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1972 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

L E T T E R

FROM

BOARD OF TRUSTEES, FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

TRANSMITTING

THE 1972 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE TRUST FUND, PURSUANT TO SECTION 1841(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND
Washington, D.C., April 1972.

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

SIR: We have the honor to transmit to you the 1972 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the seventh such report), in compliance with the provisions of Section 1841(b) of the Social Security Act, as amended.

Respectfully,

JOHN B. CONNALLY,
Secretary of the Treasury,
and Managing Trustee of the Trust Funds.

J. D. HODGSON,
Secretary of Labor.

ELLIOT L. RICHARDSON,
Secretary of Health, Education, and Welfare.

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

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1972 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 1972, the seventh such report.

HIGHLIGHTS

The more important developments since the 1971 report, all of which are discussed in more detail in later sections, are indicated below:

(*a*) The growth of the supplementary medical insurance trust fund during fiscal year 1971 was close to that predicted in the 1971 Report. Income for fiscal1971 of $2.5 billion was up about 34 percent from fiscal 1970. This increase was due mainly to the increase in the standard premium rate from $4 in fiscal 1970 to $5.30 in fiscal 1971. Benefit payments were $2.0 billion in fiscal 1971, an increase of 2.8 percent over fiscal 1970. This increase is abnormally low, however, due to a large extraordinary transfer from the supplementary medical insurance trust fund to the hospital insurance trust fund in fiscal year 1970. In the absence of such transfers, the increase would have been about 10 percent. Administrative expenses continued to increase both in amount and as a percentage of benefits paid, as a result the increased administrative actions on the part of carriers to implement and improve on claims review procedures. The $5.30 premium rate promulgated for fiscal 1971 has proved more than adequate due both to the larger than normal contingency margin included as a result of the inadequate trust fund of only $57 million at the end of fiscal 1970 and to lower benefit payments than anticipated. There has consequently been an improvement in the balance in the trust fund, which grew to $290 million by the end of fiscal 1971. The cash position has continued to improve during the first half of fiscal 1972 bringing the trust fund balance to $450 million on December 31, 1971. The trust fund balance is expected to increase during the remainder of fiscal 1972 as a result of the expected adequacy of the $5.60 standard premium rate promulgated for fiscal year 1972.

(*b*) The solvency of the trust fund, which must be measured on an accrued basis, also improved during fiscal 1971 (as did the cash basis referred to above), but was still in a deficit position at the end of that year. The estimate of claims incurred but not yet paid and the administrative expenses related thereto increased from $823 million at the end

of fiscal 1970 to $894 million at the end of fiscal 1971. This increase is due mainly to the increased cost per service for medical services performed prior to June 30, 1971 but for which no reimbursement had yet been made.

The trust fund balances are available to partially offset these outstanding liabilities. Because the trust fund balance increased from $57 million to $290 million during fiscal 1971, the amount of incurred benefit payments and administrative expenses left unfunded decreased from $766 million to $604 million during the same period. The unfunded liability is expected to decrease further during fiscal 1972 assuming that the $5.60 premium rate proves to be slightly more than adequate to cover incurred costs during the period, as expected at the time of promulgation.

(*c*) In December 1971, the standard premium rate for fiscal year 1973 was promulgated at $5.80 per month. The $5.80 premium rate level reflects the decision of the Price Commission under the Economic Stabilization Program to limit the increase in physician fees and in the recognized reasonable charges as determined under the fee screens to a rate of 2½ percent per year in the aggregate, after the wage-price freeze in 1971. Appendix I gives a statement of the actuarial assumptions and bases employed by the Secretary of Health, Education, and Welfare in determining this premium rate.

(*d*) The report of the 1971 Advisory Council on Social Security was completed, and its recommendations concerning the financing of the supplementary medical insurance program were carefully evaluated and are discussed subsequently.

SOCIAL SECURITY AMENDMENTS SINCE THE 1971 REPORT

There have been no amendments affecting the Federal Supplementary medical insurance trust fund since the passage of Public Law 90-248, approved on January 2, 1968.

Legislation which would substantially modify the current law was introduced into the House of Representatives as H.R. 1, was favorably reported by the Ways and Means Committee on May 26, 1971, and was passed by the House of Representatives on June 22, 1971. As of the submission of this report, H.R. 1 is a matter of pending business before the Senate, but it has not become law. This report necessarily assumes current law, and does not consider the changed situation when and if H.R. 1 is enacted.

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 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.

Section 1833 of the Social Security Act provides that pathology and radiology services rendered by physicians after March 1968 to hospital inpatients are not subject to the deductible and coinsurance provisions of the supplementary medical insurance program. Hospitals, at their option, are permitted to combine their billing for both hospital 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 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.

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

That portion of each trust fund which, in the judgment of the managing trustee, is not required to meet current expenditures for benefits and administration is invested in interest-bearing obligations of the U.S. Government, in obligations guaranteed as to both principal and interest by the United States, or in certain federally sponsored agency obligations that are designated in the laws authorizing their issuance as lawful investments for fiduciary and trust funds under the control and authority of the United States or any officer of the United States. Obligations of these types may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price.

In addition, the Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall have maturities fixed with due regard for the needs of the trust fund and shall bear interest at a rate based on the average market yield (computed by the Managing Trustee on the basis of market quotations as of the 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.

DETAILED OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1971

A statement of the income and disbursements of the Federal supplementary medical insurance trust fund during fiscal year 1971 and of

the assets of the fund at the beginning and end of the fiscal year is presented in table 1. Also appearing in the table are comparable amounts for fiscal year 1970.

The total assets of the trust fund amounted to $57 million on June 30, 1970. By the end of fiscal year 1971, the assets amounted to $290 million, an increase of $233 million.

Total receipts of the fund amounted to $2,515 million. Of this total, $1,253 million represented premium payments by (or on behalf of) the participants, an increase of 34 percent over premium payments by participants in the preceding fiscal year. This growth in premiums from participants resulted primarily from the increase from $4.00 to $5.30 per month in the standard premium rate that became effective on July 1, 1970.

Matching contributions received from the general fund of the Treasury, plus interest on delayed transfers, amounted to $1,245 million. This amount consisted of $1,242 million in contributions matching participants' premiums received in fiscal year 1971, $3 million in contributions matching participants' premiums received in fiscal year 1970, and about $0.2 million in interest on delayed transfers of matching contributions. (The remaining deficiency of $14 million in contributions matching participants' premiums received in fiscal year 1970 was received, along with appropriate interest, from the general fund of the Treasury in December 1971, after the close of fiscal year 1971.)

The remaining $17 million of receipts consisted of interest on the investments of the trust fund plus interest on amounts of inter-fund transfers between this trust fund and the disability insurance and hospital insurance trust funds.

Disbursements from the fund during fiscal year 1971 totaled $2,283 million. Of this total, $1,998 million represented benefits that were paid directly from the trust fund and $37 million was transferred to the hospital insurance trust fund with respect to certain costs for radiology and pathology services that were paid by that trust fund but that are liabilities of the supplementary medical insurance trust fund.

TABLE 1.—STATEMENT OF OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING FISCAL YEARS 1970 AND 1971

[In thousands

	Fiscal year 1970	Fiscal year 1971
Total assets of the trust fund, beginning of year	$377,774	$57,181
Receipts:		
Premiums from participants:		
Deducted from monthly benefits [1]	763,516	1,030,541
Deposited by States	97,209	131,472
Paid to Social Security Administration [2]	75,276	90,923
Total premiums	936,000	1,252,936
Percentage increase in premiums, 1970 to 1971	33.9	
Transfers from general fund of the Treasury:		
Government contributions:		
Matching of participants' premiums received in current fiscal year	918,870	1,241,945
Delayed matching of participants' premiums received in previous fiscal year	7,822	3,130
Total matching contributions	926,692	1,245,075
Interest on delayed transfers of Government matching contributions	1,459	207
Total transfers from general fund of the Treasury	928,151	1,245,282
Interest		
Interest on Investments	16,142	16,182
Interest on adjustments in transfers to the hospital insurance trust fund for reimbursement of benefits paid initially therefrom [3]	−4,511	800
Interest on amounts of interfund transfers due to adjustment in allocation of administrative expenses and construction costs [3]	−95	286
Total interest	11,536	17,268
Total receipts	1,875,687	2,515,486
Disbursements:		
Benefit payments:		
Paid directly from the trust fund	1,816,587	1,997,699
Transfers to the hospital insurance trust fund for reimbursement of benefits paid initially therefrom [4]	162,700	37,300
Total benefit payments	1,979,287	2,034,999
Percentage increase in benefit payments, 1970 to 1971	2.8	
Administrative expenses:		
Department of Health, Education and Welfare [5]	219,326	254,665
Treasury Department	26	44
Civil Service Commission	22	96
Construction of facilities for Social Security Administration	684	202
Interfund transfers due to adjustment in allocation of [6]—		
Administrative expenses	−3,987	−7,462
Construction costs	938	91
Gross administrative expenses	217,009	247,637
Less receipts from sale of surplus supplies, materials, etc.	16	25
Net administrative expenses	216,993	247,612
Total disbursements	2,196,281	2,282,610
Net addition to the trust fund	−320,594	232,876
Total assets of the trust fund, end of year	57,181	290,056

[1] Transferred from the old-age and survivors insurance and disability insurance trust funds, the railroad retirement account, and the civil service retirement and disability fund.

