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THE 1967 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

LETTER

FROM

THE BOARD OF TRUSTEES,
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

TRANSMITTING

THE 1967 ANNUAL REPORT OF THE BOARD OF TRUSTEES, PURSUANT TO THE PROVISIONS OF SECTION 1841(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

FEBRUARY 28, 1967.—Referred to the Committee on Ways and Means and ordered to be printed

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LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE
FEDERAL SUPPLEMENTARY MEDICAL
INSURANCE TRUST FUND,
Washington, D.C., February 28, 1967.

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

SIR: We have the honor to transmit to you the 1967 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, in compliance with the provisions of section 1841(b) of the Social Security Act, as amended, which is the second such report.

Respectfully,

JOSEPH W. BARR,
Acting Secretary of the Treasury, and
Acting Managing Trustee of the Trust Fund.

W. WILLARD WIRTZ,
Secretary of Labor.

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

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

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THE 1967 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

The Board of Trustees

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

Fiscal Year Highlights

Benefit protection and premium collection under the supplementary medical insurance program did not begin until after the close of the fiscal year covered by this report. As of July 1, 1966, approximately 17.6 million persons had enrolled in the supplementary medical insurance program (about 92 percent of those aged 65 or over on that date).

Legislation in 1965

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 is as follows:

I. COVERAGE PROVISIONS (FOR CONTRIBUTION AND BENEFIT PURPOSES)

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

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

(c) Persons failing to enroll in initial period can enroll in next general enrollment period (October to December of each odd-numbered

year), to be effective the next July; only one opportunity to enroll in this way.

(d) Termination of enrollment: Either by failure to pay premiums (for premiums not deducted from benefits) or by election to do so during a general enrollment period; individual who terminates coverage may reenroll within 3 years if he does so in a general enrollment period, with reenrollment permitted only once.

II. BENEFITS PROVIDED

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

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

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

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

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

(f) Effective date July 1, 1966.

III. FINANCING

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

enrolling late or reenrolling after terminating enrollment (10 percent additional for each full year of nonparticipation).

(b) Government contributions: Amount equal to total premiums of participants. An amount equal to 6 months' Government contributions for all eligible to participate on July 1, 1966, is to be made available as a contingency reserve on a non-interest-bearing loan basis until December 31, 1967.

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

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

Legislation in 1966

The only legislation having a significant effect on the benefit provisions or the financing provisions of the supplementary medical insurance program during 1966 was Public Law 89–384, approved April 8, 1966. This law amended the Social Security Act by extending—from March 31, 1966, to May 31, 1966—the deadline for voluntary individual election of coverage (which would be effective July 1, 1966) for persons who attained age 65 before 1966. Conforming changes were also made for persons attaining age 65 in 1966, but before July 1.

Nature of the Trust Fund

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

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

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

The managing trustee invests that portion of the trust fund which, in his judgment, is not required to meet current expenditures for benefits and administration. The Social Security Act restricts permissible investments of the trust funds to interest-bearing obligations of the U.S. Government or to obligations guaranteed as to both principal and interest by the United States. Obligations of these types may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price. In addition, the Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall have maturities fixed with due regard for the needs of the trust fund and shall bear interest at a rate based on the average market yield (computed by the managing trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month. Where such average market yield is a multiple of one-eighth of 1 percent, this is taken as the rate of interest on such special obligations; otherwise, such rate is the multiple of one-eighth of 1 percent nearest such market yield.

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

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

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

Expected Operations and Status of the Trust Fund During the Period July 1, 1966, to June 30, 1969

In the following statement of the expected operations and status of the supplementary medical insurance trust fund during the period July 1, 1966, to June 30, 1969, it is assumed that present statutory provisions affecting the supplementary medical insurance program remain unchanged throughout the period. The disbursements of the program are affected by medical and economic factors as well as by legislative provisions. Because it is difficult to foresee economic and social developments, as well as developments in medical science, the assumptions and the resulting estimates presented here are subject to some uncertainty.

