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1971 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

LETTER

FROM

BOARD OF TRUSTEES
FEDERAL SUPPLEMENTARY MEDICAL
INSURANCE TRUST FUND

TRANSMITTING

THE 1971 ANNUAL REPORT OF THE BOARD (SIXTH REPORT, PURSUANT TO THE PROVISIONS OF SECTION 1841(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

APRIL 19, 1971.—Referred to the Committee on Ways and Means, and ordered to be printed

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LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE FEDERAL
SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND,
Washington, D.C., April 15, 1971.

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

SIR: We have the honor to transmit to you the 1971 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the sixth such report), in compliance with the provisions of section 201(c) of the Social Security Act, as amended.

Respectfully,

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

Click on a Topic Below

CONTENTS

	Page
The Board of Trustees	1
Fiscal year highlights	1
Summary of the operations of the trust fund, fiscal year 1970	2
Expected operations and status of the trust fund, July 1, 1970, to June 30, 1973	5
Actuarial status of the trust fund	6
Conclusion	15
Appendixes:	
I. Statement of actuarial assumptions employed in arriving at new premium rate	17
II. Summary of principal provisions	20
III. Nature of the trust fund	22
IV. Assumptions, methodology, details of cost estimates	23
V. Legislative history affecting the trust fund	30
VI. Selected statutory provisions relating to the trust fund	31

1971 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

The Board of Trustees

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

Fiscal Year Highlights

The supplementary medical insurance program experienced a severe weakening in its financial position during fiscal year 1970. The balance in the trust fund dropped from $378 million at the beginning of fiscal year 1970 to $57 million at the end of fiscal year 1970. This drop occurred in spite of relatively favorable experience as to the level of services performed and hence in claims paid during this period. The estimate of claims incurred but not yet paid and administrative expenses related thereto decreased somewhat from $732 million at the beginning of fiscal year 1974 to $691 million at its end. Therefore, on an incurred basis the deficit for fiscal year 1970 is estimated as $280 million, resulting in an accumulated deficit, from the inception of the program through June 30, 1970, of $634 million. The accrued income of the program for fiscal year 1970 was $1,875 million, the incurred benefit payments and administrative expenses were $2,155 million.

The liabilities as of June 30, 1970, estimated to be $691 million, are for medical services already performed but for which no reimbursement has been made. They account for the difference between the $57 million positive cash position as of fiscal year end, and the $634 million deficit position on an incurred basis. Should the program be replaced by another social insurance program, any excess of this liability over the amount in the fund would have to be paid from special additional financing; otherwise these liabilities would fall back upon the insured beneficiaries.

The ability of the program to improve its financial position is limited. Enrollment is voluntary and Government matching is legally limited. Due to the substantial variation in medical costs throughout the country, many enrollees receive only the actuarial value of their benefits—despite the Government matching contribution. The premium rate can not be raised much above its actuarial value, since some

of the lower cost enrollees would find it to their advantage to drop out, raising the average cost of the remainder, and thus the premium rate required.

The deficit position of the supplementary medical insurance program results from a series of inadequate premium rates from the beginning of the program. To some extent, these premium rates were inadequate due to underestimates by the actuaries in predicting the increase in medical costs that would follow the beginning of the program, the level of administrative cost that would be required to enforce the provisions of the law relating to a reasonable fee screen, and the general inflation that has occurred in recent years—that has consistently exceeded virtually all economic projections. Further losses were incurred as a result of congressional action in maintaining the $3 premium rate during January through March 1968 and as a result of the action of the Secretary in December 1968 which maintained the $4 premium rate for fiscal year 1970.

During the fiscal year 1970, in December 1969, the standard premium rate for fiscal year 1971 was promulgated at $5.30 per month. As a result, the financial position of the program should improve during fiscal year 1971. Over the last 6 months of calendar year 1970 (the first 6 months of fiscal year 1971), the cash position improved by $131 million, bringing the trust fund balance to $188 million on December 31, 1970. The incurred position improved by approximately the same amount, reducing the estimated actuarial deficit as of December 31, 1970, to $515 million.

In December 1970, the standard premium rate for fiscal year 1972 was promulgated at $5.60 per month. 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.

No amendments to the Social Security Act affecting this program were made in fiscal year 1970 or in the succeeding 6-month period. The Advisory Council on Social Security, appointed by the Secretary of Health, Education, and Welfare in May 1969, submitted its reports to the Secretary on March 31, 1971, who thereupon transmitted the reports to the Board of Trustees. The Board has not yet had an opportunity to study the reports thoroughly, and therefore, defers comments until the Board submits its next annual report.