[2] By certain persons not receiving monthly benefits.

[3] Positive transfers of interest represent transfers of interest to the supplementary medical insurance trust fund from the other social security trust funds. Negative transfers of interest represent transfers of interest from the supplementary medical insurance trust fund to the other social security trust funds.

[4] For explanation, see text.

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

[6] Positive transfers represent transfers from the supplementary medical insurance trust fund to the other social security trust funds. Negative transfers represent transfers to the supplementary medical insurance trust fund from the other social security trust funds.

Total benefit payments from the trust fund in fiscal year 1971, therefore, amounted to $2,035 million, an increase of only 2.8 percent over the corresponding amount paid in fiscal year 1970. The rate of increase is abnormally low because of extraordinary transfers to the

hospital insurance trust fund. After adjustment for these transfers the benefit payments in fiscal year 1971 were 10% higher than in the previous fiscal year.

The remaining $248 million of disbursements was for net administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds 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 affected by interfund transfers, with appropriate interest allowances.

Table 2 compares the actual experience in the fiscal year 1971 with the estimates presented in the 1970 and 1971 Annual Reports of the Board of Trustees. The estimated amounts of participants' premiums, Government matching contributions, and benefit payments in both reports were quite close to the actual experience.

The assets of this fund at the end of fiscal year 1971, amounting to $290 million, consisted of $257 million in the form of obligations of the U.S. Government and $33 million in undisbursed balances. Table 3 shows a comparison of the total assets of the fund and their distribution at the end of fiscal years 1970 and 1971.

New securities at a total par value of $2,790 million were acquired during the fiscal year, through the investment of receipts and the reinvestment of funds made available from the maturity of securities. The par value of securities redeemed during the year was $2,546 million.

The effective annual rate of interest earned by the assets of the supplementary medical insurance trust fund during fiscal year 1971 was 6.4 percent. The interest rate on public-debt obligations issued for purchase by the trust fund in June 1971 was 6⅛ percent, compounded semiannually.

TABLE 2.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1971

[Dollar amounts in millions]

Item	Actual amount	Comparison of actual experience with estimates for fiscal year 1971 published in—			
		1971 Report		1970 Report	
		Estimated amount	Actual as percentage of estimate	Estimated amount	Actual as percentage of estimate
Premiums from participants	$1,253	$1,246	101	$1,242	101
Government matching contributions	1,245	1,248	100	1,245	100
Benefit payments	2,035	2,070	98	2,078	98

TABLE 3.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, BY TYPE, AT THE END OF FISCAL YEARS 1970 AND 1971

	June 30, 1970		June 30, 1971	
	Par value	Book Value[1]	Par value	Book Value[1]
Investments in public-debt obligations sold only to this fund (special Issues):				
Notes:				
6⅛ percent, 1978			$254,641,000	$254,641,000.00
6½ percent, 1976	$10,562,000	$10,562,000.00		
7⅞ percent, 1977	2,855,000	2,855,000.00	2,786,000	2,786,000.00
Total investments in public-debt obligations	13,417,000	13,417,000.00	257,427,000	257,427,000.00
Undisbursed balance		43,763,523.42		32,629,310.99
Total assets		57,180,523.42		290,056,310.99

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

SUMMARY OF PAST OPERATIONS OF THE TRUST FUND

The past operations of the SMI trust fund are shown in table 4 on a calendar year and fiscal year basis.

The balance of the trust fund was relatively large in the first year and a half of operation due to the lag in the payment of benefits and unfamiliarity of some of the beneficiaries with the provisions of the Medicare program. The balance declined thereafter, however, from $486 million at the end of fiscal year 1967 to $307 million at the end of fiscal year 1968, due to the continuation by Congressional action of the $3 premium rate in January through March 1968. Also a significant amount of premium income was not matched currently by general revenue appropriations, resulting in a loss of interest to the trust fund. (The law has subsequently been changed so that the trust fund will earn interest from the Treasury on such late payments.) The balance declined rapidly from $378 million at the end of fiscal year 1969 to $57 million as of June 30, 1970, due to the continuation during fiscal1970 of the $4 premium rate. The promulgation of the $5.30 premium rate for fiscal 1971, however, led to an increase in the balance in the trust fund to $290 million by the end of fiscal 1971.

As can be seen in table 4, the benefit payments in the early years increased rapidly as the lag in the payment of benefits shortened and as enrollees became familiar with the pro ram and increased their use and rate of filing for covered services. Table 4 shows an increase of about 20 percent in benefit payments for fiscal 1970 over fiscal 1969. This percentage is exaggerated due to an extraordinary transfer of funds in fiscal 1970. The increase is reduced to slightly over 10 percent after the adjustment of fiscal 1970 benefit payments for $162.7 million transferred to the hospital insurance trust fund for certain inpatient radiology and pathology professional services which were initially paid therefrom. For similar reasons the increase of 2.8 percent in fiscal 1971 benefit payments over fiscal1970 is artificially too low. This percentage increase is changed to about 10 percent after adjustment for an additional $37.3 million of trust fund transfers in fiscal 1971 for such inpatient radiology and pathology services.

The lower rate of increase in benefit payments beginning in fiscal 1970 was in part due to a series of steps taken by the Social Security Administration to lower the cost of the program. Prevailing fees were reduced, increases allowed in customary and prevailing charges were

delayed so as to reduce the amounts paid, and various actions were taken to prevent fraud or payment for uncovered services. [1] Estimates of the extent to which these changes in policy affected the recognition of increases in physician fees are given in Appendix II.

Table 5 illustrates the cost of administering the supplementary medical insurance program. Administrative expenses have increased in amount and also as a percentage of benefit payments. The present expense rate of over 12 percent is higher than in earlier years which partially reflects the increased administrative actions on the part of carriers to implement and improve on claims review procedures.

TABLE 4.—PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) FISCAL YEARS 1967-71 AND CALENDAR YEARS 1966-71

[In millions]

	Premiums from participants	Government contributions[1]	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year[2]
Fiscal year:						
1967	$647	$623	$664	[3] $134	$15	$486
1968	699	634	1,390	143	21	307
1969	903	984	1,645	195	23	378
1970	936	928	1,979	217	11	57
1971	1,253	1,245	2,035	247	17	290
Calendar year:						
1966	322		128	[3] 74	2	122
1967	640	933	1,196	109	22	412
1968	832	859	1,519	183	20	421
1969	914	907	1,865	196	18	199
1970	1,096	1,093	1,974	238	12	188
1971	1,302	1,313	2,117	260	24	450

[1] The payments shown as being from the general fund of the Treasury Include certain interest-adjustment items.
[2] Represents only a cash balance; financial status of the program depends on total net assets and liabilities of the program.
[3] Administrative expenses shown include those paid in 1965 and 1966.

TABLE 5.— COMPARISON OF ADMINISTRATIVE EXPENSES TO BENEFIT PAYMENTS FOR THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEARS 1967-71 AND CALENDAR YEARS 1966-71

[Administrative expenses as a percentage of benefit payments]

Fiscal Year	Percentage	Calendar year	Percentage
1967	[1] 20.2	1966	[1] 57.8
1968	10.3	1967	9.1
1969	11.9	1968	12.0
1970	11.0	1969	10.5
1971	12.1	1970	12.1
		1971	12.3

[1] Percentage includes administrative expenses paid in calendar 1965 and 1966.

EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND DURING THE PERIOD JULY 1, 1971 TO JUNE 30, 1974

The expected operation and status of the trust fund during the period July 1, 1971 to June 30, 1974 is summarized in table 6. Also in table 6, to serve as a basis for comparison, is a summary of the actual operations of the program and the trust fund through June 30, 1971, already presented as a part of table 4.

[1] These practices were elaborated on in previous Trustees Reports and are not repeated here.

As can be seen by an examination of table 6, income for the program is projected to increase by about 9½ percent in fiscal year 1972 over fiscal 1971. This is mainly due to the increase of $.30 in the premium rate to $5.60 per month for fiscal 1972 and the catching-up of general revenue matching for prior fiscal years. The remainder can be attributed to increased interest earnings (due primarily to the increase in the trust fund) and the continued growth in enrollment. A further increase is projected for fiscal 1973 over fiscal 1972 as a result of the new premium rate of $5.80 per month promulgated by the Secretary of Health, Education and Welfare for that fiscal year. The premium income and matching government contributions for fiscal year 1974 have been projected to be equal to one-half of the projected incurred benefit and administrative expenses for that period.

