefit changes made by the 1967 amendments, because no information was available from the program as to the proportion of diagnostic services rendered in the outpatient department of hospitals and affiliated clinics or for the professional component of inpatient radiology and pathology services. No payment records are prepared for initial submissions of less than the deductible by enrollees who later submit enough additional expenses to qualify for reimbursements. Thus, any itemization of benefit payments in payment-record data by type of service is defective. (Such information will be available when the 0.1

percent actuarial sample receives data from the 5 percent statistical sample as to such services eliminated by the deductible.)

The only information currently available to the 3.1 percent actuarial sample is based on the payment records prepared by carriers to record benefit payments. Payment records for services performed during 1966 are still being received. Also, the reconciliation between payment records for the benefits paid for 1966 and the charges to the trust fund for such benefits, which is necessary to insure that payment records were prepared covering all benefit payments, is only partially completed. Payment records for services performed during 1967 are only partially complete and are insufficient to serve as the basis of any estimate of the accrued experience in 1967, due to the absence of previous experience with a program similar to the supplementary medical insurance program.

(3) EXPECTED AND HIGH-COST ESTIMATES

Due to the absence of conclusive data as to the experience of the program during 1966-67 upon which to base projections of future experience, a substantial variation is possible in estimates of future experience. In many of the assumptions and adjustments that were required to prepare estimates of current and future experience, there was a range of possible experience. The expected estimates result from the choice from each of these ranges of possible experience of that which appears most likely to occur. The high-cost estimates are produced by selecting from the range of plausible experience the assumption that results in the highest cost.

The expected estimates of the experience most likely to occur are used to estimate the accrued-benefit payments and administrative expenses upon which the premium rate is based and from which the financial experience of the program and the trust fund are measured. The high-cost estimates of the highest cost experience thought reasonably likely to occur are used to test whether, under the proposed premium rate, there will be a sufficient cash flow of income to cover cash disbursements for benefits and administrative expenses if the experience should prove to be as disadvantageous as thought reasonably possible.

(4) BENEFITS AND ADMINISTRATIVE EXPENSES PER CAPITA ACCORDING TO THE ESTIMATES

The expected estimates of benefits and administrative expenses per calendar year per capita appear in table A. The first item "reasonable charges for covered services" refers to the total reasonable charges as determined by the carriers (for noninstitutional services) and the total reasonable costs as determined by the fiscal intermediaries (for institutional services) for all covered services received during the calendar year, divided by the average enrollment in that year. The item "net effect of the deductible" refers to the total amount deducted from total reasonable charges, including the reasonable charges for any services received by enrollees who did not have enough reasonable charges to be eligible for some reimbursement (i.e., who did not have more than $50 in such charges less the amount of deductible carried over from the previous year), divided by the average enrollment.

TABLE A.—"EXPECTED" ESTIMATES OF ACCRUED BENEFITS AND ADMINISTRATIVE EXPENSES PER CAPITA IN CALENDAR YEARS 1966-69

[In millions of dollars]

Item	Calendar year			
	1966	1967	1968 [1]	1969
Reasonable charges for covered services	$57.94	$121.76	$133.53	$144.12
Net effect of deductible	20.50	28.69	29.97	30.17
Potential benefit payments [2]	29.95	74.46	84.03	92.87
Allowance for underfiling	1.92	2.52	1.68	1.68
Benefit payments	28.03	71.94	[3] 82.35	91.19
Administrative expenses	6.12	7.20	7.62	8.16
Benefit payments and administrative expenses	34.15	79.14	89.97	99.35
Combined premium rate and matching contribution	36.00	72.00	90.00	[4] 96.00

[1] Includes new benefits effective on Apr 1, 1968.
[2] Taking into account the effect of the 20-percent coinsurance payable by the enrollee.
[3] Annual rate for January through March 1968 is $78.66 and for April through December 1968 is $83.57.
[4] Annual rate based on rate for 1st 6 months of 1969. Premium rate applicable to last 6 months of 1969 and 1st 6 months of 1970 will be promulgated before Jan. 1, 1969.

The item "potential benefit payments" refers to the total amount that would be reimbursed if all possible benefits were, in fact, claimed. It may be noted that benefit payments are low in 1966 due to the relatively greater effect of the full $50 deductible (without any carryover deductible) in a 6-month period. As a result, benefit payments per capita in 1967 are increased by the unusually high carryover deductible that results in 1967.