Summary of the Operations of the Trust Fund, Fiscal Year 1970

A statement of the income and disbursements of the Federal supplementary medical insurance trust fund during fiscal year 1970 and of the assets of the fund at the beginning and end of the fiscal year is presented in table 1.

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

Total assets of the trust fund, June 30, 1969	$377,774,133.74
Receipts, fiscal year 1970:	
Premiums from participants:	
Deducted from monthly benefits [1]	763,515,823.79
Deposited by States	97,208,601.66
Paid to Social Security Administration [2]	75,275,522.48
Total premiums	935,999,947.93
Transfers from general fund of the Treasury:	

See footnote at end of table.

Government contributions:	
Matching of participants' premiums received in fiscal year 1970	918,870,000.00
Delayed matching of participants' premiums received in fiscal year 1969	7,822,000.00
Total matching contributions	926,692,000.00
Interest on delayed transfers of Government matching contributions	1,459,000.00
Total transfers from general fund of the Treasury	928,151,000.00
Interest:	
Interest on investments	16,141,780.33
Less interest on amount of transfer to hospital insurance trust fund for reimbursement of benefits paid initially therefrom [3]	4,511,000.00
Less interest on amounts of interfund transfers for reimbursement of administrative expenses and construction costs	94,707.00
Net interest	11,536,073.33
Total receipts	1,875,687,021.26
Disbursements, fiscal year 1970:	
Benefit payments:	
Paid directly from the trust fund	1,816,587,386.33
Transferred to hospital insurance trust fund for reimbursement of benefits paid initially therefrom [3]	162,700,000.00
Total benefit payments	1,979,287,386.33
Administrative expenses:	
Department of Health, Education, and Welfare [4]	219,325,525.00
Treasury Department	26,216.07
Civil Service Commission	22,098.00
Construction of facilities for Social Security Administration	683,860.89
Reimbursement to old-age and survivors insurance trust fund for:	
Administrative expenses [5]	765,000.00
Construction costs for fiscal year 1969	938,000.00
Gross administrative expenses	221,760,699.96
Less receipts from sale of surplus supplies, materials, etc	15,672.71
Less reimbursements from disability insurance and hospital insurance trust funds due to adjustment in allocation of administrative expenses for fiscal year 1969	4,751,782.00
Net administrative expenses	216,993,245.25
Total disbursements	2,196,280,631.58
Net addition to the trust fund	−320,593,610.32
Total assets of the trust fund, June 30, 1970	57,180,523.42

[1] Transferred from the old-age and survivors insurance and disability insurance trust funds, the railroad retiremen account, and the Civil Service retirement and disability fund.
[2] By certain persons not receiving monthly benefits.
[3] For explanation, see text.
[4] Includes administrative expenses of the carriers and intermediaries.
[5] Amount represents reimbursement for a payment made initially from the old-age and survivors insurance trust fund in fiscal year 1970 for expenses of the Public Health Service.

The total assets of the trust fund amounted to $378 million on June 30, 1969. By the end of fiscal year 1970, the assets amounted to $57 million, a decrease of $321 million.

Total receipts of the fund amounted to $1,876 million. Of this total, $936 million represented premium payments by (or on behalf of) the participants, an increase of 4 percent over premium payments by participants in the preceding fiscal year.

Matching contributions received from the general fund of the Treasury, plus interest on delayed transfers, amounted to $928 million. This amount consisted of $919 million in contributions matching participants' premiums received in fiscal year 1970, $8 million in contributions matching participants' premiums received in fiscal year 1969, and about $1.5 million in interest on delayed transfers of matching contributions.

The remaining $12 million of receipts consisted of interest on the investments of the trust fund less interest on amounts of interfund transfers between this trust fund and the other three trust funds, old-

age and survivors insurance, disability insurance, and hospital insurance.

Disbursements from the fund during fiscal year 1970 totaled $2,196 million. Of this total, $1,817 million represented benefits that were paid directly from the trust fund and $163 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. (Interest of this latter amount was also transferred to the hospital insurance trust fund.) Total benefit payments from the trust fund in fiscal year 1970, therefore, amounted to $1,979 million. The remaining $217 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 for prior periods are effected by interfund transfers, with appropriate interest allowances.