Benefit expenditures for fiscal year 1972 are expected to increase by about 10 percent over fiscal1971, which would be a continuation of the trend experienced during fiscal1970 and. fiscal 1971. Benefit payments for fiscal 1973 are expected to be influenced by administrative controls implementing the National Economic Stabilization Program and are projected to rise to $2,455 million. Benefit payments for fiscal year 1974 are expected to increase by 10 percent to $2,703 million. The benefit figures for fiscal 1972 and fiscal 1973 are as shown in the President's Budget for 1973 and were developed using assumptions that are consistent with guidelines issued by the Price Commission operating under the Economic Stabilization Program, and which are assumed to be fully effective. Administrative expenses continue to increase as a percentage of benefits and for fiscal year 1972 are projected to be $298 million .or a little over 13 percent of benefit payments. For fiscal year

1973 they are expected to reach $332 million. The favorable income position for fiscal year 1972 as a result of the $5.60 premium rate effective during that period is expected to increase the trust fund balance from $290 million at the beginning of fiscal 1972 to $507 million at the end of that year. The trust fund balance at this level is equal to approximately 20 percent of the following fiscal year benefit expenditure. A similar financial situation is projected at the end of fiscal1973, when the trust fund balance is expected to be $613 million.

TABLE 6.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) FISCAL YEARS 1972-74 AND ACTUAL DATA 1967-71

[In millions of dollars]

Fiscal year	Premiums from participants	Government contributions[1]	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year[2]
Actual experience:						
1967	$647	$623	$664	[3] $134	$15	$486
1968	699	634	1,390	143	21	307
1969	903	984	1,645	195	23	378
1970	936	928	1,979	217	11	57
1971	1,253	1,245	2,035	247	17	290
Estimate of future experience:						
1972	1,355	1,377	2,240	298	23	507
1973	1,428	1,434	2,455	332	31	613
1974[4]	1,588	1,588	2,703	375	40	751

[1] The payments shown as being from the general fund of the Treasury Include certain interest-adjustment items.
[2] Represents only a cash balance; financial status of the program depends on total net assets and liabilities of the program.
[3] Administrative expenses shown include those paid in fiscal 1966 and 1967.
[4] Experience that would result assuming that premiums and Government contributions are ½ of the expected incurred benefits and administrative expenses for fiscal 1974.

REPORT OF THE 1971 ADVISORY COUNCIL ON SOCIAL SECURITY

Pursuant to section 706 of the Social Security Act, an Advisory Council on Social Security was appointed by the Secretary of Health, Education, and Welfare in May 1969. The Council submitted its report on April 5, 1971. Among its findings and recommendations are those concerning changes in the benefit provisions and coverage of the supplementary medical insurance program. These do not directly affect the financing or the operation of the trust fund and are not referred to further in this report. The Council has made certain other recommendations which do affect the financing of the trust fund. As to these, the Trustees have the responsibility of a careful evaluation, and the transmittal of the Trustees' views as a part of this, or subsequent, reports.

The Council has organized its findings m the financing area under twelve headings. Seven of these (numbers 1-6 and 11) concern the financing of the supplementary medical insurance trust fund and are discussed below.

C. FINANCING

Actuarial Soundness of the Program

1. *Current Status—Income to the supplementary medical insurance part of the Medicare program will be more than sufficient to meet incurred benefit costs over the period, established by the law, for which monthly premiums have been promulgated.*

The Board of Trustees concurs in the above statement of the Advisory Council.

Management and Investment of the Trust Funds

2. *Investment Policy—The Managing Trustee of the Social Security trust funds should adopt a policy of investing in special obligations with maturity dates equal to the maximum maturity date of Treasury notes (at present 7 years) rather than maturity dates of 15 years from date of purchase.*

The Board of Trustees concurs in this recommendation of the Advisory Council, and the Managing Trustee will adopt such a policy.

3. *Interest Rate Formula—The interest rates on special obligations issued to the trust funds should be equal to the average market yield on all marketable Treasury notes that are not due or callable until 4 or more years from the time the special obligations are issued.*

The Board of Trustees has no position as to this recommendation at the present time, pending further study as to whether the interest-rate on special obligations will be higher or lower under the Advisory Council's recommendations than under current law.

4. *Securities Issued by Federally Sponsored Agencies—The Council believes that there is adequate statutory authority for investment of trust fund money in securities issued by federally sponsored agencies. The Council recommends that the Managing Trustee establish a policy of purchasing a portion of new obligations issued by such agencies as investments for the trust funds.*

The Board of Trustees is still investigating the implications of this recommendation, and has no position at the present time.

5. *Boards of Trustees—The Council recommends that two non-government members, to be appointed by the President subject to confirmation by the Senate, be added to the Boards of Trustees of the social security trust funds.*

The Board of Trustees supports this recommendation of the Advisory Council, and recommends to Congress that the law be changed to add two non-government members.

6. *The Trust Funds and the Unified Budget—Even though the operations of the social security trust funds and other Federal trust fund programs are combined with the general operations of the Federal Government in the unified Federal budget, policy decisions affecting the social security program should be based on the objectives of the program rather than on any effect that such decisions might have on the Federal budget. The operations of the social security and other Federal trust funds should continue to be identified as such and separated from the general operations of the Government.*

The Board of Trustees agrees that the social security system should be financed in accordance with the principles of the program, and that the financing should not be set out of considerations of broad fiscal policy or because of the impact on the unified budget.

General Revenue Financing of Medicare

11. *Gradual Increase in General Revenue Financing of Medicare—The combined Medicare program should be financed with a general revenue contribution equal to one-third of total program costs, with such share being lower than one third at first and gradually increasing over a period of years to the one-third level.*

The Board of Trustees agrees with the Council's recommendation to combine the supplementary medical insurance trust fund and the hospital insurance trust fund for financing purposes. The Board of Trustees, however, does not concur with the Council's recommendation for a general revenue contribution equal to one-third of total program costs, recommending instead that the combined programs be financed primarily by payroll contributions, with the general revenue financing confined to certain non-insured persons.

ACTUARIAL STATUS OF THE TRUST FUND

1. Actuarial status of program dependent on accrued experience

The actuarial status of the program, and of the trust fund, can appropriately be measured only on an accrual basis; i.e., the solvency of the trust fund should be measured in terms of ability to pay the cost of the services performed, on the basis of which benefits must be paid. [2]

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

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 benefits for them are paid. This lag is due to the $50 deductible which must be accumulated before any benefits are payable, the tendency of enrollees to accumulate bills and submit them together (especially at the end of the year), and the time required by carriers to process and adjudicate the bills received.

This liability outstanding at any time for benefits for services performed for which no payment has been made may be referred to as "benefits incurred but unpaid". Estimates of the amount of such benefits incurred but unpaid as of the end of each calendar year, and of the administrative expenses related to processing these benefits, appear in table 7. Also included in table 7 are estimates of premiums voluntarily paid in advance and the government matching contributions for such premiums. Since they are paid for services to be performed in a subsequent year, they are a liability of the program at the end of the year specified. (The effect of this entry on the actuarial deficit is the same as if such premiums had not been paid until due.) Offsetting these liabilities are premiums due and uncollected, government matching contributions due but not yet transferred to the trust fund by the Treasury, and the cash on hand in the trust fund.

The actuarial status of the program is represented by the net of the above liabilities and assets. Any resulting accrued deficit represents the additional funds that would have to be appropriated or otherwise financed to pay for services already performed if the program were terminated or superseded by another government insurance program. Table 7 shows that at the end of calendar 1971 the SMI program has a substantial actuarial deficit equal to about 2 months of premium and matching income.

TABLE 7.—SUMMARY OF ESTIMATED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, AT THE END OF CALENDAR YEARS 1966-71

[In millions]

	As of Dec. 31					
	1966	1967	1968	1969	1970	1971
A. Assets:						
Premiums due and uncollected	$1	$1	$1	$1	$2	$2
Government matching contributions due and unpaid	323	30	5	12	18	8
Balance in trust fund (cash on hand)	122	412	421	199	188	450
Total assets	446	443	427	212	208	460
B. Liabilities outstanding:						
Premiums collected in advance	4	6	9	11	14	20
Government matching contributions with respect to premiums paid in advance	4	6	9	11	14	20
Benefits incurred but unpaid	374	581	690	661	634	697
Administrative cost for processing incurred but unpaid benefits	37	72	82	105	102	123
Total liabilities	419	665	790	788	764	860
C. Net surplus (or deficit):	27	−222	−363	−576	−556	−400

The accrual basis of measuring the actuarial status of the supplementary medical insurance program is essential. This is to assure that

the benefit costs actually incurred in a particular premium period will be met by the premiums paid by the enrollees during that period. Otherwise, since the enrollee group 1s not the same from year to year, there would be some persons paying for the costs of others. The accrued experience is presented in this section on a calendar year. basis. Since the $50 deductible applies to each calendar year, the accrued costs can be developed more accurately and easily on a calendar year basis.