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

As of July 1, 1966, approximately 17,600,000, or 92 percent of an estimated 19,150,000 persons aged 65 or over in the United States (including outlying areas) on that date, were enrolled in the supplementary medical insurance program. Some enrollees terminate coverage as a result of death, while a few (so far less than 5 percent of those paying directly) have their coverage terminated for nonpayment of premiums. On the other hand, persons attaining age 65 after July 1, 1966, are eligible to enroll. It is assumed that the net effect of these factors will be that the enrollment in the program averages 90 percent during the 3 fiscal years 1967 to 1969. This percentage is slightly higher than the average of the high and low assumptions initially used; namely, 87½ percent.

The following statement of the expected operations of the trust fund should be read with full recognition of (a) the limited amount of data available for making cost estimates for this new program, (b) the difficulties of estimating future trust fund disbursements under changing economic conditions, and (c) the assumption that the $3 standard premium rate is effective for the last 18 months of the period considered.

Estimates are presented in table 1 to show the expected operations of the trust fund in fiscal years 1967 to 1969. The estimates of disbursements are based on the same assumptions as to benefit payments and administrative expenses per capita as used for the 1966 trustees report (and used at the time that the 1965 amendments were pending in Congress). Several economic and administrative developments have occurred subsequently, which indicate that certain of these assumptions were incorrect. However, the effect of altering these assumptions in light of such developments is small as compared to the possible margin of error in the aggregate as to the overall level of benefits and administrative expenses, due to the paucity of available reliable operating data upon which to base such estimates. The estimates are based on the assumption that economic activity will expand throughout the period and that medical-care costs will increase steadily at the same rate as in the immediate past.

TABLE 1.—*Estimated future operations of the supplementary medical insurance trust fund, fiscal years 1967–69*

[In millions]

Item	1967	1968	1969
Income:			
Premiums from participants	$623	$634	$641
Contributions from general fund of Treasury	623	634	641
Interest on investments [1]	9	13	14
Disbursements:			
Benefit payments	861	1,121	1,194
Administrative expenses [2]	[3] 134	130	135
Net increase in fund	260	30	−33
Fund at end of year	260	290	257

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

NOTE.—Program starts operation as to benefit payments and income receipts at beginning of fiscal year 1967. It is assumed that the $3 monthly premium rate applies throughout the entire period, although it is subject to change effective with January 1968 (i.e., for the 2d half of fiscal year 1968 and thereafter). Not included above is the advance appropriation from the general fund of the Treasury that is to provide a contingency reserve during the period July 1966 through December 1967 (to be used only if needed and to be repayable). In interpreting the estimates, reference should be made to the accompanying text which describes the underlying assumptions. Estimates were prepared in January 1967.

Small increases in estimated premium income from participants are expected in fiscal years 1968 and 1969, reflecting the increasing population aged 65 or over. Benefit disbursements increase sharply from fiscal year 1967 to 1968, due to the period necessarily involved between the date the services are performed and the date when payment is made from the trust fund (so that in the first year of operation, this lag results in relatively low outgo on a cash disbursements basis). Also, claims will be somewhat lower in fiscal 1967 due to the application of the full deductible in the first half of that year and again in the second half (to the extent that there is no carryover). It is assumed that payment from the trust fund with respect to a particular claim will be made at the time that it is approved by the carrier. Also contributing to the increase in benefit disbursements from fiscal year 1967 to 1968 (and contributing to the increase from fiscal year 1968 to 1969) are several other factors—a larger number of persons being covered and the assumed long-range upward trend in the cost of medical care.

Income of the trust fund is expected to exceed outgo in each of the 2 fiscal years 1967 and 1968 and to be slightly less than outgo in fiscal 1969, under the assumptions made. During this period, there is an estimated net increase in the trust fund of $257 million, virtually all of which occurs in the first year (the net increase in the second year being almost exactly counterbalanced by the net decrease in the third year). The foregoing figures are on a cash basis, rather than on an accrual basis. An essential difference between the financing of the supplementary medical insurance program and social insurance systems (such as the hospital insurance program) is its voluntary character. It is possible that large numbers of persons could terminate enrollment during an enrollment period. Consequently, the premium rate charged must cover the cost of all services received during the premium-payment period, before the termination of eligibility, even though the claims for the cost of such services furnished during the

last few months before termination will generally not be paid until after the date of termination. Thus, the premium rate for a 2-year period must cover the costs of all services and administrative expenses pertaining to that period—i.e., it must be determined on an accrual or incurred basis.