Administrative costs were unusually high in 1966 due to the inclusion of startup expenses. Part of the increase in total cost in 1968 over 1967 is due to the new benefits that become effective on April 1, 1968 (approximately a 6-percent cost increase relatively).

A weighted average of the benefit payments and administrative expenses for the period from April 1, 1968, through June 1969 (the period for which a $4.00 standard premium rate is applicable) produces a monthly per capita cost for benefit payments and administrative expenses of $7.88.

(5) ASSUMPTIONS RELATING TO DEDUCTIBLE CARRIED OVER

The provision that the deductible in any year will be reduced by any reasonable charges for services received during the last quarter of the preceding year which were used to meet the deductible in that year produces higher benefit payments and administrative expenses than would have been paid without this provision. The question arises as to whether these additional costs are accrued in the year from which such deductible was carried over or in the year to which it is applied.

Since these additional costs resulting from the deductible carried over result from services performed in the prior year, it can be argued that the additional costs were accrued in that year. On the other hand, if the program were discontinued (e.g., superseded by some other program), or if an enrollee disenrolls at the end of a calendar year, there is no liability outstanding for such additional costs; this indicates that the liability for paying these additional costs arises from continuing the program and from the individual's continuing his enrollment, Also, in the case of any individual enrollee, there is no liability unless he receives enough services in the succeeding year to be eligible for benefits.

From the latter point of view, the additional costs are accrued in the succeeding year, Further, the additional costs are paid on the basis of services actually performed in the succeeding year, and the assignment of benefit payments and administrative expenses to the year prior to that in which the services were performed appears inconsistent with the principle that all costs arc accrued in the year in which the services giving rise to such costs were performed.

For calendar years beginning with 1968, the assumptions with regard to the deductible carried over will have negligible effect, since the additional costs paid as a result of deductibles carried over from the preceding year will approximately equal the deductibles carried over to the succeeding year. In 1966-67, however, due to the application of the full $50 deductible in a 6-month period for 1966, there was an unusually large amount of additional benefits paid in 1967 as a result of deductibles carried over from 1966, As a result, comparisons between the experience in 1967 and that of later years are difficult. Further, the experience in 1966 is artificially favorable, not only because of the application of the full deductible in a short period, but also because there were no deductibles carried over from a prior period.

Beginning with 1968, however, these problems disappear. Further, the assignment of additional costs resulting from the deductibles carried over to the year in which the services on the basis of which benefits were paid were performed eliminates one important adjustment, required to obtain cash outlays from accrued outlays (or vice versa). Also, although there are strong theoretical arguments in favor of each method, those in favor of assigning these costs to the year into which the deductible is carried appear stronger, since if the program were terminated, the trust fund would be liable for all benefit payments and administrative expenses for services performed prior to termination, but not for the deductibles that would have been carried over if the program had continued.

The calculations in table A assume that the additional costs resulting from the deductibles carried over are incurred in the year in which the services on the basis of which the benefits and paid were performed. Table B provides the same information, assuming that these costs are accrued in the year from which the deductible is carried over. The cost per capita per month in 1966-67 from table B is slightly higher than that derived from table A, $6.35 as opposed to $6.29, as a result of including in the former the approximately $1.25 per capita (per year) assumed to be carried over from 1967 to 1968. The results for 1968-69 are the same under either assumption.

TABLE B.—"EXPECTED" ESTIMATES OF ACCRUED BENEFITS AND ADMINISTRATIVE EXPENSES PER CAPITA IN CALENDAR YEARS 1966-69, WITH DEDUCTIBLE CARRIED OVER CHARGED TO PREVIOUS YEAR [1]

[In millions of dollars]

Item	Calendar year			
	1966	1967	1968 [2]	1969
Reasonable charges for covered services	$57.94	$121.76	$133.53	$144.12
Net effect of deductible	17.69	30.27	29.97	30.17
Potential benefit payments	32.20	73.19	84.03	92.87
Allowance for underfiling	1.92	2.52	1.68	1.68
Benefit payments	30.28	70.67	[3] 82.35	91.19
Administrative expenses	6.35	7.07	7.62	8.16
Benefit payments and administrative expenses	36.63	77.74	89.97	99.35
Combined premium rate and matching contribution	36.00	72.00	90.00	[4] 96.00

[1] See text for definition of this term.
[2] Includes new benefits effective on Apr 1, 1968.
[3] Annual rate for January through March 1968 is $78.66 and for April through December 1968 is $83.57.
[4] Annual rate based on rate for 1st 6 months of 1969. Premium rate applicable to last 6 months of 1969 and 1st 6 months of 1970 will be promulgated before Jan. 1, 1969.