2. Analysis of past accrued experience

The accrued experience of the program for any calendar year can be obtained by adjusting the cash flow of premiums, matching government contributions, benefit payments, and administrative expenses to an accrual basis by adding the net increase in each asset or liability item during the period (shown in table 7) to the corresponding item on a "cash" basis for that period. This procedure produces the estimated accrued income and disbursements shown in table 8 for calendar year 1966 through 1971. [3]

As can be seen by examination of this table, the program netted an estimated surplus of $27 million on an accrual basis during the calendar year 1966, an abnormal period due to the application of the full $50 deductible in a 6-month period, partially offset by non-recurring startup expenses. Due to the inadequacy of the $3.00 premium, however, the benefit payments and administrative expenses incurred exceeded accrued income during calendar year 1967 by an estimated $249 million, leaving an estimated deficit of $222 million on an accrual basis for the initial 1½-year period. The estimated accrued deficit increased during 1968 by $141 million to reach $363 million by December 31, 1968, and increased by $213 million during 1969 to reach an estimated $576 million as of December 31, 1969. Due to the adequate premiums charged in fiscal years 1971 and 1972, the actuarial deficit decreased by $20 million during calendar 1970 and by $156 million in calendar 1971 to result in an unfunded liability of $400 million at the end of calendar 1971.

The positive cash balances in the trust fund (shown in tables 4 and 6) are a result of the natural delay between the date that services are performed and the date on which benefit payments on the basis of services rendered are paid. The cash balance in the fund during 1966-67 was unusually large due to the newness of the program and the lack of familiarity of many enrollees with reimbursement insurance. The interest earned on these large balances reduced the net accrued deficit that would otherwise have been accrued for that period. The opposite effect was experienced during fiscal 1970 when the cash balance declined as a result of the inadequate $4.00 premium rate. The interest that was lost further contributed to the increase in the actuarial deficit for that period.

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[3] The trust fund balances shown in the various tables presented in this report do not include the contingency reserve that was authorized to be available until December 31, 1969, and has now expired.

TABLE 8.—ESTIMATED INCOME AND DISBURSEMENTS PAYABLE (ACCRUAL BASIS) UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, CALENDAR YEARS 1966-71

[In millions]

Calendar Year	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses	Interest on fund	Net operations in year	Accumulated surplus at end of year
1966	$319	$319	$502	[2] $111	$2	$27	$27
1967	638	638	1,403	144	22	−249	−222
1968	829	831	1,628	193	20	−141	−363
1969	912	912	1,836	219	18	−213	−576
1970	1,094	1,096	1,947	235	12	20	−556
1971	1,296	1,297	2,180	281	24	156	−400
Total, 1966-71	5,088	5,093	9,496	1,183	98	−400	−400

[1] Includes interest paid in subsequent years for the delay in Government matching for the given calendar years.
[2] Administrative expenses shown include those incurred in 1965 and 1966.

The accrued per capita costs of the program which account for the aforementioned actuarial deficits are presented for past premium paying periods in table 9. The premium rate for the period from July 1966 through December 1967 was about 10 percent lower than the combined benefits and administrative expenses accrued during this period. The initial unfavorable experience resulted primarily from physician fees increasing at about twice the 3 percent rate assumed in setting the $3.00 premium rate. A special action of Congress continued the $3.00 rate until the 1967 amendments went into effect on April 1, 1968. Consequently, a much larger deficit arose in this period than if a higher premium rate had been promulgated to be effective in January 1968.

A premium rate of $4.00 was promulgated for the 15-month period April 1968 through June 1969. This rate proved inadequate by about 5 percent due to an unexpected influenza epidemic in the winter of 1968-69. Additional costs above those expected were also incurred due to increased physicians fees and the cost and utilization of institutional services covered by the program. Administrative expenses continued to rise somewhat faster than benefit costs and to exceed those estimated. The result is that total per capita costs for this period are now estimated to be $8.50.

A premium rate of $4.00 was also promulgated for fiscal year 1970, despite recommendations by the actuaries that a premium rate of at least $4.40 would be required. The continuance of the $4.00 rate was accompanied by a variety of steps taken by the Social Security Administration designed to lower the cost of the program. These actions [4] included restricting increases in allowed customary charges, freezing the prevailing charge level, and implementing certain other measures to control utilization and prevent fraud and unethical practices. Despite these measures which were effective to some extent, the program registered monthly per capita costs of $9.12 which were substantially above even the initial estimates by the actuaries.

In December 1969, a premium rate of $5.30 was promulgated by the Secretary to be effective for the fiscal year beginning July 1970. This rate now appears to have been adequate to cover the monthly per capita cost incurred in the period which is now estimated to have been

$9.78, and to reduce the actuarial deficiency of the program built up during fiscal year 1970. To a considerable extent the administrative

[4] These actions were spelled out in detail in previous Trustees' Reports.

actions put into effect prior to fiscal 1971 continued to have a pronounced impact during this period in reducing the containing cost and price inflation.

For example, during the first half of fiscal 1971, the prevailing fee screen continued to be based on calendar year 1968 customary charge levels. Not until January 1, 1971 was the prevailing fee screen updated to recognize calendar 1969 customary charges. Although permitting increases in most fees, this action still included a lag of nearly 2 years in recognition of increases in fees previously limited by the screen. In addition, as of January 1, 1971 the prevailing fee for any type of service was set at the 75th percentile of the calendar 1969 customary fees rather than the 83rd percentile as previously in force. Other actions by the Social Security Administration have continued to increase the effectiveness of carrier implemented procedures to contain over-utilization and fee escalation during fiscal 1971 and beyond. These results are evident in carrier statistics showing that during calendar 1971 about 57 percent of the claims [5] that were processed were reduced or denied. This resulted in over $300 million being disallowed and reductions of 11 percent of covered charges or about $350 million.

TABLE 9.—COMPARISON OF INCOME AND EXPENDITURES INCURRED PER CAPITA PER MONTH IN FISCAL YEARS 1971-74

Period	Applicable premium rate	Benefit payments	Administrative costs	Total per capita costs	Total income per capita [1]
July 1966 through December 1967	$3.00	$5.93	$0.80	$6.73	$6.08
January 1968 through March 1968 [2]	3.00	7.32	.87	8.19	6.09
April 1968 through June 1969	4.00	7.60	.90	8.50	8.09
July 1969 through June 1970	4.00	8.15	.97	9.12	8.06
July 1970 through June 1971	5.30	8.70	1.08	9.78	10.68

[1] Includes interest credited during period, i.e., on a cash basis.

[2] The premium rate was not changed for January 1968 as originally scheduled due to action by the Congress to delay the change until legislation then under consideration was enacted.

It may also be noted that these administrative actions can affect the rate at which physicians accept assignments. There may be a trend toward fewer assignments (the data show a slight decrease in the assignment rate from 1970 to 1971) with the possible result that beneficiaries are charged by physicians for the amounts not allowed by carrier fee screens. This phenomenon is discussed more fully in Appendix II.

3. Expected future accrued experience

The experience of the SMI program must be projected several years ahead in order to determine as of each December the adequate premium rate to be charged for the following fiscal year. The accrued experience is also adjusted to a cash basis for budget purposes and presentation in the preceding sections of this report. The base period used for these estimates is the most recent period for which the data collected can be considered to be statistically representative of the actual experience.

[5] A claim is one or more bills submitted for payment which contain one or more charges for services rendered. In the tabulation process, if any one of the charges on a claim is reduced or denied, then that claim is counted as a claim being reduced or denied. Thus, the percentage of the claims being reduced does not represent the percentage of the separate charges being reduced.

The accrued experience was estimated from sample data for calendar year 1970 which was considered to be over 90 percent complete. The lag in the collection of data as well as the fact that only a 5 percent sample of payments to physicians is available for recent years must be considered a limitation on the accuracy to which the program can be measured. Other difficulties in determining the base year accrued costs are discussed in Appendix II. The base period costs are then projected using utilization and price factors that will affect the future costs of the program (see Appendix I).

These factors are subject to variations as a result of economic, social, and other influences. Therefore, the assumptions are chosen on a "most probable" basis in order to produce estimates of the incurred experience that is most likely to result. These assumptions take into account administrative measures that are expected to continue to reduce the cost of the program through fiscal 1972. The reductions due to these measures are not expected to continue at the accelerating rate that was experienced in the past. For example, the customary and prevailing fee screen was updated beginning July 1, 1971, to recognize calendar year 1970 charge levels. The prevailing fee level continued to be set at the 75th percentile but at the newly recognized calendar 1970 charge levels. Estimates of the effect of these changes in policy with respect to recognition of increases in physician fees are shown in Appendix II.

