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BOARD OF TRUSTEES OF THE 1976 ANNUAL REPORT OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

COMMUNICATION

FROM

THE BOARD OF TRUSTEES, FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

TRANSMITTING

THE 1976 ANNUAL REPORT OF THE BOARD, PURSUANT TO SECTION 1841(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

MAY 24, 1976.—Referred to the Committees on Ways and Means and Interstate and Foreign Commerce and ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
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LETTER OF TRANSMITTAL

BOARD OF TRUSTEES
OF THE FEDERAL SUPPLEMENTARY
MEDICAL INSURANCE TRUST FUND,
Washington, D.C., May 24, 1976.

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

SIR: We have the honor to transmit to you the 1976 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the 11th such report), in compliance with the provisions of section 1841(b) of the Social Security Act.

Respectfully,

WILLIAM E. SIMON,
Secretary of the Treasury,
and Managing Trustee of the Trust Fund.

W. J. USERY, Jr.,
Secretary of Labor.

DAVID MATHEWS,
Secretary of Health, Education, and Welfare.

JAMES B. CARDWELL,
Commissioner of Social Security.

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Washington, D.C., May 24, 1976.

The PRESIDENT OF THE SENATE,
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Click on a Topic Below

CONTENTS

1976 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

The Board of Trustees

The Federal Supplementary Medical Insurance Trust Fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1841(b) of the Social Security Act, as amended. The Board is comprised of three members who serve in an ex-officio capacity. The members of the Board are the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Secretary of the Treasury is designated by law as the Managing Trustee. The Commissioner of Social Security is Secretary of the Board. The Board of Trustees reports to the Congress once each year, in compliance with Section 1841(b)(2) of the Social Security Act. This Report is the annual report for 1976, the eleventh such report.

Highlights

(a) Expenditures of the supplementary medical insurance trust fund increased 27 percent in fiscal year 1975 over 1974. Part of this increase is related to the recent additon of disabled beneficiaries to the program. Most of the increase, however, was due to substantial increases in per capita benefit costs.

(b) Income to the trust fund increased 13 percent in fiscal year 1975 over 1974. This resulted from an increase in the standard monthly premium rate paid by enrollees, from increased adequate actuarial rates which determine the general revenue contribution, and from increased enrollment in the program.

(c) The trust fund increased $152 million to $1424 million during 1975. However, projections of incurred expenses through 1975 indicate that liabilities increased more rapidly than the trust fund so that the ratio of assets to liabilities declined slightly in 1975. A further decline in the asset to liability ratio is projected for fiscal year 1976 and then an improvement in the funding by June 1977.

(d) In December of 1975, the Secretary of the Department of Health, Education, and Welfare promulgated adequate actuarial rates of $10.70 for aged enrollees and $19.00 for disabled enrollees for the year beginning July 1, 1976. P.L. 94–182, passed in December 1975 permitted the standard premium rate to be increased in proportion to OASDI benefit increases. OASDI benefits were increased 8.0 percent in July 1975. Accordingly, the standard monthly premium rate was increased to $7.20 effective July 1, 1976.

(e) 21.7 million persons aged 65 and over were enrolled in the program in July 1975. This is about 95 percent of the aged population. An additional 2.0 million disabled beneficiaries were enrolled in the same month.

H. Doc. 94-503---2

Social Security Amendments Since the 1975 Report

Public Law 94–182, which was enacted on December 31, 1975, includes a provision which removed a tecnhical defect in the law which prevented increases in the part B standard premium. Under this provision, the part B standard premium rate established in December for the following July will be increased by the percentage by which OASDI benefits are increased over the 12-month period ending May 1 of the year in which the premium rate becomes effective.

Nature of the Trust Fund

The Federal supplementary medical insurance trust fund was established on July 30, 1965, as a separate account in the United States Treasury to hold the amounts accumulated under the supplementary medical insurance program. All the financial operations which relate to the system of supplementary medical insurance are handled through this fund.

The major sources of receipts of the trust fund are (1) premiums paid by eligible persons who are voluntarily enrolled in the program and (2) contributions of the Federal Government that are authorized to be appropriated and transferred from the general fund of the Treasury. Eligible persons aged 65 and over have been able to enroll in the program since its inception in July 1966. Since July 1973, disabled persons under age 65, who meet certain eligibility requirements, have also been able to enroll in the program.

The premiums paid by participants are based on the standard monthly premium rate, which is the same for participants aged 65 and over and for disabled participants under age 65. Premiums paid for fiscal years 1967 through 1973 were matched by an equal amount of Government contributions. Beginning July 1973, the amount of Government contributions corresponding to premiums paid by each of the two groups of participants is determined by applying a ratio, prescribed in the law for each group, to the amount of premiums received from that group of participants. The ratio is equal to (1) twice the amount of the adequate actuarial rate applicable to the particular group of participants, minus the amount of the standard monthly premium rate, divided by (2) the amount of the standard monthly premium rate.

Standard monthly premium rates and adequate actuarial rates are promulgated each year by the Secretary of Health, Education, and Welfare. The standard premium rates in effect from the beginning of the program, July 1966, through June 1976, and the rate promulgated for July 1976 through June 1977, are shown in table 1. Adequate actuarial rates in effect from July 1973 through June 1976, and the rates promulgated for July 1976 through June 1977, are also shown.

Another source from which receipts of the trust fund are derived is interest received on investments held by the fund. The investment procedures of the fund are described later in this section.

Section 201(i) of the Social Security Act authorizes the Managing Trustee to accept and deposit in the trust fund unconditional money gifts or bequests made for the benefit of the fund or for any activity financed through the 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 Department of the Treasury in carrying out the supplementary medical insurance provisions of Title XVIII of the Social Security Act 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.

Hospitals, at their option, are permitted to combine their billing for both hospital costs and physician components of radiology and pathology services rendered hospital inpatients by hospital-based physicians. Where hospitals elect this billing procedure, payments are made initially from the hospital insurance trust fund, with reimbursement later to it from the supplementary medical insurance trust fund. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.

The Social Security Amendments of 1967 and 1972 authorize the Secretary of Health, Education, and Welfare to develop and conduct a broad range of experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under the hospital insurance and supplementary medical insurance programs. The cost of such experiments and demonstration projects are paid out of the hospital insurance and supplementary medical insurance trust funds.

Congress has authorized expenditures from the trust funds for construction, rental, and lease or purchase contract of office buildings and related facilities for the Social Security Administration. Both the capital costs of construction financed directly from the trust funds and the rental, lease, or purchase contract costs of acquiring facilities are included in trust fund expenditures. In 1974, construction of several large facilities was begun under purchase contract authority, wherein initial capital costs are borne by the private sector. Under this method of facilities acquisition, trust fund expenditures for use and ultimate Government ownership of a facility are made over periods of from 10 to 30 years. Whatever the manner of acquisition, the net worth of facilities and other fixed capital assets is not carried in the statements of the operations of the trust fund presented in this report. This is because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures, and therefore is not viewed as being a consideration in assessing the actuarial status of the funds.

That portion of the 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 United States Government (including special public-debt obligations described below), 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.

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 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 four years from the end of such calendar month.

TABLE 1.—STANDARD MONTHLY PREMIUM RATES AND ADEQUATE ACTUARIAL RATES

Period	Standard monthly premium rate	Adequate actuarial rate	
		Participants aged 65 and over	Disabled participants under age 65
July 1966–March 1968	$3.00	----------	----------
April 1968–June 1970	4.00	----------	----------
12 month period ending June 30 of:			
1971	5.30	----------	----------
1972	5.60	----------	----------
1973	5.80	----------	----------
1974 [1]	6.30	$6.30	$14.50
1975	6.70	6.70	18.00
1976	6.70	7.50	18.50
1977	7.20	10.70	19.00

[1] In accordance with limitations on the costs of health care imposed under phase III of the economic stabilization program, the standard premium rate for July and August 1973 was set at $5.80 and $6.10, respectively. Effective September 1973, the rate increased to $6.30.