(6) PRINCIPAL ASSUMPTIONS REQUIRED IN ESTIMATES

The principal factors which have a major impact on costs, concerning which it has been necessary to make assumptions without fully adequate information, are as follows:

(a) Proportion of enrollees who will have reasonable charges for covered services in excess of the deductible in a full 12-month period

Data from the current medicare survey and from the 0.1 percent actuarial sample show that, in the 6-month period, from July through December 1966, approximately 23 percent of those enrolled at anytime during this period accumulated more than $50 in charges for covered services and that about 21 percent actually claimed benefits. The expected estimate projected that 42 percent of those enrolled at any time would have more than $50 in reasonable charges and that, on the average, these persons would not file claims for all covered services, resulting in an average decrease in benefit payments of $7.50 per capita per year.

(b) Rate of increase in average fees charged by physicians

Nearly all benefits under the program are for professional services, primarily for those of physicians. The unit prices of these services can be expected to rise at approximately the same rate as all earnings from employment in the United States. The annual increases in physicians' fees, as measured by the Consumer Price Index for physician fees, and the annual increases in average earnings, as measured by the average increase in the average earnings in employment under the social security program, appear in table C.

TABLE C.—AVERAGE ANNUAL RATE OF INCREASE IN PHYSICIANS' FEES AND IN AVERAGE EARNINGS IN EMPLOYMENT COVERED BY SOCIAL SECURITY, 1955-67

[In percent]

Year [1]	Physician' fees [2]	Average earnings in employment covered by social security
1956	3.0	5.7
1957	4.3	5.5
1958	3.4	3.3
1959	3.4	3.3
1960	2.5	4.3
1961	2.5	3.1
1962	2.9	4.2
1963	2.2	2.4
1964	2.3	3.1
1965	3.5	1.6
Average 1955-65 [3]	3.0	3.6
1966	5.7	4.4
1967	7.3	6.3
Average 1955-67 [3]	3.6	3.9

[1] Increase from June of previous year to June of year listed for 1st column and from 1st quarter of previous year to 1st quarter of year listed for last column.
[2] As measured by Consumer Price Index of physician fees.
[3] Arithmetic average of increases for years included in period.

As can be seen from table C, physicians' fees had been increasing by an average of 3 percent per year during the decade 1955-65, or at a rate slightly lower than that for all earnings (3.6 percent). During 1966-67, however, physicians' fees increased at a rate of 6.5 percent per year, somewhat higher than the average rate of increase for all earnings. Over the 12-year period, however, physicians' fees increased 3.6 percent per year, and the average earnings in employment covered by social security increased 3.9 percent per year. Thus, it appears reasonable to assume that physicians' fees will continue to increase at an annual rate lightly below that projected for the average earnings of persons covered by social security.

The average fees charged by physicians were assumed, for the expected estimate, to increase by 5 percent per year between July 1967 and July 1969, and by 3 percent per year thereafter—in line with the anticipated increases of earnings in employment covered by the social security program.

In the high-cost estimate, average fees were assumed to increase at the highest rate expected to be obtained in collective-bargaining agreements by a large group of employers—at 7 percent between July 1967 and July 1968, at 6 percent between July 1968 and July 1969, and at 5 percent between July 1969 and July 1970.

The original cost estimates (prepared in 1965) assumed that physician fees would rise by 6 percent between July 1965 and July 1967. The actual average rise in fees during this period, as measured by the index of physician fees in the Consumer Price Index was 13.3 percent, which resulted in benefit costs that were $0.38 per capita per month higher than anticipated.

(c) Rate of increase in utilization of services

There is a long-term trend in the United States of increasing use of physician services per capita that amounts to somewhat less than 1 percent per year. The increase in use of physician services by enrollees who were not insured for these services prior to coverage under the program is much higher. Also, the reimbursement on the basis of itemized bills, effective in April 1968, may result in increased utilization. Further, there were no major epidemics of respiratory diseases during 1967-68, and utilization may have been unusually low in those years.

The expected estimates assume an increase in utilization of 2 percent per year between July 1967 and July 1969 and of 1 percent per year thereafter. The high-cost estimates assume an increase in utilization of 5 percent per year throughout this period.