The most likely experience to result, if the Price Commission's guidelines limiting physician fee increases to 2½ percent per year are strictly followed, is presented in Appendix I along with the development of the $5.80 premium rate effective for fiscal year 1973. The monthly basic premium rate necessary for fiscal year 1972 is estimated to be $5.40 compared to the applicable premium rate of $5.60. The estimated surplus of $.20 per capita per month in the premium rate (plus a similar amount in the general revenue matching) plus interest earnings on the trust fund during the second half of fiscal 1972 is expected to further reduce the estimated $400 million unfunded accrued liability outstanding on December 31, 1971. For fiscal year 1973, the estimated monthly basic premium rate necessary to cover the incurred benefits and administrative expenses is $5.81. The premium rate of $5.80 charged during fiscal 1973 and the interest earnings on the trust fund should be sufficient to keep the actuarial status of the trust fund during fiscal1973 at the same relative level as at the end of fiscal year 1972.

CONCLUSION

As has been discussed in the preceding section, the premium rates of $5.30 for fiscal 1971 and $5.60 for fiscal 1972 are expected to be more than adequate to cover the benefits and administrative costs incurred in those periods. As shown in Table 5 this results in an increasing trust fund balance which helps to improve the actuarial solvency of the program by partially offsetting previous unfunded liabilities. The balance in the trust fund is expected to increase in the periods beyond fiscal 1972.

However, even if the trust fund balance increases during fiscal 1973, it remains to be seen whether the $5.80 premium rate will be adequate to cover all incurred costs in that period. The effectiveness of the Phase II

controls on physician fees and the manner in which the Social Security Administration implements the updating of the physician fee screens (the present Price Commission ruling is that they must not be increased more than 2½ percent per annum) will be crucial to whether the estimates reflect the actual experience.

APPENDICES

APPENDIX I. STATEMENT OF ACTUARIAL ASSUMPTIONS AND BASES EMPLOYED IN ARRIVING AT THE AMOUNT OF THE STANDARD PREMIUM RATE FOR THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM BEGINNING JULY 1972 [6]

This is a statement of actuarial assumptions and bases employed in arriving at $5.80 as the amount of the standard monthly premium rate for the Supplementary Medical Insurance Program for the period July 1972 through June 1973.

The actuarial determination has been made on the basis of the actual operating experience under the program, projected through the year beginning July 1972. Virtually complete operating experience figures through June 30, 1971 are now available, as to the cash income and disbursements under the program, and some data is available for the early months of fiscal 1972. The premium rate, however, must be adequate to cover benefits and related administrative costs for all services performed in the period to which the premium rate is applicable. Experience on such a basis (hereafter called an "incurred" basis) is available for most components of the program through calendar 1970; that for the other components must be estimated.

ANALYSIS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

The balance on the SMI Trust Fund at the end of each of the last three fiscal years, the liability outstanding for benefits and related administrative costs for services performed prior to the end of that fiscal year but not yet paid for at the end of that fiscal year ("liability for incurred but unpaid services"), and the monthly premium rate in effect for each of these fiscal years are as follows:

Period ending June 30	Monthly premium rate	Fund at end of period (in millions)	Liability for incurred but unpaid services (millions)
1969	$4.00	$378	$928
1970	4.00	57	823
1971	5.30	290	894

The liabilities outstanding on June 30, 1971, for incurred but unpaid services, are estimated to have been $894 million, while the balance in the trust fund on the same date amounted to $290 million. Due to past deficiencies in the premium rate, the fund on June 30, 1971, was about 32 percent of this liability.

It is expected that the trust fund balance will continue to increase during fiscal year 1972. As of October 31, 1971, the fund had almost

[6] This statement was published in the Federal Register for January 5, 1972 (Vol. 37, pp. 103-4)

reached $385 million. By the end of June 1972, the trust fund balance is estimated to be about $490 million, about 50 percent of the liability for incurred but unpaid services then outstanding.

ANALYSIS OF PAST EXPERIENCE

Estimates of the basic premium necessary to finance both benefit payments and administrative expenses are shown below, on both a cash and an incurred basis. Under the law, the premium rate must be set on an incurred basis. Cash figures must be adjusted for the estimated increase in liability for incurred but unpaid services. Monthly premium rates on both the cash and incurred bases are compared for the three most recent fiscal years with the premium rate actually charged.

Fiscal year ending June 30	Premium rate charged	Premium rate required for benefits and administrative expenses	
		Cash basis	Incurred basis
1969	$4.00	$4.07	$4.23
1970	4.00	4.47	4.56
1971	5.30	4.82	4.89

Basic Estimates for Future Experience on an Incurred Basis

In estimating the cost of the program for July 1972 through June 1973, it is first necessary to project incurred results for fiscal year 1972, and then to continue the projection for one more year. The assumptions used for the purpose of these projections are shown below:

AVERAGE INCREASE ASSUMED OVER PREVIOUS YEAR

[In percent]

Calendar year	Physicians' services		Institutional services	
	Fees [1]	Number and mix [2]	Unit costs	Number and mix [2]
1971	6.2	2	7.1	3.9
1972	2.5	2	4.9	4.7
1973	2.5	2	4.7	5.1

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

The Price Commission has promulgated a guideline for physicians' services which on the average limits the increase in the price a physician receives for any service to 2½ percent per year. The Price Commission has also determined that the reasonable charge for any procedure for any physician will also be increased no more than 2½ percent per year.

Administrative expenses in fiscal 1973 are estimated to be 13 percent of benefits paid, reflecting a moderate trend to higher administrative costs per dollar of benefits paid.

On the basis of the foregoing assumptions it is now estimated that the monthly basic premium rate necessary to cover both benefit payments and administrative expenses on an incurred basis is $5.40 for fiscal year 1972, and $5.81 for fiscal year 1973. An allowance was included for the average cost of influenza or other epidemics, none of which occurred in the base period.

The $5.81 figure for fiscal year 1973 is rounded down to $5.80.

CONTINGENCY MARGIN

There is a $0.01 deficiency arising from the rounding indicated above. The interest earnings on the trust fund (estimated to be the equivalent of about $0.06 in terms of the premium rate) are available to make up the deficiency and to provide a very small margin for contingencies.

RECOMMENDATION AND SUMMARY

Based on all available evidence and analysis, the standard premium rate for fiscal 1973 should be promulgated at $5.80 per month, up $0.20 (or about 3½ percent) from the current $5.60 rate. This recommended rate contains an estimated $0.05 margin for contingencies, when interest earnings are taken into account. The explanation of the $0.20 increase in the standard monthly premium rate for the new premium period can be summarized as follows:

(a) The level of physicians' fees recognized by the program is assumed to be higher in the new period, as physicians' fees increase modestly under wage-price guidelines—about $0.14.

(b) Use of more physicians' services per capita and some shift toward more expensive services—about $0.21.

(c) Increase in cost, quality, and utilization of the institutional services covered by the program—about $0.06.

These added costs would require an increase of $0.41 in the premium rate. However, the more favorable experience now projected for fiscal 1972 than was previously assumed (18 cents) and a small difference (3 cents) in the effects of rounding the premium to the nearest $0.10, hold the increase in premium to $0.20.

APPENDIX II. STATEMENT OF ACTUARIAL ASSUMPTIONS, METHODOLOGY, AND DETAILS OF COST ESTIMATES

(Prepared by Office of the Actuary-Social Security Administration)

The basic assumptions and methodology used to prepare the actuarial cost estimates are described in this appendix, accompanied by more detailed data from these estimates.

(A) BASIS OF FINANCING THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM: INCURRED BASIS OF PROGRAM, CASH BASIS OF BUDGET

The premium rate for the supplementary medical insurance program for any period is based on the services performed in that period, regardless of when paid; that is, on the incurred costs rather than the cash expenditures in the period. Consequently, premium rates for any future period must be based on projections of the liability that will accrue during the period for benefits and administrative costs related to services performed in that period.

Budget estimates, however, are for the cash disbursements that will be made from the supplementary medical insurance trust fund by the Treasury. Such disbursements are based on amounts transferred under "letters of credit" [7] from the bank accounts of the Treasury to those of the various carriers and intermediaries [8], and in the case of direct payments to certain providers, on actual Treasury disbursements authorized by the Social Security Administration. The actual cash payments to beneficiaries and providers must necessarily lag a few days behind such transfers (except to the extent that some carriers utilize the float on the checks disbursed, so as to minimize the bank balances). Payment for most supplementary medical insurance services will lag behind the incurred liability due to the time required for providers or beneficiaries to submit the claims and for the intermediaries and carriers to adjudicate and pay them. In addition, there is a lag in the settlements with institutions for the differences between final and interim payments. Such differences have resulted in payment of substantial additional reimbursements to these institutions. Only in the case of payments to group practice plans who have elected to deal directly with the Social Security Administration are payments made on a relatively current basis. The financing of the program is set only for short periods into the future; consequently, no long-range projections of the experience of the program are prepared. The premium rate for each fiscal year period is promulgated before the January 1, that precedes the beginning of such year. Under normal circumstances, the cash income should exceed the cash disbursements in the period for which the experience is projected,

[7] Letters of credit are a financial device that permit intermediaries to minimize idle cash balances, so that cash is not transferred from the Treasury accounts until actually needed.