Table 2 compares the actual experience in the fiscal year 1970 with the estimates presented in the 1970 annual report of the board of trustees. The estimated amounts of participants' premiums, Government matching contributions, and benefit payments were quite close to the actual experience. Estimated assets at the end of the fiscal year were $9 million higher than the actual assets.

TABLE 2.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1970

[Amounts in millions of dollars]

Item	Actual amount	Estimated amount published in 1970 report	Estimate as percentage of actual
Premiums from participants	$936	$922	99
Government matching contributions	928	928	100
Benefit payments	1,979	1,949	98
Assets, end of year	57	66	

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

The assets of this fund at the end of fiscal year 1970, amounting to $57 million, consisted of $13 million in the form of obligations of the U.S. Government and $44 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 1969 and 1970.

TABLE 3.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, BY TYPE, AT END OF FISCAL YEARS 1969 AND 1970

	June 30, 1969		June 30, 1970	
	Par value	Book value [1]	Par value	Book value [1]
Investments in public-debt obligations sold only to this fund (special issues):				
Notes:				
4¾-percent, 1974	$134,238,000	$134,238,000.00		
5⅝-percent, 1975	6,527,000	6,527,000.00		
6½-percent, 1976	217,206,000	217,206,000.00	$10,562,000	$10,562,000.00
7⅝-percent, 1977			2,855,000	2,855,000.00
Total investments in public-debt obligations	357,971,000	357,971,000.00	13,417,000	13,417,000.00
Undisbursed balances		19,803,133.74		43,763,523.42
Total assets		377,774,133.74		57,180,523.42

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

New securities at a total par value of $1,880 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 $2,225 million. A summary of transactions for the fiscal year, by type of security, is presented in table 4.

TABLE 4.—STATEMENT OF TRANSACTIONS IN PUBLIC-DEBT SECURITIES FOR THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1970

[All amounts represent par values]

	Acquisitions	Dispositions
Obligations sold only to this fund (special issues):		
Certificates of indebtedness:		
6⅝-percent, 1970	$306,081,000	$306,081,000
6¾-percent, 1970	153,098,000	153,098,000
7-percent, 1970	463,353,000	463,353,000
7¼-percent, 1970	153,744,000	153,744,000
7⅝-percent, 1970	469,053,000	469,053,000
7¾-percent, 1970	166,542,000	166,542,000
7⅞-percent, 1970	165,613,000	165,613,000
Notes:		
4¾-percent, 1974		134,238,000
5⅝-percent, 1975		6,527,000
6½-percent, 1976		206,644,000
7⅝-percent, 1977	2,855,000	
Total transactions	1,880,339,000	2,224,893,000

Expected Operations and Status of the Trust Fund During the Period July 1, 1970, to June 30, 1973

The expected operation and status of the Trust Fund during the period July 1, 1970, to June 30, 1973 (fiscal years 1971–73) are summarized in table 5. Also in table 5, to serve as a base for comparison, is a summary of the actual operations of the program and the trust fund through June 30, 1970.

As can be seen by an examination of table 5, income for the program is projected to increase by approximately a third in fiscal year 1971 over fiscal 1970, due to the increase in the premium rate to $5.30 per month at the beginning of that fiscal year. A further increase is projected for fiscal 1972 over fiscal 1971, as a result of the new premium rate of $5.60 per month promulgated by the Secretary for that fiscal year. Since the premium rate for fiscal year 1973 will not be promulgated by the Secretary until December 31, 1971, income has been projected for fiscal year 1973 under the assumption that the $5.60 rate is continued for that period. This assumption is not realistic since a continuation of the $5.60 rate would be inconsistent with the projected accrued expenditures for fiscal year 1973 shown in this report, and the Secretary is required by law to set the rate at a level that would produce accrued revenue in excess of accrued expenditures. Such a rate would produce at least a small surplus on a cash basis, increasing the trust fund by such an amount during fiscal year 1973.

TABLE 5.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), FISCAL YEARS 1971-73, AND ACTUAL DATA FOR 1967-70

[In millions]

Fiscal year	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses	Interest on fund [1]	Balance in fund at end of year [2]
Actual experience:						
1967	$647	$623	$664	[3] $134	$15	$486
1968	699	634	1,390	142	20	307
1969	903	984	1,645	195	23	378
1970	936	928	1,979	217	11	57
Estimate of future experience:						
1971	1,246	1,248	2,070	244	17	254
1972 [4]	1,339	1,339	2,300	273	33	392
1973	1,358	1,358	2,631	302	33	208

[1] The payments shown as being from the general fund of the Treasury do not include any interest-adjustment items (which are included in the interest column).