Summary of the Operations of the Trust Fund, Fiscal Year 1975

A statement of the income and disbursements of the Federal Supplementary Medical Insurance Trust Fund during fiscal year 1975 and of the assets of the fund at the beginning and end of the fiscal year is presented in table 2. Comparable amounts for fiscal year 1974 are also shown in the table.

The total assets of the trust fund amounted to $1,272 million on June 30, 1974. During fiscal year 1975, total receipts amounted to $4,322 million and total disbursements were $4,170 million. Total assets thus increased $152 million during the year to a total of $1,424 million on June 30, 1975.

Of the total receipts, $1,736 million represented premium payments by (or on behalf of) participants aged 65 and over, and $151 million represented premium payments by (or on behalf of) disabled participants under age 65. Total premium payments amounted to $1,887 million, an increase of 10.7 percent over premium payments by participants in the preceding fiscal year. This increase in premiums from participants resulted primarily from (1) the increase from $6.30 to $6.70 per month in the standard premium rate that became effective on July 1, 1974, and (2) the expected growth in the number of persons enrolled in the supplementary medical insurance program.

Contributions received from the general fund of the Treasury amounted to $2,330 million. This amount consisted of $1,711 million representing contributions relating to premiums paid by participants aged 65 and over and $619 million representing contributions relating to premiums paid by disabled participants under age 65.

TABLE 2.—STATEMENT OF OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING FISCAL YEARS 1974 AND 1975

[In thousands of dollars]

	Fiscal year—	
	1974	1975
Total assets of the trust fund, beginning of year	745,722	1,272,177
Receipts:		
Premiums from participants:		
Participants aged 65 and over	1,578,919	1,736,209
Disabled participants under age 65	125,452	150,753
Total premiums	1,704,371	1,886,962
Transfers from general fund of the Treasury:		
Government contributions:		
For premiums received from participants aged 65 and over	1,577,045	1,710,559
For premiums received from disabled participants under age 65	451,880	619,029
Total Government contributions	2,028,926	2,329,588
Interest on delayed transfers of Government contributions		2
Total transfers from general fund of the Treasury	2,028,926	2,329,590
Interest:		
Interest on investments	77,243	104,403
Interest on amounts of interfund transfers due to adjustment in allocation of administrative expenses and construction costs [1]	−1,318	1,136
Total interest	75,924	105,539
Gifts	4	
Total receipts	3,809,225	4,322,090
Disbursements:		
Benefit payments:		
Paid directly from the trust fund for costs of health services	2,867,602	3,759,225
Transfers to the hospital insurance trust fund for reimbursement of payments made initially from that fund for costs of radiology and pathology services [2]	6,000	6,000
Total benefit payments	2,873,602	3,765,225
Costs of experiments and demonstration projects [2]	47	172
Administrative expenses:		
Department of Health, Education, and Welfare [3]	379,319	423,316
Treasury Department	88	113
Railroad Retirement Board	814	1,101
Civil Service Commission	78	72
Construction of facilities for Social Security Administration	−72	213
Interfund transfers due to adjustment in allocation of—		
Administrative expenses [4]	28,881	−20,891
Construction costs [4]	42	533
Gross administrative expenses	409,150	404,458
Less receipts from sale of surplus supplies, materials, etc.	29	
Net administrative expenses	409,121	404,458
Total disbursements	3,282,770	4,169,855
Net addition to the trust fund	526,455	152,235
Total assets of the trust fund, end of year	1,272,177	1,424,413

[1] A positive figure represents a transfer of interest to the supplementary medical insurance trust fund from the other social security trust funds. A negative figure represents a transfer of interest from the supplementary medical insurance trust fund to the other social security trust funds.

[2] For explanation, see text.

[3] Includes administrative expenses of the carriers and intermediaries.

[4] A positive figure represents a transfer from the supplementary medical insurance trust fund to the other social security trust funds. A negative figure represents a transfer to the supplementary medical insurance trust fund from the other social security trust funds.

The remaining $106 million of receipts consisted almost entirely of interest on the investments of the trust fund.

Of the $4,170 million in total disbursements, $3,759 million represented benefits paid directly from the trust fund for health services

covered under Title XVIII of the Social Security Act. In addition, transfers were made to the hospital insurance trust fund consisting of $6 million for inpatient professional radiology and pathology services that were paid initially from the hospital insurance trust fund but that are liabilities of the supplementary medical insurance trust fund. Total benefit payments from the trust fund in fiscal year 1975, therefore, amounted to $3,765 million, an increase of 31.0 percent over the corresponding amount paid in fiscal year 1974.

Reference has been made in an earlier section to provisions which authorize payment from the trust fund for costs of experiments and demonstration projects in providing health care services. In fiscal year 1975, payments for such costs amounted to about $172,000.

The remaining $404 million of disbursements was for net administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds—old-age and survivors insurance, disability insurance, hospital insurance, and supplementary medical insurance—on the basis of provisional estimates. Periodically, as actual experience develops and is analyzed, adjustments to the allocations of administrative expenses and costs of construction for prior periods are effected by interfund transfers, with appropriate interest allowances.

In table 3, the experience with respect to actual amounts of participants' premiums, Government contributions, and benefit payments in fiscal year 1975 is compared with the estimates for fiscal year 1975 which appeared in the 1974 and 1975 annual reports. The actual experience was relatively close to the estimates.

The assets of the trust fund at the end of fiscal year 1975 totaled $1,424 million, consisting of $1,378 million in the form of obligations of the United States Government and an undisbursed balance of $46 million. Table 4 shows a comparison of the total assets of the fund and their distribution at the end of fiscal years 1974 and 1975. A comparison of the assets of the trust fund with liabilities for incurred but unpaid benefits (and related administrative expenses) is shown in a later section.

The net increase in the par value of the investments held by the fund during fiscal year 1975 amounted to $148 million. New securities at a total par value of $3,660 million were acquired during the fiscal year, through the investment of receipts and reinvestment of funds made available from the redemption of securities. The par value of securities redeemed during the year was $3,513 million. Included in these amounts is $3,483 million in certificates of indebtedness that were acquired and redeemed within the fiscal year.

The effective annual rate of interest earned by the assets of the supplementary medical insurance trust fund during fiscal year 1975 was 7.1 percent. The interest rate on public-debt obligations issued for purchase by the trust fund in June 1975 was 7⅜ percent, payable semiannually.