[8] The Intermediaries who assist the Social Security Administration in paying claims are referred to as "intermediaries" if reimbursement is to be made on the basis of "reasonable costs" (i.e., to institutions) and "carriers" if reimbursement is made on the basis of "reasonable charges."

since the lag in the payment of benefits results in a cash surplus which provides some margin to ensure enough assets on hand at any time to pay benefits should the premium prove inadequate by a moderate amount.

(B) METHODOLOGY USED IN PROJECTING INCURRED AND CASH EXPERIENCE

The estimates of future cash expenditures under the program are projected using two distinct approaches. First the estimates of future accrued experience are adjusted for the lag in payments to produce a cash series. Secondly, the cash actually paid in the most recent year is projected to future years allowing indirectly for the effects of the various actuarial factors discussed below. This procedure provides for a check on the general level of estimates prepared. Reasonable agreement between the two methods of estimating future costs on a cash basis was achieved.

The accrued cost financing of the program requires that estimates of future accrued experience be made. In fact, the principal economic variables involved in such projections--such as price increases, increases due to the greater use of more complex and expensive procedures or to more use of specialists, changes in the level of utilization, effects of influenza and other epidemics, changes in operating philosophies of institutions or physicians, etc.—are in general related to the services at the time they are performed and not to the period when payment is made. The assumptions as to the future level of these economic variables are chosen on a "most probable" basis in order to produce "maximum-likelihood" estimates of future accrued experience. This procedure involves applying these price and utilization factors to estimated per capita reasonable charges for some recent calendar base year. The per capita reasonable charges are developed for each principal source of data (these components are discussed in detail later). The per capita reimbursement amounts are then computed by deducting from the reasonable charges the derived values for cost sharing (namely the $50 deductible and 20 percent coinsurance payments made by the beneficiary). The expected total accrued benefits for any year is computed as the product of the per capita reimbursement amount and the estimated exposure (average enrollment) in that year. Total administrative expenses (related to services performed) are projected as a percentage of accrued benefits. The results of the projection of accrued program experience which were used in the development of the premium rate for fiscal 1973 are given in Appendix I.

The future cash expenditures shown in this report are based on estimates used to prepare the budget, and agree with amounts shown therein. The methodology described below produced estimates that were reasonably close to the budget estimates prepared by adjusting accrued expenses for the various types of lag in payments and other non-recurring factors. In fact, in the absence of radical changes in program policy, changes in the general level of benefits paid tend to take place slowly, so that reasonably accurate projections of the short-run (i.e., 1 or 2 years) cash outlays of the program can be made by simply projecting the cash actually paid in the most recent period, using economic and actuarial assumptions appropriate to the periods in which the services

for which payment is made were performed. Further, adjustment can be made in anticipation of the effect of changes in the primary economic variables or in administrative policy and the lag with which they will take effect, and the projections adjusted accordingly. One aspect which simplifies the cash projection is the fact that policy affecting the carrier's reasonable charge screen relates to charges at the time they are screened for payment and not when the services were actually rendered. Besides allowing for price and other increases in the cost of services received, the cash projection reflects increased costs due to the leverage of the $50 static deductible and increased enrollment. The administrative expenditures are projected to be in line with increased workloads, payroll expenses, and other estimates prepared for the budgetary process.

(C) DEVELOPMENT OF BASE YEAR PROGRAM COSTS

Benefits under the supplementary medical insurance program can be distinguished both by the type of service or provider for which the benefit is paid and the type of payment mechanism used. Program administration may affect both the amount paid and the promptness of payment by directly affecting the benefit paid (as in the case of fee screen policy) or by affecting the payment mechanism (for example, the regulations barring payments to institutions which have not submitted cost reports with reasonable promptness). Further, for purposed of projecting the present levels of program benefits, the benefits must be divided by types of payment mechanism, since this is the form in which data from the program are available.

The primary forms of payment are: (1) through "carriers" (Blue Shield plans or other insurance companies), which establish the "reasonable charge" for each service and reimburse providers if an assignment has been made and enrollees otherwise, (2) through "intermediaries" (primarily Blue Cross) who make interim payments to institutions (hospitals, certain rehabilitation and public agencies, extended care facilities, and home health agencies), and later adjust these payments for the difference between such interim payments and audited "reasonable costs", and (3) direct payments to group practice plans and institutions electing to deal directly with the Social Security Administration.

Since each of these payment mechanisms involves its own lags between the dates on which services are performed and the dates on which payments are made and other administrative peculiarities, a separate series of adjustments was made for each payment mechanism. Further, administrative policy is generally directed to benefits paid under a particular mechanism; e.g., the policy regarding the prevailing fee level applies to services paid through the carriers and not to either the institutional or the direct payments. Finally, the currency and quality of the basic date-and consequently the accuracy of estimates made from it-varies substantially by source.

For these reasons, estimates of the incurred experience for the base year and preceding years were derived separately for (1) radiology and pathology for inpatients, (2) other physician services and miscellaneous services paid by carriers, (3) all institutional services, and (4) group practice plans dealing directly with the Social Security Administration.

Tables A, B, and C summarize the estimated past incurred benefits by payment source.

Calendar year 1970 was chosen as the base year for the projection because it was the latest year for which the data was considered to be sufficiently complete (about 90 percent) to permit an accurate estimate of the total. The incurred experience is analyzed by calendar years which most readily permit proper analysis of the effect of the $50 deductible (which is applicable to calendar year expenses). The increased reimbursements made in any calendar year due to any carry-over deductible from the prior year are assumed to be incurred in the calendar year for which they are payable.

TABLE A.—REIMBURSEMENT FOR SERVICES ON PAYMENT RECORDS

Calendar year	Average enrollment (millions)	Reimbursement (millions)		Reimbursement per capita	
		Accrued	Cash	Accrued	Cash
1966	17.7	$473.6	$120.9	$26.73	$6.82
1967	17.9	1,313.2	1,134.2	73.40	63.40
1968	18.5	1,479.5	1,425.9	79.83	76.93
1969	19.1	1,637.1	1,599.8	85.71	83.75
1970	19.5	1,738.8	1,702.5	88.96	87.11

TABLE B.—REIMBURSEMENT FOR INSTITUTIONAL SERVICES ON PROVIDER BILLS

Calendar year	Average enrollment (millions)	Interim Reimbursement (millions)		Final settlements (cash) [1] (millions)	Interim Reimbursement per capita	
		Accrued	Cash		Accrued	Cash
1966	17.7	$17.2	$2.7	0	$0.97	$0.15
1967	17.9	54.6	42.0	$0.3	3.05	2.35
1968	18.5	81.0	71.6	2.1	4.37	3.86
1969	19.1	109.7	102.6	9.9	5.74	5.37
1970	19.5	108.2	108.0	39.6	5.53	5.52

[1] Exclusive of radiology and pathology adjustments.

TABLE C.—SUMMARY OF ACCRUED BENEFITS PER CAPITA BY SOURCE OF PAYMENT

Calendar year	Payment records	Combined billing inpatient R. & P.	Institutions			Total
			GPPP	Interim	Adjustment	
1966	$26.73	0	$0.38	$0.97	$0.26	$28.34
1967	73.40	0	1.16	3.05	.83	78.44
1968	79.83	$1.20	1.24	4.37	1.18	87.82
1969	85.71	1.71	1.44	5.74	1.55	96.15
1970	88.96	2.30	1.34	5.53	1.50	99.63

It should be noted that any inadequacies in the base year data will be compounded as the experience is projected to future years. The lag in the collection of data as well as the fact that only a 5 percent sample of payments to physicians on an incurred basis is available must be considered a limitation on the accuracy with which the base year can be estimated. The estimated base year per capita incurred cost of $99.63 must, therefore, be considered to be only within 3-5 percent of the actual liability. In spite of these limitations, primary reliance is put on program data. The principal sources of data are elaborated on more fully in the following section.

(D) PRIMARY RELIANCE ON PROGRAM DATA

There are many variables that affect the difference in the level of services that will be sought and performed for a population that is insured under a specific program and a population insured under a different kind of program or mix of programs or not insured at all. Although data illuminating the behavior of most of the important variables affecting health insurance are incomplete and scarce, data concerning the variables that affect the difference in levels of utilization between the different types of programs are particularly scarce and inconclusive. Much more reliable data is available for the cost of particular insured groups where statistics are available from actual programs. Far more accurate estimates can be made of the future cost of a particular program by paying attention to data derived directly from experience under that program, rather than attempts to use other data.

1. Benefits paid through carriers (benefits on payment records)

Approximately 89 percent of supplementary medical insurance benefits are paid by carriers; and carriers are required to submit payment records covering all payments made. These payment records are tabulated by date of service rendered on a 5 percent and a .1 percent actuarial sample basis, which permits analysis of the program on an accrued basis. Described below are several corrections that must be made to this data to eliminate biases resulting from the processing system.