(7) ESTIMATES OF ACCRUED COSTS, LIABILITIES OUTSTANDING AT THE END OF EACH CALENDAR YEAR, AND FUTURE CASH FLOW UNDER THE PROGRAM

During 1966-67, approximately 92 percent of those aged 65 or over were enrolled in the program. This percentage of participation was assumed to continue in the future under both the expected and high-cost estimates (for reasons given earlier, a large variation in the number enrolled would not affect the financial soundness of the program). The premiums, Government matching contributions, and benefit payments accrued were obtained by multiplying the corresponding rate per capita by the projected enrollment. Interest earnings were calculated from the anticipated experience of the trust fund on a cash basis (projected as explained below).

The cash benefits estimated to be paid during 1968 were projected from those paid in the last part of 1967. Benefit payments beyond 1968 were calculated from the corresponding accrued item, under the assumption that the total benefit payments incurred but unpaid at the end of each period would be the same as at December 31, 1968 (which is equivalent to the assumption that the lag in payment of benefits is assumed to decrease gradually). As a percentage of benefit payments accrued in the preceding year, benefit payments incurred but unpaid are thus assumed to decrease from about 35 percent on December 31, 1967, to about 20 percent as of December 31, 1970.

Premiums collected in cash for years beyond 1967 are assumed to equal those accrued. Government matching contributions transferred are expected to catch up early in 1968 with the premiums collected and to continue thereafter at the same rate as premiums collected.

Administrative expenses for fiscal years 1968 and 1969 on a cash basis were obtained from the Budget Document of the United States for fiscal year 1969. The liability outstanding at the end of each period for the administrative expenses for processing benefit payments incurred but unpaid was assumed to be 9 percent of such benefit payments. This procedure, based on budget figures, produces administrative expenses accrued of approximately 10 percent of benefit payments, which is somewhat higher than the 9 percent that was assumed in the calculations of administrative expenses per capita (as in table A).

APPENDIX V. 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 calendar year.

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. The 1965 amendments also provided that between July 1 and October 1, 1967 (and every 2 years thereafter), the Secretary of Health, Education, and Welfare could adjust the standard premium rate so that income to the program would be in balance with outgo for benefit payments and administrative expenses (with inclusion of an appropriate contingency margin in the premium rate). Because the 1967 amendments were then pending and their final form indeterminate, on September 30, 1967, Public Law 90-97 was enacted to permit the promulgation to be deferred until December 31, 1967, with the adjusted premium rate to become effective for April 1968. The rate so promulgated was $4. The 1967 amendments provide that the premium rate is to be determined annually, during December of each year, and is to apply initially for April 1968 through June 1969, and beginning with July 1969 for 12-month periods. The standard premium rate applies to persons who enroll in their initial enrollment period. The premium rate for persons who enroll later than the first period when enrollment was open to them or who re-enroll after their enrollment was terminated is the standard premium rate increased by 10 percent for each full year during which they could have been 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. The 1967 amendments provide for payment of interest, after June 30, 1967, when the Government contribution is not made promptly.

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 $18 times 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, which would have expired at the end of 1967, was extended to the end of 1969 by the 1967 amendments. Any amounts actually used by the supplementary medical insurance trust fund are repayable (without interest) to the Treasury.

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 designed 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 VI. STATUTORY PROVISIONS, AS OF JANUARY 2, 1968, CREATING THE TRUST FUND, DEFINING THE DUTIES OF THE BOARD OF TRUSTEES, AND PROVIDING FOR ADVISORY COUNCILS OF SOCIAL SECURITY

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

FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Section 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 Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the managing trustee of the Board of Trustees (hereinafter in this section referred to as the "managing trustee"). The Commissioner of social security shall serve as the secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the trust fund;

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

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

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

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

(*c*) It shall be the duty of the managing trustee to invest such portion of the trust fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or

(2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the trust fund. Such obligations issued for purchase by the trust fund shall have maturities fixed with due regard for the needs of the trust fund and shall bear interest at a rate equal to the average market yield (computed by the managing trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The managing trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(*d*) Any obligations acquired by the trust fund (except public-debt obligations issued exclusively to the trust fund) may be sold by the managing trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

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

(*f*) 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

Section 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 deductions 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 the 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 periods, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

(*e*) (1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5, United States Code, or any other law 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 law 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

Section 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—

(1) A Government contribution equal to the aggregate premiums payable under this part and deposited in the trust fund, and

(2) Such sums as the Secretary deems necessary to place the trust fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess

of the premiums deposited in the trust fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the trust fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the trust fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

(*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 1969 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

Section 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.