TABLE 3.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1975

[Dollar amounts in millions]

Item	Actual amount	Comparison of actual experience with estimates for fiscal year 1975 published in—			
		1975 report		1974 report	
		Estimated amount	Actual as percentage of estimate	Estimated amount	Actual as percentage of estimate
Premiums from participants	$1,887	$1,868	101	$1,845	102
Government contributions	2,330	2,364	99	2,327	100
Benefit payments	3,765	3,816	99	3,623	104

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

TABLE 4.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, BY TYPE, AT THE END OF FISCAL YEARS 1974 AND 1975

	June 30, 1974		June 30, 1975	
	Par value	Book value [1]	Par value	Book value [1]
Investments in public-debt obligations sold only to this fund (special issues):				
Notes:				
5¾-percent, 1979	$232,150,000	$232,150,000.00	$232,150,000	$232,150,000.00
6⅛-percent, 1978	159,101,000	159,101,000.00	129,200,000	129,200,000.00
6⅝-percent, 1980	281,762,000	281,762,000.00	281,762,000	281,762,000.00
Bonds:				
7⅜-percent, 1981			11,547,000	11,547,000.00
7⅜-percent, 1982			11,547,000	11,547,000.00
7⅜-percent, 1983			11,546,000	11,546,000.00
7⅜-percent, 1984			11,546,000	11,546,000.00
7⅜-percent, 1985			11,546,000	11,546,000.00
7⅜-percent, 1986			11,547,000	11,547,000.00
7⅜-percent, 1987			11,547,000	11,547,000.00
7⅜-percent, 1988			11,547,000	11,547,000.00
7⅜-percent, 1989			11,547,000	11,547,000.00
7⅜-percent, 1990			73,510,000	73,510,000.00
7¼-percent, 1981	61,964,000	61,964,000.00	61,964,000	61,964,000.00
7¼-percent, 1982	61,964,000	61,964,000.00	61,964,000	61,964,000.00
7¼-percent, 1983	61,964,000	61,964,000.00	61,964,000	61,964,000.00
7¼-percent, 1984	61,964,000	61,964,000.00	61,964,000	61,964,000.00
7¼-percent, 1985	61,964,000	61,964,000.00	61,964,000	61,964,000.00
7¼-percent, 1986	61,963,000	61,963,000.00	61,963,000	61,963,000.00
7¼-percent, 1987	61,963,000	61,963,000.00	61,963,000	61,963,000.00
7¼-percent, 1988	61,963,000	61,963,000.00	61,963,000	61,963,000.00
7¼-percent, 1989	61,963,000	61,963,000.00	61,963,000	61,963,000.00
Total investments in public-debt obligations	1,230,685,000	1,230,685,000.00	1,378,214,000	1,378,214,000.00
Undisbursed balance		41,492,279.79		46,198,547.97
Total assets		1,272,177,279.79		1,424,412,547.97

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

Expected Operations and Status of the Trust Fund During the Period July 1, 1975 to December 31, 1978

Financing for the supplementary medical insurance program is established annually on the basis of standard monthly premium rates (paid by or on behalf of the participants) and adequate actuarial rates

(on which general revenue contributions are based) which are applicable to a period of July 1 thorugh the following June 30. Also, in recent years, allowable fee limits for physician services have been established to apply to the same July 1 to June 30 period. In the following statement of expected operations of the trust fund through December 31, 1978, it is assumed that this practice will be continued. There is, however, some ambiguity in the law regarding the timing of the updating of allowable fees. This ambiguity results from the change of the Federal Government fiscal year to an October 1 through September 30 basis.

Standard premium rates and adequate actuarial rates have been promulgated for periods through June 30, 1977. It has been assumed in this report that financing after that time will be established to cover the incurred expenses of the program.

The projections assume that allowable fees for physician services increased an average of 7.2 percent in July 1975 and will increase 10.0 percent in July 1976. The costs per enrollee for institutional services under part B are projected to increase 35 percent in fiscal year 1976 over 1975 and an additional 25 percent in the following twelve months. Further details of the projection assumptions and methodology are shown in Appendix B of this report.

Table 5 shows the projected operations of the trust fund on a fiscal year basis through fiscal year 1978. Table 5A shows the corresponding development on a calendar year basis. The trust fund is projected to decline through September 1976 to about $1 billion due primarily to cost increases higher than those anticipated when the fiscal year 1976 financing was established. The adequate rates for the period July 1, 1976 to June 30, 1977 have been promulgated with a specific margin to improve the status of the trust fund. As a result, the fund is shown to increase sharply to $1.9 billion by the end of fiscal year 1977.

TABLE 5.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), FISCAL YEARS 1976–78 AND ACTUAL DATA FOR 1967–1975

[In millions of dollars]

Fiscal year	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses	Interest on fund	Total income	Total expenditures	Balance in fund at end of year
Actual experience:								
1967	647	623	664	[2] 134	15	1,285	799	486
1968	698	634	1,390	143	21	1,353	1,532	307
1969	903	984	1,645	195	23	1,911	1,840	378
1970	936	928	1,979	217	12	1,876	2,196	57
1971	1,253	1,245	2,035	248	17	2,516	2,283	290
1972	1,340	1,365	2,255	288	29	2,734	2,544	481
1973	1,427	1,430	2,391	246	45	2,902	2,637	746
1974	1,704	2,029	2,874	409	76	3,809	3,283	1,272
1975	1,887	2,330	3,765	404	106	4,322	4,170	1,424
Estimate of future experience:								
1976	1,921	2,939	4,687	550	86	4,946	5,237	1,133
Interim [3]	528	878	1,416	131	19	1,425	1,547	1,011
1977 [4]	2,162	5,053	5,905	565	97	7,312	6,470	1,853
1978 [4]	2,369	5,348	6,918	657	135	7,852	7,575	2,130

[1] The payments shown as being from the general fund of the Treasury include certain interest-adjustment items.
[2] Administrative expenses shown include those paid in fiscal 1966 and 1967.
[3] Interim period is period from July 1 to Sept. 30, 1976.
[4] Beginning with fiscal year 1977 the fiscal year is the 12-month period ending with Sept. 30 of the year indicated.

TABLE 5A.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), CALENDAR YEARS 1976–78 AND ACTUAL DATA FOR 1966–75

[In millions of dollars]

Calendar year	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses	Interest on fund	Total income	Total expenditures	Balance in fund at end of year
Actual experience:								
1966	322	0	128	75	3	324	203	122
1967	640	933	1,197	110	24	1,597	1,307	412
1968	832	858	1,518	183	21	1,711	1,702	421
1969	914	907	1,865	196	18	1,839	2,061	199
1970	1,096	1,093	1,975	238	12	2,201	2,212	188
1971	1,302	1,313	2,117	260	24	2,639	2,377	450
1972	1,382	1,389	2,325	290	37	2,808	2,614	643
1973	1,550	1,705	2,526	318	57	3,311	2,844	1,111
1974	1,804	2,225	3,318	410	95	4,124	3,728	1,506
1975	1,918	2,648	4,273	462	106	4,673	4,735	1,444
Estimate of future experience:								
1976	2,016	3,752	5,174	534	103	5,871	5,708	1,607
1977	2,214	5,185	6,157	584	136	7,535	6,741	2,401
1978	2,421	5,577	7,183	673	173	8,171	7,856	2,716

[1] The payments shown as being from the general fund of the Treasury include certain interest-adjustment items.

Actuarial Status of the Trust Fund

1. ACTUARIAL SOUNDNESS OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

The concept of actuarial soundness, as it applies to the supplementary medical insurance program, is closely related to the concept as it applies to private group insurance. The supplementary medical insurance program is essentially yearly renewable term insurance intended to be self-supporting from premium income paid by the enrollees and from income contributed from general revenue in proportion to premium payments; in testing its actuarial soundness, it is not appropriate to look beyond the period for which the standard premium rate and the level of general revenue financing have been established. Financing has now been established through June 1977.

The primary test of actuarial soundness relates to the adequacy of the income for future years for which the premium rate and the level of general revenue financing have been established. The income for such years should be sufficient to meet the benefits incurred and associated administrative expenses for the period. The law requires the Secretary of Health, Education, and Welfare to establish the income on this basis.