There is a substantial lag between the date on which services are performed, and the date on which payment records are received by the Social Security Administration. A major part of the lag is due to physicians or beneficiaries collecting a number of bills before submitting them to carriers for payment. Further delays result from the time required by carriers to query Baltimore for the status of the deductible and to adjudicate and pay the claims. This is especially so if the information submitted is incomplete or special handling is required to determine the reasonable fee or whether the services are covered. There may be a further delay before payment records are submitted. There is also strong evidence that payment records for some benefits paid have never been submitted.

Finally, editing and processing of payment records by the Social Security Administration is required before tabulation, and if the edit produces any inconsistencies, a very long delay may result from returning the payment record to the carrier for correction. In the first years of the program, many payment records that were returned to carriers were never resubmitted, probably because some carriers did not maintain adequate documentation with which to meet Social Security Administration specifications. Consequently, the .1 percent actuarial sample was based only on those records corrected and resubmitted. Currently, however, the proportion never returned is very small, as determined by statistical controls.

Thus, in order to estimate the level of benefits accrued for any recent period, adjustments must be made for payment records covering services that have been performed but for which payment records have not been tabulated by the Social Security Administration. These "accrued but

unreported" payment records must be added to those already received for the period in question.

In addition to this adjustment for the lag between the data on which a service is performed and the data the payment record is tabulated by the Social Security Administration, there are other corrections that must be made to the data to eliminate understatement and biases.

One correction is made to the sample data to eliminate the estimated understatement due to payment records that were never submitted to the Social Security Administration for processing. Another correction is made to the sample data for the estimated difference between the mean cost of enrollees in the sample and the average cost for all of the enrollees in the program. These differences are due to:

(a) selection of the sample enrollees in a manner such that their health and geographic distribution may not be representative of all enrollees (i.e., the expected value of their cost is different from that of all enrollees),

(b) statistical fluctuations in the sample average cost about the expected value for these enrollees, and

(c) the manner in which the sample is drawn (slightly less than .1 percent of all enrollees are sampled).

2. Inpatient radiology and pathology paid initially through the hospital insurance program

As a result of the 1969 amendments, hospital-based radiologists and pathologists have the option of concluding agreements with a hospital under which the hospital bills for their services. Where these agreements are in effect, payment is made for these services from the hospital insurance trust fund by the hospital insurance intermediary. The hospital insurance trust fund is subsequently reimbursed from the supplementary medical insurance trust fund. Interim payments to hospitals are made on the basis of an estimated average cost for all inpatient radiology and pathology professional services reimbursed by the hospital insurance program for that hospital. The actual liability of the program however, depends on subsequent cost settlements with the hospitals. No data concerning accrued costs is available, due to the failure of the data system intended to provide information on interim payments. Consequently, estimates of the liability of the program as a result of this payment mechanism must be based on cost settlement data reported to the Social Security Administration on a monthly basis by intermediaries. Presently there is little information on which to judge the completeness of this data. This inadequacy in the data available from the program gives rise to the possibility of substantial errors in estimating this component of the cost of the program.

3. Institutional services reimbursed by intermediaries

Payments by intermediaries to hospitals for outpatient hospital services, to hospitals for services for beneficiaries who have exhausted their hospital insurance benefits, to extended care facilities for outpatient services, and to home health agencies for services not covered by hospital insurance are on an interim basis, and adjusted by a subsequent settlement with the institution on the basis of an audited cost report. As in the case of benefits under the hospital insurance program, interim bills are submitted to support claims for interim payments. These bills are tabulated by date of service, and an estimate

is made of the interim payments for these services on an accrued basis. The data tabulated in the .1 percent actuarial sample, however, contain substantial biases. It is estimated that there has been a deficiency in the accumulated experience for the years 1966-70 of around 9 percent, but these estimates rest on very tenuous evidence. A study of a very small sample of cost settlements and an analysis of total retroactive cost settlements made through June 1971 indicate that the interim payments must be increased by around 27 percent in order to reflect the level of total accrued costs.

4. Group practice plans dealing directly with the Social Security Administration

Group practice plans that deal directly with the Social Security Administration are reimbursed on a cost basis. They are financed on an interim payment basis designed to keep current the reimbursements for services performed. Analysis of retroactive cost settlements made to these plans through June 1971, however, suggests that these interim payments should be increased by about 8 percent to reflect the level of accrued costs.

5. Institutions reimbursed directly by the Social Security Administration

The same basic procedures used by intermediaries are also followed by the Social Security Administration to reimburse institutions that have elected to be paid directly by the Social Security Administration rather than through intermediaries. Although data from this source might be analyzed separately, the amount involved has been too small to merit separate attention. Consequently, direct institutional reimbursements were analyzed jointly with other institutional benefits.

(E) ASSUMPTIONS USED IN PROJECTIONS

1. Increases in prices and costs

Economic data concerning the trends of the cost of health care are generally available by the type of service performed. Thus, for the purpose of projecting the future levels of the services performed, it is convenient to break down the supplementary medical insurance benefits by the type of service which is provided. In general, this requires a further subdivision of services paid by each type of payment mechanism. Thus, the benefits paid by carriers and recorded on payment records are separated into those for house visits, office visits, inpatient visits, surgery, x-ray, and laboratory, radiologists, and pathologists for care of inpatients, outpatient radiology and pathology, and miscellaneous. Institutional benefits are divided into services provided by hospital outpatient departments, independent clinics, home health agencies, extended care facilities, and hospital inpatient departments (for patients who have exhausted their hospital insurance benefits). For convenience, however, and also because no accuracy is sacrificed, weighted factors were derived for price increases (and certain other increases described subsequently) only for (1) radiology and pathology for inpatients, (2) other physician services and miscellaneous services paid by carriers, (3) all institutional services, and (4) group practice plans.

The average price increases in physicians fees shown in table D through calendar 1971 are based on the weighted averages of the Bureau of Labor Statistics indexes for house and office visits and special indexes for geriatric inpatient surgical and heart care. The 2.5 percent increase shown for calendar years 1972 and 1973 is in accordance with the Phase II Price Commission Guidelines for physicians under the Economic Stabilization Program. The effect of the fee screen on increases in physician charges (price being only one component thereof) is also shown in table D. Table E shows the combined increase in future reasonable costs for the institutional and direct dealing group practice components of the program. The increase factors other than price increases are discussed next.

TABLE D.—ESTIMATED INCREASE IN PHYSICIANS' CHARGES (RECOGNIZED BY THE PROGRAM AS REASONABLE)

[In percent]

Calendar year	Prices	Change in effect of fee screens [1]	Increase in reasonable charges	Residual increases [2]
1967/1966	6.2	−0.6	12.3	6.3
1968/1967	6.2	−.8	5.8	.3
1969/1968	6.6	−2.7	5.1	1.1
1970/1969	6.5	−5.1	3.2	1.7
1971/1970	6.2	−.8	7.5	2.0
1972/1971	2.5	+.1	6.2	3.5
1973/1972	2.5	0.0	6.1	3.5

[1] Effect of reductions between year y and y+1. Initial reductions in 1966 were about 2½ percent of the charges on payment records.
[2] See text for explanation.

TABLE E.—ESTIMATED INCREASES RECOGNIZED BY THE PROGRAM (ALL INCREASE FACTORS COMBINED)

[In percent]

Calendar year	Physician Services	Inpatient radiology and pathology	Group practice plans	Institutions
1971/1970	7.5	11.0	8.3	11.9
1972/1971	6.2	9.3	6.1	10.5
1973/1972	6.1	8.7	6.1	11.3
1974/1973	7.5	10.2	7.4	11.3

2. Residual factors affecting future costs

In addition to price increases the costs of the program are affected by a number of other economic factors. The residual increase in physician charges shown in table D is due to (but not limited to) (a) changes in the mix of services rendered reflecting trends to use new, more complex, and more expensive techniques, (b) changes in the delivery of care, including increased specialization, (c) changes in utilization as a result of chance fluctuations in health (e.g. epidemics) or other conditions giving rise to a different number of physician visits per capita, (d) any tendency of physicians' fees which are below the customary fee to increase faster than the customary fee (any tendency for such increases to be less than average would have a negative impact on the residual component), (e) changes in the manner in which physicians bill for their services, and (f) any difference between the actual and estimated increase in reasonable charges due to price increases or to the fee screen.

The substantial increase in the residual component in 1967 over 1966 as shown in table D was due in large part to the rapid acceptance of the program as beneficiaries became more familiar with the benefits. The average trend of over 2 percent experienced in the past is anticipated to continue into the future with additional increases assumed during the period of price controls. Part of the latter is necessary for consistency with the method by which the residual was derived.

Increases in the cost of institutional care under the program are also influenced by the economic factors discussed above for physicians' services. The anticipated combined effect of future price and other increases recognized by the program are shown in table E. As can be seen from table E, the institutional component of the program is expected to rise much more rapidly over the next few years than the physician component, reflecting trends in the recent past.