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

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

As stated previously, the estimates of benefit payments and administrative expenses per capita are those used in the 1966 trustees report. Since these estimates were prepared, there have been several developments which indicate that the assumptions used in these estimates were incorrect. For example, it was assumed that physicians' charges would increase at the same rate as the average earnings of employed persons and that such increase would average 3.2 percent per year. During 1966, however, average earnings rose at a much faster pace, and there is some evidence that physicians have raised their fees at a rate comparable to such rise in average earnings, which is higher than the original estimated increase and is, therefore, a factor tending to produce an increase in the premium rates.

It was assumed in the original cost estimates that the carriers would use the same administrative procedures as are employed by the most efficient insurers on their large group cases. However, the administrative procedures that have been adopted are somewhat more complex and detailed than had been originally envisioned, in that they consider more factors in establishing the benefit payments, so that administrative expenses may be somewhat higher than originally estimated.

The effect of alteration of the foregoing assumptions would be small, however, compared to the margin of error possible in the basic assumptions concerning benefits per capita. It was in recognition of such possible errors that Congress authorized the appropriation of a contingency reserve. Final calculations of the cost of the program will not be possible until all claims for services performed during calendar year 1966 have been submitted and processed. There will still be the problem of estimating the number who did not accumulate $50 in eligible expenses during July to December 1966, but who would have had enough for a claim if they had been covered for a full calendar year.

The trust fund balances shown in table 1 do not include the contingency reserve that is established by an appropriation from the general fund of the Treasury and is to be available until December 31, 1967. The size of this reserve is to be $18 times the estimated number of persons eligible to participate in the program on July 1, 1966, if they

had so elected. Any amounts used from this contingency reserve are to be repayable, without interest, to the general fund of the Treasury. Based on 19.0 million eligibles, the size of this contingency reserve should be $342 million; $100 million of this amount was appropriated in the fiscal year 1966. Under the estimates presented in table 1, it will not be necessary to draw upon this contingency reserve.

Actuarial Status of the Trust Fund

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

Two estimates of the progress of the supplementary medical insurance trust fund for the calendar years 1966–68 are shown in table 2. These estimates use low-cost and high-cost assumptions, respectively. For calendar years 1966–67, the estimates are those which were derived at the time that the 1965 amendments were enacted, except that a 90-percent participation rate is used (rather than alternative assumptions of 80 and 95 percent). The 1968 estimates are an extension of those for 1966–67 and are based on the premise that the standard premium rate of $3 per month, which is applicable in 1966–67, will be continued beyond 1967. Table 2 also shows the actual experience for calendar year 1966.

Table 2.—*Estimated progress of supplementary medical insurance trust fund, calendar years 1966–68, and actual data for 1966*

[In millions]

Calendar year	Premiums from participants	Government contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
	Actual experience					
1966	$322	0	$128	[1] $74	$2	$122
	Low-cost estimate					
1966	$308	$308	$242	[1] $75	$6	$305
1967	627	627	1,005	94	15	475
1968	637	637	1,072	96	21	602
	High-cost estimate					
1966	$308	$308	$383	[1] $95	$3	$141
1967	627	627	1,194	105	5	101
1968	637	637	1,274	106	2	−3

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

Note.—Not included above is the advance appropriation from the general fund of the Treasury that provides a contingency reserve during 1966–67 (to be used only if needed and to be repayable). The 1968 estimates assume that the standard premium rate of $3 per month continues beyond 1967.

A significant balance was estimated to develop in the trust fund in 1966 under both estimates, due to the lag in benefit payments that results from the delay in presenting claims and in administrative processing. The income from premium payments by individuals went into the trust fund beginning in the early part of July 1966; in the cost estimates, it was assumed that the matching Government contributions would go into the trust fund simultaneously.