[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 incurred in fiscal 1966 and 1967.

[4] Experience that would result if the standard premium rate was continued at $5.60 per month after June 1972.

Benefit expenditures for fiscal year 1971 are projected to increase by 4.6 percent over fiscal 1970, reaching $2,070 million. This increase is relatively small compared both to those in prior years and those projected for future years, due primarily to the inclusion in 1970 of a large transfer from the supplementary medical insurance trust fund to the hospital insurance trust fund to reimburse the latter for expenditures made on behalf of the former for inpatient radiology and pathology benefits covering fiscal year 1969 as well as 1970. Benefits are projected to increase to $2,300 million in fiscal 1972 and $2,631 million in 1973. Administrative expenses are also projected to increase, due primarily to personnel costs and to additional processing as a result of increased utilization of services under the program. Interest earned by the trust fund, after reaching a low of $11 million in fiscal year 1970 is projected to increase to $17 million in fiscal year 1971 and $33 million in fiscal year 1972 and fiscal year 1973, reflecting a similar increase in the trust fund.

The balance in the trust fund is projected to increase sharply from $57 million at the beginning of fiscal year 1971, reaching $254 million by the end of fiscal year 1971 and $392 million at the end of fiscal year 1972. Under the unrealistic assumption that the premium rate will not be raised for fiscal year 1973, the trust fund would decline sharply during fiscal 1973, reaching $248 million by the end of that fiscal year. The actual experience during fiscal 1973 will depend on the premium rate promulgated by the Secretary.

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.[1]

[1] The dependence of the actuarial status of the program on the accured experience is recognized in sec. 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." [Emphasis 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 6. Also included in table 6 are estimates of premiums voluntarily paid in advance and the Government matching contributions for such premiums, since they were paid for services to be performed in a subsequent year, 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 (negligible), Government matching contributions due but not yet transferred to the trust fund by the Treasury, and the cash on hand in the trust fund—which were available at the end of each year to pay the liabilities then outstanding. The net of the liabilities less the assets is the deficit accrued, and represents the additional funds that would have to be appropriated or otherwise financed to pay for services already performed if the program were superseded by another social insurance program.

TABLE 6.—SUMMARY OF PROJECTED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, AT END OF CALENDAR YEARS 1966–70[1]

[In millions of dollars]

	As of Dec. 31—				
	1966	1967	1968	1969	1970
A. Assets:					
Premiums due and uncollected	0	0	0	0	0
Government matching contributions due and unpaid	322	29	2	10	14
Balance in trust fund (cash on hand)	122	412	421	199	188
Total assets	444	441	423	209	202
B. Liabilities outstanding:					
Premiums collected in advance	3	1	3	3	11
Government matching contributions with respect to premiums paid in advance	3	1	3	3	11
Benefits incurred but unpaid	355	497	603	586	605
Administrative cost for processing benefits incurred but unpaid	38	58	65	90	90
Total liabilities	399	557	674	682	717
C. Net surplus (or deficit)	45	−116	−251	−473	−515

[1] All figures in this exhibit reflect an accounting change which, under the new procedure, charges the amounts payable in any year due to the carryover deductible provision to the year in which it is payable. For a discussion of this change, see app. IV. The net surplus indicated is increased by this change by approximately $1.30 per capita in all years except 1966, when the increase was $2.70 per capita.

The actuarial status of the program and the financial status of the trust fund at any time can thus be found by adjusting the balance in the trust fund account by the net of these asset and liability items on

that date (as in item C of table 6). The accrued experience of the program for any period can be obtained by adjusting the cash flow of premiums, matching Government contributions, benefit payments, and administrative expenses to an accrual basis by adding the net increases in each asset or liability item during the period to the corresponding item on a "cash" basis for that period.

The accrual basis of measuring the actuarial status of the supplementary medical insurance program is a reasonable, even essential, procedure. This approach, if successfully carried out, assures 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 is not the same from year to year, there would be some persons paying for other persons' costs.