A second test of actuarial soundness is whether the trust fund assets, at the end of the period for which the premium rate and the level of general revenue financing have been established, will be as large as the liabilities for services (and associated administrative expenses) that have been performed but for which reimbursement has not yet been made. This test will be met if the primary test of actuarial soundness has been met for all prior periods but it may not be met, even though the financing is currently adequate and the primary test is therefore met, if in the past the income was inadequate to meet incurred benefits and administrative expenses.

Even if these two tests of actuarial soundness are not met, the program can continue to operate if the trust fund remains at an adequate level to permit the payment of claims as presented.

2. INCURRED EXPERIENCE OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Both of the tests of actuarial soundness of the supplementary medical insurance program noted above rely on the incurred experience of the program. 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 lag between the time that services are performed and the time that payments for them are made.

The experience of the program is substantially more difficult to determine on an incurred basis than on a cash basis. In the early months of program operations, it appears that some bills containing errors were never resubmitted following correction. Payment for some services is reported only on a cash basis and the incurred experience must be inferred from the cash payment information. For recent time periods, the tabulations of bills are incomplete due to normal processing delays.

Finally, since bills are tabulated for only a sample of beneficiaries, the data is subject to bias and random fluctuation inherent in the sampling process.

Table 6 shows the estimated transactions of the trust fund on an incurred basis. For the reasons stated above, the incurred experience must be viewed as an estimate even for historical years. Various controls, such as cash outlay data, assure that the estimates are reasonably close, however.

Table 6 shows that income during fiscal years 1975 and 1976 is projected to be less than the cost of services rendered during those two years. This results from cost and utilization increases greater than those anticipated at the time the adequate rates for that period were determined. The adequate actuarial rate for the aged for the year ending June 30, 1977 contains a specific margin to amortize some of the deficit that results from the earlier underfinancing. Thus a surplus of income over outgo is shown for the year ending June 30, 1977.

TABLE 6.—ESTIMATED INCOME AND DISBURSEMENTS INCURRED UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, 12-MONTH PERIODS ENDING JUNE 30, 1967–77

[In millions of dollars]

12-month period ending June 30	Premiums from participants	Government contributions	Benefit payments	Administrative expenses	Interest on fund	Net of operations in year
Past experience:						
1967	647	647	1,109	[1] 190	15	10
1968	698	698	1,450	149	21	−182
1969	903	903	1,774	210	23	−155
1970	936	936	1,905	209	12	−230
1971	1,253	1,253	2,055	250	17	218
1972	1,340	1,340	2,264	289	29	156
1973	1,427	1,427	2,501	257	45	141
1974	1,704	2,031	3,163	450	76	198
1975	1,887	2,395	4,048	434	106	−94
Projected:						
1975	1,921	2,908	4,969	583	91	−632
1977	2,112	4,597	5,995	587	97	224

[1] Includes administrative expenses incurred prior to the beginning of the program.

3. ACCUMULATED SURPLUS OR DEFICIT OF THE PROGRAM

The liability outstanding at any time for the cost of services performed for which no payment has been made may be referred to as "benefits incurred but unpaid." Estimates of the amount of benefits incurred but unpaid as of June 30 of each year, and of the administrative expenses related to processing these benefits, appear in table 7.

For most years of the program, the trust fund has not been as large as the outstanding liabilities. Nonetheless, the fund has remained positive allowing claims to be paid. As of June 1974 the fund slightly exceeded the estimated liability for incurred but unpaid claims and associated administrative expenses and thus could be considered sound according to the second test of actuarial soundness stated earlier.

The financing deficit in fiscal 1976 referred to above is projected to result in a program deficit of $573 million by June 1976. However, the trust fund is projected to remain substantial and at an adequate level to permit the payment of claims.

Although the deficit is not expected to interfere with the operation of the program, it is still serious in that it indicates that liabilities are not being funded as they occur. Thus if the program should terminate or should the funding scheme be changed, there would not be sufficient assets available to pay for all services incurred to the date of the change.

Because of the margin included in the adequate actuarial rate for the aged for the year ending June 30, 1977, the trust fund is shown to grow both in absolute dollar amounts and as a percentage of liabilities during that year.

If experience develops as projected, it will be necessary to include margins in future adequate actuarial rates to return the trust fund to soundness on an incurred basis.

TABLE 7.—SUMMARY OF ESTIMATED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, ON JUNE 30, 1967-77

[In millions of dollars]

	Past experience as of June 30,									Projected as of June 30,	
	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977
A. Assets:											
Balance in trust fund	486	307	378	57	290	481	746	1,272	1,424	1,133	1,759
Government contributions due and unpaid	24	88	7	15	22	−3	−7	−5	60	34	0
Total assets	510	395	385	72	312	478	739	1,267	1,484	1,167	1,759
B. Liabilities:											
Benefits incurred but unpaid	445	505	634	560	580	589	699	988	1,271	1,553	1,886
Administrative cost thereon	56	62	77	69	71	72	83	124	154	187	219
Total liabilities	501	567	711	629	651	661	782	1,112	1,425	1,740	2,105
C. Net surplus (or deficit)	9	−172	−326	−557	−339	−183	−43	155	59	−573	−346
D. Ratio of assets to liabilities	1.02	.70	.54	.11	.48	.72	.95	1.14	1.04	.67	.84

4. SENSITIVITY TESTING

Some of the assumptions underlying the projection presented in this report are highly uncertain and variations in these assumptions would have a substantial impact on expenditures. In order to test the future

status of the program under varying assumptions a low cost projection and a high cost projection were prepared by varying these key assumptions. These assumptions and the resulting status of the trust fund are shown in table 8 along with the intermediate projection used in this report.

The average increase in allowable physician fees is made uncertain primarily by the recent introduction of an economic index which restricts the increase in prevailing fees. The intermediate projection assumes that this index will reduce average fee increases by approximately 2 percent each year. The low cost projection assumes that the index will have a greater effect (eventually a 3 percent reduction) and the high cost projection assumes that it will have a lesser effect (a 1 percent reduction).

Increases in the use of physician services per enrollee is projected to be near the long term historical level by 1977 in the intermediate projection. The low cost projection assumes that increases in utilization will drop below historical levels. The high cost projection assumes that the high increases experienced in fiscal years 1973 to 1975 will continue. A similar rationale underlies the selection of assumptions for outpatient hospital and home health services.

Table 8 indicates that under the low cost assumptions, the fund will exceed liabilities by June 1977. Under the high cost assumptions, the deficit will increase substantially but the trust fund will remain positive allowing claims to be paid.

TABLE 8.—ACTUARIAL STATUS OF THE SMI TRUST FUND UNDER 3 SETS OF ASSUMPTIONS FOR THE 12-MONTH PERIOD ENDING WITH JUNE OF THE YEAR SHOWN

	Intermediate projection (this report)		Low cost projection		High cost projection	
	1976	1977	1976	1977	1976	1977
Per enrollee increases over prior year in (percent):						
Physician fees	7.2	10.0	7.0	9.0	8.2	11.0
Physician utilization	4.0	3.0	3.0	2.0	6.0	6.0
Outpatient hospital and home health agencies	35.0	25.0	25.0	20.0	50.0	50.0
Assets as of June 30 (in millions)	$1,167	$1,759	$1,253	$2,097	$1,004	$964
Liabilities as of June 30 (in millions)	$1,740	$2,105	$1,695	$2,001	$1,825	$2,378
Assets minus liabilities (in millions)	−$573	−$346	−$442	$96	−$821	−$1,414
Ratio of assets to liabilities	67	84	74	105	55	41

Conclusion

The financing of the supplementary medical insurance program has been established through June 30, 1977 by the promulgation of standard monthly premium rates (paid by or on behalf of the enrollee) of $6.70 for the year ending June 30, 1976 and $7.20 for the year ending June 30, 1977 and adequate actuarial rates which determine the amount to be contributed from general revenue on behalf of each enrollee.