Under the low-cost estimate, the trust fund is estimated to have a balance of $305 million at the end of 1966, $475 million at the end of 1967, and $602 million at the end of 1968. On the other hand, under the high-cost estimate, the balance in the trust fund at the end of 1966 is estimated at $141 million, $101 million at the end of 1967, and to be exhausted at the end of 1968. These balances, however, will have developed on a "cash disbursements" basis, rather than on an "accrual" basis, and will be smaller than the then-existing liability for incurred but unpaid claims. Not included in the foregoing figures is the $100 million that was actually appropriated out of the $342 million that is established as a potential contingency reserve, which is on the basis of an advance, repayable appropriation from the general funds of the Treasury.

The actual experience as to benefit disbursements and premium income in calendar year 1966, of course, covers only the last 6 months of the year and is not typical because of the unique conditions that usually occur at the beginning of operations of any new program. The actual premiums collected from the participants, amounting to $322 million, were about 5 percent above the estimate. In accordance with the general basis of the supplementary medical insurance program, it was estimated that an equal amount to the premiums from the participants would be appropriated as Government contributions, but in actuality no appropriations from this source were transferred during the calendar year (the appropriation was enacted toward the close of the year, but no actual transfer was made until January 1967, when about $366 million was transferred to the trust fund, which amount closely approximated the participant premiums for July 1966 through January 1967).

The actual benefit payments in calendar year 1966 totaled $128 million, approximately half of the low-cost estimate and one-third of the high-cost estimate. This significant difference is primarily due to the administrative lag (in filing claims and in the adjudicative process) that arose in making the benefit payments and cannot be considered to be indicative of actual incurred costs being so much lower than the estimates. In fact, at this point (and until detailed analyses can be carried out), no statement can be made with certainty as to whether the actual cost experience is nearer to the low-cost estimate or to the high-cost estimate. It is of interest to note that benefit payments for December 1966 amounted to $48 million. If this rate had prevailed during the 6 months that the program was in operation, the benefit disbursements would have been $288 million, or 89 percent of the income in premiums from participants.

The actual administrative expenses in calendar year 1966 were about $74 million, which was almost exactly the same as the low-cost estimate. However, the major part of the administrative expenses is the cost of processing claims. Due to the considerable administrative lag and to the unknown, but sizable, proportion of claims not

yet presented for payment, a large proportion of the administrative expenses attributable to medical services performed in 1966 have also not occurred. Thus, it appears that administrative expenses with respect to services performed in 1966 will be somewhat above those in both the low-cost and high-cost estimates. Further, about half of the estimated administrative expenses shown for 1966, or $40 to $45 million, represented such expenses after June 30, but of the $74 million of actual administrative expenses in 1966, $51 million was for this period. This indicates that the expenses of administering the program in the last half of 1966 were 10 to 20 percent higher than the estimates.

The balance in the supplementary medical insurance trust fund on December 31, 1966 was $122 million, which is about 10 percent below the corresponding figure in the high-cost estimate and less than half of the corresponding figure in the low-cost estimate. This result occurred essentially because the absence of Government-contribution receipts during the year more than offset the low level of benefit payments that resulted from administrative lag. The picture in the ensuing months of 1967 will be considerably changed because both of these elements will be altered, and it is difficult to say what the net effect will be on actual future trust fund balances as compared with the estimates.

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

Conclusion

The current actuarial cost estimates for the supplementary medical insurance program indicate that its premium rate is adequate to meet the benefit payments and administrative expenses for at least the first 1½ years of operation, July 1966 through December 1967. The premium rate for subsequent years can be adjusted by the Secretary of Health, Education, and Welfare in accordance with the developing experience.