(*2*) *Necessary limitations on accuracy of estimates of past and future experience* [1]

There are many difficulties in projecting the cost of a service benefit program that are not encountered in projecting the cost of cash benefit programs, due to the additional economic and social factors involved. There is special difficulty in projecting the rate at which physician fee increases will be recognized by the program as well as in projecting the increase in utilization of services. Further difficulties result from the absence of firm estimates of the present and immediate past experience of the program, on which projections of future experience can be based, and any errors in the former are necessarily incorporated into the latter. The estimates of the 1971–72 experience could vary as much as 15 percent from the actual experience, and estimates for subsequent years could vary further from the actual experience.[1]

Final conclusions as to the accrued experience of the program for 1969 and 1970 will not be possible until the deadlines for filing claims based on services performed then have passed, all claims have been adjudicated and documented by carriers and intermediaries, and payment records and bills covering all benefit payments have been prepared and forwarded to the Social Security Administration.

(*3*) *"Expected" estimates*

The financing of this program is essentially different from that for the cash benefit and hospital insurance programs in that the premium is set in December of each year for a 1-year period beginning the following July; consequently, estimates are needed only for 1½ years into the future. Due to the lags mentioned in obtaining data from the program experience, however, the forecasting period from a firm benchmark of data or experience to the year for which a premium is set is really 2½ to 3½ years. In addition, the cost of some items must be estimated entirely on indirect information, since no relevant data is available from the program for any period. The financing of the system is set at the level thought most likely to be actually required (i.e., a "maximum likelihood" estimate).

Although the law requires that the promulgated premium rate should be determined by considering only the estimated incurred benefit costs and administrative expenses, interest is normally earned on

[1] See the Actuarial Appendix (app. IV) for a more detailed discussion of these problems.

the trust fund assets as a result of the lag between payment of premiums and settlement of claims. For example, if the premium rate is exactly adequate to meet the benefit costs and administrative expenses on an accrual basis, the program will show a surplus due to these interest earnings. If premiums cover benefit costs fully, interest earnings would provide a margin for reserves.

The "expected" estimates of the per capita costs of benefits and administrative expenses that were accrued during calendar years 1966–69 and those anticipated for calendar years 1970–72 are given in appendix I. Since the $50 deductible applies to each calendar year, these costs can be developed only for calendar-year periods. The premium rate, however, is determined for fiscal-year periods (except for the initial period July 1966–March 1968 and the period from April 1968 to June 1969). The prorated average monthly rate of these costs for the periods for which a particular premium rate was forecast, allocating interest on a cash basis, are as follows:

Period	Applicable premium rate	Benefit payments [1]	Administrative costs [1]	Total disbursements [1]	Total income [2]
July 1966 to December 1967 [3]	$3.00	$5.68	$.76	$6.44	$6.10
January 1968 to March 1968	3.00	7.36	.86	8.22	6.11
April 1968 to June 1969	4.00	7.65	.91	8.56	8.11
July 1969 to June 1970	4.00	8.34	1.00	9.34	8.05

[1] Assuming disbursements paid due to the carryover deductible are accrued in the year payable.
[2] Includes interest credited during period, i.e. on a cash basis.
[3] The premium rate forecast was not implemented on the date originally scheduled by law, due to action by the Congress to delay the change until legislation then under consideration was enacted.

The estimates of the accrued liability in each period reflect a basic accounting change. Previously, the additional amounts paid in any year due to the carryover deductible provision were charged to the previous year. This procedure was originally adopted so that the accrued costs shown for 1966 and 1967 would reflect more acccurately the actual trend in levels of the costs of services performed in 1966–67. The application of the full deductible to the last 6 months of 1966 resulted in artificially low accrued claims that year; and, through the carryover deductible, artificially higher accrued costs in 1967. Under present normal conditions, the carryover from the prior year is approximately equal to the carryover from the current year to the next so that this procedure would not alter the accrued costs by a significant amount.

There does not appear to be any convincing reason to follow this chargeback procedure any longer, and the natural procedure of charging claims to the date at which they are first actually payable has been put into effect. The net effect of this change is to decrease the net accrued deficit for the entire experience through the end of any calendar year (i.e., table 6, line C, and table 7, last column) by approximately $1.30 per capita in all years after 1966. Also, the net deficit in the premium rate for 1966–67 is reduced by $0.11 per month, and that for all other periods is unaffected.