3. Administrative policy affecting program costs

Policy changes in the administration of the reasonable and customary fee screen have a substantial impact on future benefits payable under the Supplementary Medical Insurance Program. The customary fee charged by a physician for a given procedure is defined as the median of all such fees charged by that physician during a particular calendar year. The prevailing fee for a given procedure and locality is set at a certain percentile of the distribution of the customary fees for that procedure of all physicians in that locality.

The general methodology followed by the Social Security Administration in implementing the fee screens is to base the customary charges (and hence the prevailing charges which are derived from customary charges) for any fiscal year when a particular premium rate is in effect on data derived from the previous calendar year. This policy allows six months after the end of a calendar year for carriers to tabulate the data required to derive such customary charges, to compile customary and prevailing charges, and to substitute the new charges in the fee screens. Since physician fees have been rising in excess of 6 percent per year, as a result of general fee increases by physicians on the average of once every three years, this policy alone (without any reductions due to a prevailing charge screen) reduces about one third of all charges and reduces the amount paid by approximately 7 percent, due purely to the delay in recognition of customary fees.

These policies have not been followed systematically, however. Throughout calendar year 1970 the customary and prevailing fee screens were based on calendar year 1968 charge levels. The prevailing fee limit was set at the 83rd percentile of calendar 1968 customary fees. As shown in table D the effect of this administrative action was to markedly reduce recognized increases in physicians fees during calendar year 1970. Claims processed between January and June 1971 were compared to a fee screen based on calendar 1969 charges. Accompanying this updating of the fee screen was an administrative decision to lower the prevailing fee limit from the 83rd to the 75th percentile of calendar 1969 charges. The claims processed during the second half of calendar year 1971 (as well as those processed through June 1972) were compared to a customary prevailing fee screen which was based on calendar 1970 charges. As can be seen from table D the use of more recent data as a base for the fee screen in calendar 1971 reduced the change in the effect

of the fee screen in 1971 over that for 1970. The wage-price freeze in the latter part of calendar 1971 also contributed to slowing the increased number of fees reduced by the screen. Prior to the promulgation of the premium rate for fiscal year 1973, the Price Commission ruled that during fiscal year 1973 the program should recognize no more than a 2½ percent increase in physicians customary fees. The cost estimates in this report were prepared under the assumption that the fee screen set by the Social Security Administration for fiscal 1973 would be in full and complete compliance with the Price Commission ruling. The updating of the customary and prevailing fee screen as of July 1, 1972, to recognize calendar 1971 charges is therefore to recognize customary (and hence prevailing) fee increases of no more than 2½ percent is the aggregate. The same limitation of 2½ percent is also assumed to apply to the updating of the fee screen on July 1, 1973, for application in fiscal 1974. As mentioned previously the cost estimates in this report also assume that physicians will limit fee increases to 2½ percent per annum for calendar year 1972-73. Since the fee screen and physician fees generally are expected to go up at about the same rate, the result is that there will be little change in the effect of the fee screen during calendar 1972 and 1973 over the 1971 level (i.e., fee screen reductions as a percentage of charges are expected to continue at about the 11.5 percent level experienced in calendar 1971). In general, physicians will accept assignments if (i) the reimbursements received on previously assigned bills are reasonably close to the amount the doctor expects to receive, or if (ii) the doctor expects to encounter difficulty in collections or to produce a difficulty for the patient he does not wish to occur. Carrier statistics indicate that the rate at which physicians accept assignments has decreased 2-3 percent during 1971.

Thus if there is too large a discrepancy between fees being charged by physicians and those recognized by the program, assignments will tend to be accepted only for low income patients. The effect will be to provide less comprehensive insurance than originally intended for those able to pay and force those unable to pay for their services to find physicians who are either willing to perform services for less than the going rate or are willing to donate some portion of the value of the services provided. On both accounts the intent of the program would not be accomplished For this reason, the level of fees recognized by the program cannot fall far behind the going rate without causing a fall in the assignment rate and potential difficulties to beneficiaries. It remains to be seen what effect the Phase II physician price guidelines and the fee screen will have on assignments in 1972 and beyond.

4. Enrollment

The enrollment in the supplementary medical insurance program is projected to be 96 percent of the total aged population. The assumption as to the number aged 65 or over is the same as that made in the projection of the old-age, survivors and disability insurance program.

5. Interest rate

An interest rate of 6 percent was assumed in estimating the future interest earnings of the supplementary medical insurance trust fund.

APPENDIX III. SUMMARY OF PRINCIPAL PROVISIONS

Public Law 89-97, approved July 30, 1965, amended the Social Security Act by establishing the supplementary medical insurance program. A summary of its principal provisions, as amended by subsequent legislation up to and including the date of this report, is as follows:

1. COVERAGE PROVISIONS (FOR CONTRIBUTION AND BENEFIT PURPOSES)

(a) Persons aged 65 and over on December 31, 1965—voluntary individual election of coverage during period through May 31, 1966, by any individual eligible for hospital insurance benefits or by any other citizen or any other alien lawfully admitted for permanent residence who has at least 5 consecutive years or residence immediately preceding enrollment (except with respect to persons convicted of certain specified offenses such as treason, espionage, etc.), effective July 1, 1966.

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

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

(d) Termination of enrollment—either by failure to pay premiums (for premiums not deducted from benefits) or by election to do so at any time (to be effective at the end of the following calendar quarter). An individual who terminates coverage may reenroll if he does so in a general enrollment period that begins within 3 years after such termination, with reenrollment permitted only once.

2. BENEFITS PROVIDED

(a) Types of benefits—physician and surgeon services (including anesthesiologist, pathologist, radiologist, and physical medicine in hospital), hospital outpatient services (prior to April 1, 1968, such services that were of a diagnostic nature and were furnished by a particular hospital in an amount in excess of $20 during a 20-day period were excluded from this program because they were included in the hospital insurance program; currently, all these outpatient services are consolidated in the Supplementary Medical Insurance Program), home health services (as in the hospital insurance program, but without requirement that they be furnished after hospitalization), and certain other medical services, such as limited ambulance services, prosthetic devices, rental of hospital equipment used at home (or purchase thereof if not more expensive, after December 31, 1967), and surgical dressings.

(b) Amount of reimbursement—plan pays:

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

(ii) for all other services, 80 percent of reasonable charge (or, in the case of institutional services, 80 percent of reasonable cost) after the participant has paid a calendar-year deductible of $50; special limits on out-of-hospital mental-care costs (50 percent coinsurance and $250 maximum annual, reimbursement), and on home health services (100 visits per calendar year).

(c) Basis of payment—reimbursement on a "reasonable charge" basis to the enrollee or to individ•1al suppliers of services on the basis of an assignment from the enrollee, or on a "reasonable cost" basis to the particular institution for institutional suppliers of services. When payment is made on a "reasonable charge" basis directly to individual suppliers (by assignment), the "reasonable charge" determination by the carrier must be accepted as the full charge for the services, and the supplier cannot bill the patient for amounts in excess of the "reasonable charge"; otherwise, payment is made to the enrollee on the basis of an itemized bill, whether or not receipted (prior to January 2, 1968, payment was made to participant only upon presentation of a receipted bill).

(d) Services not covered—self-administered drugs (only covered under hospital insurance, and then only when the individual is receiving covered hospital or extended earn facility services and only when ordinarily furnished in and by such hospital or facility), private duty nursing, dental services, routine physical and eye examinations, elective cosmetic surgery, services performed by a relative or household member, services performed by a governmental agency (except when it provides services to the public generally as a community institution or agency), eyeglasses and hearing aids, and cases eligible under workmen's compensation.

(e) Administration-by Department of Health, Education, and Welfare, through carriers (such as Blue Shield and insurance companies) who are selected by the Department, according to regulations promulgated by the Secretary of Health, Education and Welfare. Carriers are paid their reasonable costs of administration.

3. FINANCING

(a) Participant premiums—flat monthly premium at a standard rate determined by Secretary of Health, Education, and Welfare. A rate of $5.60 was promulgated for fiscal year 1971, and a rate of $5.80 has been promulgated for fiscal year 1972. The rate applicable to each succeeding fiscal year will be promulgated by the Secretary before the preceding January 1. Such rate for any period is intended to be adequate, along with other income of the system, to support the cost of the benefits and administration for services received by enrollees during the period on an accrual basis, plus a margin for contingencies. A higher rate than the standard one is to be paid by those enrolling late or reenrolling after terminating enrollment (a surcharge of 10 percent of the premium rate for each full year during which an individual enrolling late could have participated but did not).

(b) Government contributions—amount equal to total premiums paid by or on the behalf of participants.

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

(d) Supplementary Medical Insurance Trust Fund—established on same basis as old-age and survivors insurance, disability insurance, and hospital insurance investment procedures. Premiums paid or deducted from benefits on the behalf of enrollees are transferred to this trust fund. In addition, matching funds are appropriated from the general fund of the Treasury and are transferred to the trust fund simultaneously with the premiums (with proper interest adjustment if any difference in timing occurs).