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

A contingency reserve is authorized to be appropriated from the general funds of the Treasury and is to be available through 1967. In accordance with the provisions of the law, the amount to be appropriated has been determined to be $342 million; however, only $100 million was actually appropriated in 1966. If any of this contingency reserve is used, it is repayable, without interest. This is to serve as a safeguard that the benefit payments will be made. The actuarial cost estimates indicate that there will be no need to make use of this contingency reserve. Rather, under all cost estimates, a sizable balance in the trust fund will be accumulated; however, under the high-cost estimate, this balance will have developed on a "cash

disbursements" basis, rather than on an "accrual" basis, and will be smaller than the liability for incurred but unpaid claims, but under the low-cost estimate there will be a favorable balance on an "accrual" basis as well as on a "cash disbursements" basis. Accordingly, it may be said that the short-range actuarial status of the program is favorable under the initial premium rate established by the 1965 amendments.

APPENDIXES

Appendix I. Assumptions, Methodology, and Details of Cost Estimates

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

Benefit cost assumptions

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

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

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

Relative future trends of medical costs

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

Administrative expenses

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

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

Interest rate

An interest rate of 4 percent is used in developing the progress of the trust fund during the first few years of operation for which computations are made. This rate is applied to the total assets of the trust fund, thus recognizing that only part of the assets will be invested (although probably at an interest rate of about 5 percent—based on current rates available). A higher or lower rate would not significantly affect the financing of the program, which is on a current-cost basis, with a fund being accumulated only for contingencies.

Timing of benefit payments

The estimates of benefit payments under the low-cost estimates are based on the assumption that, because of the effect of the $50 deductible and the lag in the presentation of claims and the approval thereof by the carriers, the net effect is the same as though only 3 months of benefit costs are met during calendar year 1966. This means that the accrued liability at the end of the year is another 3 months of benefit costs. In the high-cost estimate, the same procedure is followed except that the estimated benefit disbursements in calendar year 1966 represent 4 months of benefit costs, with the accrued liability at the end of the year for incurred but unpaid claims amounting to 2 months of benefit costs.

Total per capita costs of benefit payments and administrative expenses

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

For both cost estimates, it is necessary to keep in mind that the costs for starting up the program which are incurred in the last half of 1965 and in the first half of 1966 have to be met from the financing available through the premiums from the participants and the contributions from the Federal Government.

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

APPENDIX II. LEGISLATIVE HISTORY AFFECTING THE TRUST FUND

Board of Trustees.—Beginning with July 30, 1965, when the Federal supplementary medical insurance trust fund was established, the three members of the Board of Trustees, who serve in an ex officio capacity, have been the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. Since the establishment of the fund, the Secretary of the Treasury has been managing trustee. The Commissioner of Social Security has been secretary of the Board of Trustees. The Board of Trustees meets not less frequently than once each 12 months.

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

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

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

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

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

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

FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1841. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

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

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

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

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

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund.

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

(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

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

(f) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(g) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

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

PAYMENT OF PREMIUMS

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

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

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

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance

Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

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

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

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

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

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

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

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

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1967 for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in

July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

ADVISORY COUNCIL ON SOCIAL SECURITY FINANCING

SEC. 706. (a) During 1968 and every fifth year thereafter, the Secretary shall appoint an Advisory Council on Social Security for the purpose of reviewing the status of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund in relation to the long-term commitments of the old-age, survivors, and disability insurance program and the programs under parts A and B of title XVIII, and of reviewing the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs under this Act.

(b) Each such Council shall consist of the Commissioner of Social Security, as Chairman, and 12 other persons, appointed by the Secretary without regard to the civil service laws. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public.

(c)(1) Any council appointed hereunder is authorized to engage such technical assistance, including actuarial services, as may be required to carry out its functions, and the Secretary shall, in addition, make available to such Council such secretarial, clerical, and other assistance and such actuarial and other pertinent data prepared by the Department of Health, Education, and Welfare as it may require to carry out such functions.

(2) Appointed members of any such Council, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government employed intermittently.

(d) Each such Council shall submit reports of its findings and recommendations to the Secretary not later than January 1 of the second year after the year in which it is appointed, and such reports and recommendations shall thereupon be transmitted to the Congress and to the Board of Trustees of each of the Trust Funds. The reports required by this subsection shall include—

(1) a separate report with respect to the old-age, survivors, and disability insurance program under title II and of the taxes imposed under sections 1401(a), 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.

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