(4) *Analysis of past experience*

The premium rate for the period from July 1966 through December 1967 was about 7 percent lower than the combined benefits and admin-

istrative expenses accrued during this period. The somewhat unfavorable experience during this period resulted primarily from an increase of approximately 13 percent in the average fees charged by physicians between July 1965 (when the premium rate was determined) and July 1967 (the approximate midpoint of the period in which the benefits were paid), as compared with the 6-percent increase assumed for this period. Further, the administrative expenses were higher than originally estimated; the actual ratio of administrative expenses to benefit payments on an accrual basis was 9½ percent in 1967 and 12 percent in 1968, as against the initial estimate of 8 percent. A special action of Congress continued the $3 rate until the 1967 amendments went into effect on April 1, 1968. Consequently, a much larger deficit occurred in this period than would have occurred if the current schedule with which premium rates are promulgated had been in effect.

A premium rate of $4 was promulgated for the 15-month period April 1968 through June 1969. This rate proved to be inadequate by approximately 5.5 percent due to the following factors:

(*a*) A severe influenza epidemic in November 1968 through January 1969 added, for the entire premium-rate period, an estimated $0.30 per capita per month to disbursements.

(*b*) Physician fees, utilization of physician services, and the cost of utilization of institutional services covered by the program continued to rise more than estimated. The rise in physican fees was due partially to continuing general inflationary conditions. The rise in cost and utilization of outpatient hospital and clinic services and of home health agency services was especially pronounced (and has continued).

(*c*) Administrative costs continued to rise somewhat faster than benefit costs, and to exceed those estimated. Excluding initial startup expenses, administrative expenses were approximately 9½ percent of benefits paid in 1966–67; the current ratio is approximately 12 percent. The additional cost primarily reflects the additional cost of improved operation of the reasonable charge screens and compilation of statistical information.

A premium rate of $4 was also promulgated for fiscal year 1970, despite actuarial recommendations that a premium rate of at least $4.40 would be required. The estimate of the fiscal year 1969 base which was used to estimate the premium rate for fiscal year 1970 was too low, however, in part because of the influenza epidemic that occurred in the middle of fiscal year 1969, the implications of which were not understood in November 1968 when this estimate was made.

The per capita cost for the period April 1, 1968, through June 30, 1969, is now estimated to have been $8.56. Similarly, the per capita cost for fiscal year 1970 is now estimated to have been about $9.33 per month compared to the recommended premium rate, matching contribution, and interest earning of $8.85.

The continuance of a $4 premium rate was accompanied by a variety of steps, taken by the Social Security Administration designed to lower the cost of the program. Increases in allowed charges were restricted, starting with January 1969, as follows:

(*a*) The customary charge for any service could be increased only in individually identified situations where equity clearly required such an adjustment. For example, generally, when physi-

cians raised their fees only those who had not raised their fees for 3 years would be considered administratively to have raised their customary charges which were reimbursable under the program.

(*b*) Until July 1970, the prevailing charges recognized by carriers participating in administration could be increased only with the approval of the Social Security Administration. No increases in prevailing charges were approved. New standards of carrier performance were promulgated, including detailed specifications for applying the customary and prevailing charge screens. Under these new standards, the definition of prevailing charges was changed by (i) promulgating uniform standards as to the definition of prevailing fees at a level generally lower than that set by carriers, so that reimbursements would cover in full a lower proportion of charges, and (ii) generally to preclude changes in these limits more often than annually after June 1970. In addition, the definition of the customary charge of a physician was altered so as to preclude upward adjustments unless there is adequate evidence that the new higher fees have been in effect for a substantial period of time; that is, increases in fees would be recognized only after the delay required to accumulate direct evidence in statistical data from actual charges by a physician, and to abulate and analyze such data.

Also, physician charges for purchased laboratory services were set at the reasonable charges made by laboratories to physicians.

In addition, the following actions were taken to control utilization and prevent fraud and unethical practices;

(*a*) Instructions provided to all carriers on methods of appraising and improving claims review.

(*b*) Tabulation and distribution to carriers of data on physicians with highest amounts of reimbursement and analysis of results.

(*c*) Issuance of more exacting criteria governing when physical therapy services may be paid for under the program.

(*d*) Increased staffing for and emphasis on program integrity and on fraud detection and prevention.

(*e*) Changes in regulations to permit questionable practices to be referred to medical societies.

(*f*) Increased investigation of allegations of fraud against the program, and referral of cases to the Justice Department for consideration of prosecution.