The rates for fiscal year 1976 are projected to be inadequate due to cost and utilization increases larger than anticipated at the time the rates were established. As a result, the trust fund is projected to decrease $291 million during fiscal year 1976 to a level of $1,133 million. The rates promulgated for the period July 1976 through June 1977 are projected to be sufficient to cover benefit and administrative costs incurred during that period and to make up part of the deficiency incurred during fiscal year 1976. Accordingly the trust fund is pro-

jected to increase by $626 million during the 12 month period ending June 1977 to a level of $1,759 million. The fund would then be 84 percent of program liabilities. The remaining deficit will have to be made up by margins in future adequate actuarial rates.

Under the intermediate assumptions used in this report, and under alternate, more pessimistic, assumptions the fund is projected to remain positive throughout the period for which financing has been established allowing claims to be paid as presented.

APPENDIX A

Statement of Actuarial Assumptions and Bases Employed in Determining the Monthly Adequate Actuarial Rates and the Standard Monthly Premium Rate for the Supplementary Medical Insurance Program Beginning July 1976 [1]

This is a statement of actuarial assumptions and bases employed in determining the adequate actuarial rates and the standard monthly premium rate for the supplementary medical insurance program for the period July 1976 through June 1977. The monthly adequate actuarial rate for enrollees age 65 and over is $10.70. The monthly adequate actuarial rate for disabled enrollees is $19.00. The standard premium monthly rate for both types of enrollees is $7.20.

I. ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

The law requires that the supplementary medical insurance (SMI) program be financed on an incurred basis. That is the income to the program during the 12-month period for which adequate rates are effective must be sufficient to pay for services (including associated administrative costs) rendered during that period even though payment for some of these services will not be made until after the close of the period. The portion of income required to cover those benefits not paid until after the close of the year is added to the trust fund until needed. Thus, the trust fund at any time should be equal to the cost of the benefits and administration incurred but not yet paid. Because the adequate rates are established prospectively, they are subject to projection error. As a result, the income to the program may not be equal to incurred costs and therefore the trust fund may not be equal to the value of incurred but unpaid expenses. Modest deficiencies in the trust fund balance do not interfere with the operation of the program if the fund is large relative to outlays and if future financing is established to correct the deficiencies. Table I summarizes the estimated actuarial status of the trust fund as of June 30, 1974, 1975, and 1976.

TABLE I

[Amounts in millions]

Year ending June 30	Fund at end of period	Liability for incurred but unpaid services	Fund-liabilities
1974	$1,272	$1,146	$126
1975	1,424	1,462	−38
1976	1,176	1,775	−599

[1] This statement appeared in the Federal Register of January 7, 1976. Projections shown in this statement differ slightly from the projections shown in the rest of this report because of minor changes in assumptions since the rates were promulgated.

The sizeable deficit shown at the end of fiscal year 1976 results from program cost increases substantially in excess of those anticipated in setting the adequate rates for 1976. In particular, outpatient hospital and home health costs per enrollee appear to have increased approximately 50 percent in 1975, well in excess of typical increases of 20 to 25 percent. Also, "utilization" of physician services appears to have increased at the rate of 6 percent per year in 1973 through 1975 after several years of 2–3 percent increases. ("Utilization" here, is measured indirectly and refers to increased costs per capita due to added visits, the use of more expensive services, and other factors not explained by simple price per service increases.) This deficiency must be considered in establishing the financing for subsequent years.

II. MONTHLY ADEQUATE ACTUARIAL RATES FOR ENROLLEES AGE 65 AND OLDER

The monthly adequate actuarial rate is one-half the monthly projected per capita cost for benefits and administrative expenses adjusted to allow for interest earninsg on the fund, to allow for a contingency margin, and to allow for amortization of the program surplus or deficit.

The monthly adequate actuarial rate for enrollees age 65 and older for the year ending June 30, 1977, was determined by projecting the fiscal year 1974 per capita cost by type of service. The projected cost for the years ending June 30, 1974, 1975, 1976, and 1977 are shown in table II. The 1974 values were established from program data. Subsequent years were projected using a combination of program data and data from external sources. The projection factors used are shown in table III.

TABLE II.—DERIVATION OF SMI AGED RATE REQUIRED FOR YEARS ENDING JUNE 30, 1974–77

	1974	1975	1976	1977
Covered services (at level recognized):				
Physicians' reasonable charges	$7.06	$8.11	$9.04	$10.25
Radiology and pathology	.32	.36	.39	.43
Group practice plans	.16	.18	.20	.22
Independent lab	.06	.07	.07	.08
Home health agencies	.08	.12	.17	.21
Outpatient hospital and other institutions	.89	1.33	1.80	2.25
Total services	8.57	10.17	11.67	13.44
Cost sharing:				
Deductible	−1.60	−1.64	−1.68	−1.73
Coinsurance	−1.31	−1.61	−1.89	−2.21
Total benefits	5.66	6.92	8.10	9.50
Administrative expenses	.65	.80	.88	.94
Incurred expenditures	6.31	7.72	8.98	10.44
Value of interest on fund	−.14	−.18	−.15	−.17
Margin for contingencies and to amortize unfunded liabilities	.13	−.84	−1.33	.43
Promulgated rate	6.30	6.70	7.50	10.70

TABLE III

[In percent]

	Year ending June 30		
	1975	1976	1977
Physicians' services:			
Fees[1]	8.4	7.2	10.0
Number and mix[2]	6.0	4.0	3.0
Outpatient hospital and home health agencies	50.0	35.0	25.0
Group practice plans	15.0	10.0	10.0
Other	10.0	10.0	10.0

[1] As paid by the program.
[2] Increase in the number of services received per capita and greater relative use of more expensive services.

There is some ambiguity created by the change in fiscal year (to an October through September basis) regarding the updating of the physician reasonable charge screens. This ambiguity affects the projection factor to be used for physician fees in the July 1976 to June 1977 period. This projection assumes that the screens will be updated in July 1976 based on calendar 1975 fees—the same procedure as has occurred in the past. Taken literally, the law implies that the screens would be updated in October 1976 based on calendar 1975 fees; but the screens for July to September 1976 are not defined. Presumably this ambiguity will be resolved by technical amendment during the next few months.

The projected monthly rate required to pay for benefits and administrative costs for the year ending June 30, 1977, net of interest is $10.27. The monthly actuarially adequate rate of $10.70 will allow approximately 40 percent of the $599 million projected deficit to be amortized between July 1976 and June 1977.

III. ADEQUATE ACTUARIAL RATE FOR THE DISABLED

The monthly adequate actuarial rate for disabled enrollees applies to persons eligible because they have been entitled to disability insurance benefits for not less than 24 months or because they are suffering from chronic renal disease. Data on an incurred basis are not yet complete enough to be used in the cost projection of these enrollees. From the cash payments it is possible to infer, at least approximately, the level of incurred costs for the disabled. Table IV summarizes the results of this procedure. The monthly rate required to pay for benefits and administrative costs for disabled beneficiaries for the year ending June 30, 1977, net of interest earnings is projected to be $19.08. The monthly actuarially adequate of $19.00 is appropriate in view of the excess amounts estimated for disabled enrollees in prior years.