While the administrative actions that were taken did not contain the cost of the protection provided under the program to a level that could be met by a $4 standard premium rate, they appear to have lessened the increase in cost that might otherwise have been expected. Estimates of the effect of these changes in policy adopted with respect to recognition of increases in physician fees are shown in table A in appendix IV, under the heading "Effect of Screens." During fiscal year 1970, the program recognized only a 3-percent increase in the general level of physician fees, although nationwide the actual increases in physician fees averaged between 6 and 7 percent. Also, during that fiscal year, there was an increase in the rate of denial of claims for services that were judged by the carriers not to be medically necessary.

59-543 O—71——3

Efforts to administer the program in a way that will constrain overutilization and fee escalation have continued through the current fiscal year. By December 1969, about 30 percent of the claims [1] submitted were reduced or denied. The monetary effect of reductions of billed charges to the level allowable under the program is estimated, on the basis of data submitted by the carriers, to have been at a rate of about $155 million a year (these effects include both those arising under the previous procedure for determining reasonable charges and those arising under the new procedures described earlier in this section). At the same time, about 6.5 percent of claims submitted were being denied as noncovered.

A premium rate of $5.30 was promulgated for fiscal 1971. This premium rate contained a somewhat larger margin for contingencies than usual due to the poor financial condition of the program at that time. As a result, the financial position of the program has improved and is expected to improve further through June 1971. The trust fund had reached such a low level in June 1970 that adverse experience, such as a flu epidemic like that which occurred in 1968–69, might have resulted, unless additional funds were advanced by the Treasury, in a situation in which the program was unable to pay for the services already provided to enrollees and for which premiums had been paid. As a result of the higher premium rate for fiscal year 1971, however, the trust fund increased rapidly, reaching $188 million by the end of 1970, and is expected to increase to $254 million by June 1971.

The measures taken to reduce the cost of the program continue to have a significant impact on benefit payments for physicians' services. A survey conducted in October 1970 indicated that 40 percent of the bill of the physician services covered by the program were being reduced with the aggregate reduction being 10.5 percent of physician benefits. It is estimated that total reductions during 1970 were 10 percent of the amounts that would have been paid had no reductions been made; this represented a 4-percent increase over the reductions made during 1969.

Two fundamental facts about the reductions made in the fees recognized by the program should be noted.

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 to the patient he does not wish to occur.

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 prevailing fees can-

[1] A claim is a bill submitted for payment which contains 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 changes being reduced.

not fall far behind the going rate without causing difficulties to beneficiaries.

(2) The reductions in fees recognized by the program result from—

(i) Basing customary and prevailing fees on actual experience in a past period, i.e. sufficiently after the end of a period on which the experience is to be based to allow for tabulations, analysis, and reprograming.

The effect of the policy followed is that on the average prevailing fees for any period are based on the fees charged by physicians one and one-half years before. To the extent that fees are rising rapidly, the fee level recognized by the program increase less rapidly, however, the increase in recognized fees will be higher than that which has actually taken place. Something of this nature is expected to take place over the next two years; for example, in 1971–72 the level of fees recognized by the program will increase more rapidly than physicians' fees are expected to increase in those years, due to the fees allowed to those physicians whose fees are being reduced catching up. There will still be a net reduction from the level of payments that would have been made had there been no fee screen.

(ii) The interpretation of what is a prevailing fee.

The definition currently used is that a prevailing fee is that which is charged most often by a physician who is substantially above the median for customary charges for that fee, i.e., the 75th percentile of customary fees.

Because many services are provided at the same fee level, general use of the 75th percentile of fees as a limit will result in payment in full for more than 75 percent of services, perhaps 80 percent. The lag between the date for which the data were compiled and that for which they are used reduces somewhat the percent payable in full, since, on the average, fees are rising about 6 percent a year. Over half (by amount) of all bills are paid on an assignment basis, however, so that a majority of services are reimbursed in full.

In all cases, the fee screens are based on a recent body of data. To the extent that physicians raise fees, the recognized fees must rise also. For example, if every physician exactly doubled his fee in some year, the recognized fees under the program would also double, but with a lag of several years. Thus the authority under the program only enables the administration to delay recognition of fee increases. There is no authority to postpone indefinitely recognition of fee increases or to eliminate or reduce them.