TABLE IV.—DERIVATION OF SMI DISABLED RATE REQUIRED FOR YEAR ENDING JUNE 30, 1974–77

	1974	1975	1976	1977
Total benefits	$7.85	$10.89	$14.78	$17.63
Administrative expenses	3.08	1.34	1.62	1.75
Incurred expenditures	10.93	12.23	16.40	19.38
Value of interest on fund	−.09	−.27	−.27	−.30
Margin for contingencies and to amortize unfunded liabilities	3.66	6.04	2.37	−.08
Promulgated rate	14.50	18.00	18.50	19.00

IV. SENSITIVITY TESTING

Several factors contribute to uncertainty about future trends in medical care costs, notably, the recent deviations from long-term trends referred to above. In view of this, it seems appropriate to test the adequacy under alternative assumptions of the rates promulgated here. The most unpredictable factors which contribute significantly to future costs are outpatient hospital costs, physician utilization and the increase in physician fees as constrained by the reasonable charge screens and the newly implemented economic index. Two alternative sets of assumptions and the results of those assumptions are shown in able V. All assumptions not shown in table V are the same as in table III.

Table V indicates that under fairly optimistic assumptions the monthly rates promulgated will result in a surplus of $79 million by the end of June 1977. Under fairly pessimistic assumptions the deficit increases to $1,421 million but the trust fund remains positive allowing the program to continue paying claims as presented.

V. STANDARD PREMIUM RATE

The law provides that the standard monthly premium rate, promulgated in December to apply for both aged and disabled enrollees under the supplementary medical insurance program, shall be the lesser of:

A. The actuarial rate for enrollees age 65 and older; or

B. The standard monthly premium currently being charged, increased by the same percentage that old-age, survivors, and disability insurance benefits were increased since the May preceding the promulgation (and rounded to the nearer dime).

The standard monthly premium currently being charged is $6.70. The OASDI benefit table was increased 8 percent in June 1975. The $6.70 rate increased by 8 percent is $7.20 rounded to the nearer ten cent multiple. Since this is less than the $10.70 actuarial rate, the standard premium rate is $7.20 for the twelve months ending with June 1977.

TABLE V.—ACTUARIAL STATUS OF THE SMI TRUST FUND UNDER 3 SETS OF ASSUMPTIONS

	This projection		Low assumption		High assumption	
	1976	1977	1976	1977	1976	1977
Per enrollee increases in (percent):						
Physician fees	7.2	10.0	7.0	9.0	8.2	11.0
Physician utilization	4.0	3.0	3.0	2.0	6.0	6.0
Outpatient hospital and home health agencies	35.0	25.0	25.0	20.0	50.0	50.0
Trust fund as of June 30 (in millions)	$1,176	$1,798	$1,251	$2,119	$1,002	$991
Liabilities as of June 30 (in millions)	1,775	2,141	1,730	2,040	1,859	2,412
Trust fund, liabilities	−599	−343	−479	79	−857	−1,421

APPENDIX B

Actuarial Methodology and Principal Assumptions for Cost Estimates for the Supplementary Medical Insurance Program

1. SUMMARY OF THE METHODOLOGY

a. Aged beneficiaries

Estimates for aged beneficiaries are prepared by establishing, as accurately as possible, reasonable charges incurred per person in a recent year (fiscal 1974 for this report) and projecting these charges through the estimating period. The per capita charges are then converted to reimbursement amounts by subtracting out the per capita values of deductibles and coinsurance. Aggregate reimbursement amounts are calculated by multiplying the per capita values by the projected enrollment. Finally, in order to estimate the cash disbursements of the program an allowance is made for the delay between receipt of a service and payment therefor.

b. Disabled beneficiaries

Persons on the disability insurance rolls for at least 24 months and persons suffering from chronic kidney disease first became eligible for coverage under SMI in July 1973. The experience of these enrollees has not yet matured in the sense that their use of services is still increasing more rapidly than is expected in the long run and in the sense that an accurate historical series of their cost patterns can not be constructed from the sparse data so far available. Also, the number of covered chronic kidney disease patients is expected to continue to increase rapidly for the next few years. Therefore certain modifications in the projection methodology have been required for these beneficiaries and further modifications may be necessary in the future as experience emerges.

2. ESTIMATES FOR AGED BENEFICIARIES

a. Establishing a suitable base for projection

(1) Physician services: Reimbursement amounts for physician services (and a small amount of other services) are paid through fiscal intermediaries, referred to as carriers. The carriers determine whether billed services are covered under the program and the allowable charge for the service. The amount reimbursed after reductions for coinsurance and the deductible is transmitted to the Social Security Administration in the form of a payment record.

Payment records for 0.1 percent of aged beneficiaries are tabulated by date of service, thus putting the data base on an incurred basis. Having the data on an incurred basis makes it possible to meet the

statutory requirement that the program be financed on this basis and also makes possible comparison of program experience with non-program data sources.

Certain minor adjustments are made to the tabulated sample data to correct for biases and random fluctuation inherent in the sampling process. The incurred reimbursement amounts for fiscal year 1967 through 1974 are shown in table B1. Also shown are the average enrollment figures for each of those years and the average reimbursement per capita.

Finally as a check on the quality of the tabulations, the incurred expenses are compared with the cash expenditures reported by the carriers through an independent reporting system. In a program with continuously increasing expenditures it is to be expected that cash payments will be slightly lower than incurred expenses except in the first year when the difference should be substantial. These differences between cash and incurred expenses occur because of the lag between receipt of services and payment therefor. Table B1 also shows the cash expenditures related to services reported on payment records.

TABLE B1.—AGED BENEFITS PAID FOR SERVICES ON PAYMENT RECORDS

Fiscal year	Average enrollment (millions)	Incurred		Cash	
		Total (millions)	Per capita	Total (millions)	Per capita
1967	17.750	$1,056	$59.49	$632	$35.61
1968	18.038	1,335	74.01	1,312	72.74
1969	18.833	1,557	82.67	1,523	80.87
1970	19.312	1,665	86.22	1,652	85.54
1971	19.664	1,783	90.67	1,780	90.52
1972	20.043	1,956	97.59	1,959	97.74
1973	20.428	2,144	104.95	2,075	101.58
1974	20.988	2,412	114.92	(1)	(1)

[1] Allocation of cash payments between aged and disabled beneficiaries is not available for fiscal year 1974.

(2) Institutional services: Institutional services under part B of Medicare are paid by the same fiscal intermediaries that pay for part A services. The principal institutional services covered under part B are for outpatient hospital care and home health agency services.

Reimbursement for institutional services occurs in two stages. Provider bills are submitted to the intermediaries and an interim payment is made based on these bills. The bills are then submitted to SSA and tabulations are prepared in a manner parallel to that for payment records and for the same sample of beneficiaries.

At the close of the provider's accounting period, a cost report is submitted and lump sum payments or recoveries are made to correct for the difference between interim payments made to providers and their actual cost for providing services (net of coinsurance and deductible amounts). The amounts of these final settlements are reported on a cash basis and approximations are necessary to allocate these payments to time of service.

Table B2 shows the approximated total incurred reimbursement amounts and the actual cash expenditures as reported on both an interim and final settlement basis.

TABLE B2.—BENEFITS PAID FOR INSTITUTIONAL SERVICES

Services		Incurred		Cash			
Fiscal year	Average enrollment (millions)	Total (millions)	Per capita	Interim	Final	Total	Per capita
1967	17.750	$40	$2.25	$18.1	$0.1	$18.2	$1.03
1968	18.038	70	3.88	55.4	1.0	56.4	3.13
1969	18.833	120	6.37	91.5	4.7	96.2	5.11
1970	19.312	135	6.99	102.3	26.2	128.5	6.65
1971	19.664	175	8.90	111.9	50.4	162.3	8.25
1972	20.043	215	10.73	140.4	71.8	212.2	10.59
1973	20.428	265	12.97	160.3	71.2	231.5	11.33
1974	22.639	320	15.25	(1)	(1)	(1)	(1)

[1] Allocation of cash payments between aged and disabled beneficiaries is not available for fiscal year 1974.

(3) Other services: Certain group practice prepayment plans are reimbursed directly by the Social Security Administration on a cost basis. Data are available for these payments only on a cash basis and approximations must be made to assign expenses to the period when services were rendered.

Certain hospital based physicians are reimbursed through the hospital and payments are reported only on a cash basis. Again, the incurred cost must be approximated from the cash data.

b. Analysis of historical trends

Table B3 summarizes the incurred reimbursement amounts per capita for the various services described through fiscal year 1974. In order to analyze the historical trends in prices and use of services, these reimbursement amounts are converted to the reasonable charges or costs on which reimbursement was based. This is necessary largely because the fixed deductible becomes a smaller percentage of charges each year and thus causes reimbursement to rise faster than charges or costs.

Table B4 shows the covered charges per capita corresponding to the reimbursement values shown in Table B3.

TABLE B3.—SUMMARY OF AGED INCURRED BENEFITS PER CAPITA

Fiscal year	All services	Physician services [1]	Inpatient radiology and pathology [2]	Outpatient hospital	Home health agencies	Group practice plan
1967	$62.56	$59.49	----------	$1.48	$0.78	$0.81
1968	80.37	73.36	$1.89	2.47	1.41	1.24
1969	94.19	79.84	6.57	4.41	1.96	1.41
1970	98.67	83.11	7.14	5.49	1.50	1.43
1971	104.49	87.03	7.21	7.78	1.12	1.35
1972	112.94	93.82	6.77	9.68	1.04	1.63
1973	122.43	100.61	6.99	11.94	1.04	1.85
1974	135.67	110.17	7.78	13.75	1.50	2.47

[1] Includes all services on payment records (other than for inpatient radiology and pathology after 1967).
[2] Includes services on payment records and those using combined billing; amounts shown are for April 1968 and later when combined billings are authorized and inpatient radiology and pathology charges are reimbursed at 100 percent (see text).

TABLE B4.—INCURRED REASONABLE CHARGES OR COSTS PER CAPITA FOR THE AGED: PAST EXPERIENCE

Fiscal year	All services	Physician services [1]	Inpatient radiology and pathology [2]	Outpatient hospital	Home health agencies	Group practice plan
1967	$109.58	$104.20	----------	$2.59	$1.37	$1.42
1968	128.49	118.34	$1.89	3.98	2.28	2.00
1969	146.30	127.32	6.57	7.03	3.13	2.25
1970	152.40	131.90	7.14	8.71	2.38	2.27
1971	160.39	137.04	7.21	12.25	1.76	2.13
1972	171.75	145.79	6.77	15.04	1.62	2.53
1973	186.25	156.36	6.99	18.56	1.47	2.87
1974	205.52	170.66	7.78	21.30	1.95	3.83

[1] Includes all services paid on the basis of reasonable charges (except those for inpatient radiology and pathology after 1967).

[2] Includes services on payment records and those using combined billing; amounts shown are for April 1968 and later when combined billings are authorized and inpatient radiology and pathology charges are reimbursed at 100 percent.

c. Increase in per capita reasonable charges for physician services

Per capita charges for physician services are affected by a variety of factors. Some of these can be identified explicity. Others can only be recognized by the fact that the explicitly quantifiable factors do not explain all of the increase in per capita charges year to year.

(1) Charges: Increase in average charge per service is one of the important elements creating increasing charges per capita. The physician services component of the Consumer Price Index provides a reasonable estimate of the increase in charges per service. Increases in this index are shown in the first column of table B5.

Bills submitted to the carriers for payment are subject to reduction (according to statute) if they exceed the median charge that the physician assessed for that particular service in the calendar year preceding the fiscal year in which the bill is submitted. (This median charge is called the "customary" charge.) Bills are subject to further reduction if they exceed the prevailing charge for the locality. (Prevailing charge is defined as the 75th percentile of customary charges for a particular service in a particular area.) Prevailing charges may not be increased year to year more than the Secretary finds to be justified on the basis of economic index data. The customary and prevailing charge limits maintained by the carrier are called "fee screens". Recognized fees are the charges after they have been reduced by the fee screens.

The average reduction in submitted fees has increased each year due both to deliberate administrative actions and to differentials in the rate of increase of fees between the calendar year in which the screens are established and the fiscal year in which the screens are applied. The result is that the recognized fees have grown more slowly than submittd fees. Column 2 of table B5 shows the extent to which increases in submitted fees have been reduced each year by the screens. Column 3 shows the resulting increase in recognized fees.

(2) Residual effects: Per capita charges are also increased each year as a result of more physician visits per enrollee, increasing use of specialists and more expensive techniques and by other factors. Column 6 of table B5 shows the increase in charges per capita resulting from these residual causes. Because the measurement of increased recognized charges per service is subject to error, this error is also included under residual causes.

The proportion of claims that are denied for noncovered care has increased in most years. Changes in the denial rate can be identified

from program data and is shown in column 5 of table B5. Thus it is possible to see the growth rate of these residual elements without the distorting effects of denial changes. This increase rate is shown in column 4 of table B5. This column is used in the projection to indicate the amount of cost increases to be expected in the future from residual causes.

The last column of table B5 shows the total increase in charges per capita for services paid through carriers. It includes the effects of all the items discussed above.

TABLE B5.—COMPONENTS OF INCREASES IN REASONABLE CHARGES PER CAPITA FOR PHYSICIAN AND MISCELLANEOUS SERVICES[1]

[In percent]

Fiscal year	Actual fees	Effect of screens[2]	Recognized fees	Residual causes	Effect of denials[3]	Net residual	Recognized charge
1968	5.9	−0.6	5.3	9.7	−1.4	8.3	13.6
1969	6.2	−1.4	4.8	3.2	−0.4	2.8	7.6
1970	6.7	−2.8	3.9	2.8	−3.1	−0.3	3.6
1971	7.5	−3.1	4.4	2.7	−3.2	−0.5	3.9
1972	5.2	−1.2	4.0	2.0	+.4	2.4	6.4
1973	2.6	−0.5	2.1	5.8	−0.6	5.2	7.3
1974	5.0	−1.6	3.4	6.3	−0.6	5.7	9.1

[1] Increase over prior year.
[2] Change in reduction due to screen from previous to current year.
[3] Change in denials from previous to current year.

d. Per capita cost increases for other services

The historical increases in per capita cost for physician services and for other services covered by the program are shown in table B6. The year to year changes in some services are quite erratic and provide little guidance to future trends in these components.

e. Projected increases in recognized charges and costs per capita

(1) Physician services: The projection factors for the cost of physician services are shown in table B7. Column 1 shows the increase in recognized charges that are projected to result from the operation of the fee screens.

TABLE B6.—INCREASES IN REASONABLE CHARGES AND COSTS INCURRED PER CAPITA FOR THE AGED (AS RECOGNIZED BY THE PROGRAM)[1]

[In percent]

Year ending June 30	Physician services[2]	Inpatient radiology and pathology	Outpatient hospital	Home health agencies	Group practice plan
1968	13.6	----------	53.7	66.4	40.8
1969	7.6	−13.1	76.6	37.3	12.5
1970	3.6	8.7	23.9	−24.0	0.9
1971	3.9	1.0	40.6	−26.1	−6.2
1972	6.4	−6.1	22.8	−8.0	18.8
1973	7.3	3.2	23.4	−9.3	13.4
1974	9.1	11.3	14.8	32.7	33.4

[1] Increase over prior year.
[2] Includes all services paid for on the basis of reasonable charges except those for inpatient professional radiology and pathology.

As explained earlier, these screens are updated based on the experience of the calendar year preceding their implementation. After July 1, 1975 prevailing fees are to be limited by an economic index intended to represent increases in the cost of a physician's practice. There is not sufficient experience available at this time to be able to judge the final impact of this index. Presumably the effect will vary year to year depending on relative increases of recognized fees and the index itself. Based on the very limited evidence since July 1, 1975 and some information on historical values of components of the index, it is assumed that, on the average, the index will retard charge increases by about 2 percent each year. The residual increases through June 1976 are estimated mostly from cash flow experience through the date of this report. After that period the residuals are assumed to be close to the historical level.

(2) Other services: Table B8 shows the projected increases in charges or costs per capita for physician services and other services. The factors for non-physician services through June 1976 are chosen to be consistent with cash flow data through the time of this report. After that time the factors reflect historical levels of increases.

TABLE B7.—COMPONENTS OF INCREASES IN REASONABLE CHARGES PER CAPITA FOR PHYSICIAN AND MISCELLANEOUS SERVICES[1]

[In percent]

Year ending June 30	Actual fees with fee screens	Effect of economic index[2]	Recognized fees	Net residual	Recognized charges
1975	8.4	0	8.4	6.6	15.0
1976	9.2	−2	7.2	4.3	11.5
1977	12.0	−2	10.0	3.3	13.3
1978	8.3	−2	6.3	3.2	9.5
1979	8.0	−2	6.0	3.2	9.2

[1] Increase over prior year.
[2] Percentage by which the economic index reduces the average rate of increase in recognized fees in the year.

TABLE B8.—PROJECTED INCREASES IN RECOGNIZED CHARGES AND COSTS INCURRED PER CAPITA FOR THE AGED[1]

[In percent]

Year ending June 30	Physician services[2]	Inpatient radiology and pathology	Outpatient hospital	Home health agencies	Group practics plane
1975	15.0	10	50	50	15
1976	11.5	10	35	35	10
1977	13.3	10	25	25	10
1978	9.5	10	20	10	10
1979	9.2	10	20	10	10

[1] Increase over prior year.
[2] Includes all services paid on the basis of reasonable charges except those for inpatient professional radiology and pathology.

(3) Aggregate benefits: Table B9 shows the per capita charges or cost for fiscal year 1974 as shown earlier in this report and the projections of those charges or costs based on the assumptions in table B8.

TABLE B9.—INCURRED RECOGNIZED CHARGES AND COSTS PER CAPITA FOR THE AGED: PROJECTION

Year ending June 30	All services	Physician services [1]	Inpatient radiology and pathology	Outpatient hospital	Home health agencies	Group practice plan
1975	$244.16	$196.27	$8.56	$32.00	$2.93	$4.40
1976	280.22	218.80	9.42	43.20	3.96	4.84
1977	322.47	247.84	10.36	54.00	4.95	5.32
1978	358.87	271.37	11.40	64.80	5.45	5.85
1979	399.04	296.30	12.54	77.76	6.00	6.44

[1] Includes all services paid on the basis of reasonable charges except those for inpatient radiology and pathology.

Table B 10 shows the total reimbursement amounts per capita that result from substracting the average amounts of copayment per period from the total covered charges in table B9.

TABLE B10.—PROJECTED BENEFITS INCURRED PER CAPITA [1]

Year ending June 30	Benefits incurred
1975	$166.19
1976	194.58
1977	227.90
1978	256.44
1979	288.00

[1] For aged beneficiaries only.

Finally, the aggregate expenditures for aged beneficiaries are derived by multiplying average enrollment by average reimbursement for benefits. Table B11 shows this calculation. Table B11 also shows the cash outlays that result from allowing for the lag between time of service and time of payment.

TABLE B11.—PROJECTION OF AGGREGATE INCURRED BENEFITS AND CASH BENEFITS PAID FOR THE AGED

Year ending June 30	Average enrollment (millions)	Benefits incurred		Fiscal year	Aggregate benefits paid (millions)
		Per capita	Aggregate (millions)		
1975	21.471	$166.19	$3,568	1975	$3,335
1976	21.889	194.58	4,259	1976	4,034
1977	22.281	227.90	5,078	Interim	1,203
1978	22.684	256.44	5,817	1977	5,003
1979	23.074	288.00	6,645	1978	5,777

3. COST ESTIMATES FOR THE DISABLED AND PERSONS SUFFERING FROM CHRONIC KIDNEY DISEASE

Persons who have been entitled to disability insurance benefits for at least two years and certain persons suffering from chronic kidney disease have been eligible for part B coverage since July 1973.

It is not possible at this point to determine very accurately the level of utilization to be anticipated from disabled beneficiaries. Cash outlays for these beneficiaries appear to have stabilized near the end of fiscal year 1975 and into the early months of fiscal year 1976.

Therefore, projections shown at the top of table B12 are based on the same projection factors used for the aged (except for population) after fiscal year 1976. The 1975 and 1976 estimates are based largely on cash flow data available through the time of this report.

The projected costs for those beneficiaries entitled only on the basis of chronic kidney disease are shown at the bottom of table B12. Again, coverage of these beneficiaries is too recent to provide a good historical basis for projections. Some information is available on the proportions of beneficiaries using various facilities and the cost of the different forms of treatment. This information has been combined with a population model for this group to prepare the estimates shown. The results of this procedure appear reasonable compared to cash flow information to date.

TABLE B12.—PROJECTION OF AGGREGATE INCURRED BENEFITS AND CASH BENEFITS PAID FOR DISABLED ENROLLEES AND THOSE WITH CHRONIC KIDNEY DISEASE

12-month period ending June 30	Average enrollment (thousands)	Benefits incurred		Fiscal year	Aggregate benefits paid (millions)
		Per capita	Aggregate (millions)		
A. Disabled enrollees:					
1975	1,824	$178.18	$325	1975	$293
1976	1,985	250.60	497	1976	458
1977	2,149	299.50	644	Interim	149
1978	2,366	343.48	813	1977	632
1979	2,581	393.46	1,016	1978	806
B. Enrollees with chronic kidney disease:					
1975	13	11,923.08	155	1975	137
1976	16	13,312.50	213	1976	195
1977	18	15,166.67	273	Interim	64
1978	20	16,900.00	338	1977	270
1979	22	18,727.27	412	1978	335

4. ADMINISTRATIVE EXPENSES

In developing incurred administrative expenses, it is assumed that the expense required to settle incurred but unpaid claims would be approximately the same on a percentage basis as required to settle paid claims. The projected cash administrative expenses are shown in table B13 and the historical and projected ratios of paid administrative expenses to paid claims in table B14.

TABLE B13.—PROJECTED ADMINISTRATIVE EXPENSES PAID IN FISCAL YEARS 1975–78

Fiscal year	Amount (millions)
1975	$404
1976	550
Interim	131
1977	565
1978	657

TABLE B14.—RATIO OF ADMINISTRATIVE EXPENSES TO BENEFIT PAYMENTS

Fiscal year	Cash basis
Actual experience (for all enrollees):	
1967	202
1968	103
1969	119
1970	110
1971	122
1972	128
1973	103
1974	142
1975	108
Projected (for all enrollees):	
1976	117
Interim	093
1977	096
1978	095