(5) Estimates of the past accrued experience

The estimates for the past accrued experience of the supplementary medical insurance program for calendar years 1966–70 appear in table 7.[1] As can be seen by examination of this table, the program netted an estimated surplus of $45 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 nonrecurring startup expenses. Due to the inadequacy of the $3 premium, however, the benefit payments and administrative expenses incurred exceeded accrued income during calendar year 1967 by an estimated $161 million,

[1]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 Dec. 31, 1969, and has now expired.

leaving an estimated deficit of $116 million on an accrual basis for the initial 1½-year period. The estimated accrued deficit increased during 1968 by $135 million to reach $251 million by December 31, 1968, increased by $222 million during 1969 to reach an estimated $473 million as of December 31, 1969, and increased by $42 million in 1970 to $515 million on December 31, 1970.

TABLE 7.—ESTIMATED INCOME AND DISBURSEMENTS PAYABLE (ACCRUAL BASIS) UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, CALENDAR YEARS 1966–70 [1]

[In millions]

Calendar year	Premiums from participants	Government contributions	Benefit payments	Administrative expenses	Interest on fund	Net of operations in year	Accumulated surplus at end of year
1966	$319	$319	$483	[2] $112	$2	$45	$45
1967	642	642	1,338	130	23	−161	−116
1968	830	830	1,625	190	20	−135	−251
1969	915	915	1,848	222	18	−222	−473
1970	1,088	1,088	1,993	237	12	−42	−515
Total	3,794	3,794	7,287	891	75	−515	−515

[1] All figures in this exhibit reflect an accounting change which under the new procedure charges the amounts payable in any year due to the carry-over deductible provision to the year in which it is payable. For a discussion of this change, see appendix IV. The net surplus indicated is increased by this change by approximately $1.30 per capita in all years except 1966, when the increase was $2.70 per capita.

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

As explained previously, the large positive balance in the trust fund is a result of the natural delay between the date that services are performed and the date on which benefit payments made on the basis of the services are paid. The balance in the fund during 1966–68 was unusually large due to the newness of the program and the lack of familiarity of many enrollees with reimbursement insurance. The interest earned on these unusually large balances reduced the net accrued deficit that would otherwise have been accrued for that period.

(6) Past experience on a cash basis

The income and disbursements of the trust fund on a "cash" basis for calendar years 1966–70 appear in table 8. Cash income exceeded cash disbursements during 1966–67 by a large margin, resulting in a cash balance in the trust fund at the end of 1967 of $412 million, although the program actually had an estimated net deficit of $116 million on that date, due to the large liabilities outstanding on account of incurred but unpaid claims (as shown in table 6). Cash disbursements were slightly lower than cash income during calendar year 1968 despite the inadequacy of the $3 premium rate during the first quarter of the year, and the balance in the trust fund increased to $421 million at the end of the year. In 1969, however, due to the promulgation of a rate known to be considered inadequate by the actuaries, disbursements exceeded income by a large margin, resulting in a reduction of 50 percent in the trust fund, from $421 million as of December 31, 1968, to $199 million as of December 31, 1969, and to $57 million on June 30, 1970. Further, interest receipts in succeeding years will be reduced as a result, requiring higher premium rates.

TABLE 8.—PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), CALENDAR YEARS 1966–70

[In millions]

Calendar year	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses	Interest on fund [1]	Balance in fund at end of year
1966	$322		$128	[2] $74	$2	$122
1967	640	$933	1,196	110	23	412
1968	832	859	1,519	183	20	421
1969	915	907	1,865	197	18	199
1970	1,096	1,092	1,974	237	12	188
Total, 1966–70	3,805	3,791	6,682	801	75	188

[1] The payments shown as being from the general fund of the Treasury do not include any interest-adjustment items (which are included in the interest column).
[2] Administrative expenses shown include those incurred in 1965 and 1966

(7) *Summary of actuarial status of program*

The actuarial status of the program and the financial status of the trust fund depend on the determination and measurement of the accrued income, and benefit payments and administrative expenses incurred under the program. Due to the inadequacy of the initial $3 rate, there was an estimated net deficit in the operations of the program from July 1966 through December 1967 of about 7 percent and hence in the estimated accrued balance at the end of this period. However, due to the normal delay between the time that services were furnished and the time at which benefits were claimed on the basis of these services, there was an adequate cash balance in the trust fund, and this balance has proved adequate through fiscal year 1970, albeit by a narrow margin.

The premium rate of $5.30 that is set for the period July 1970 through June 1971 is estimated to be more than adequate to meet the benefit costs and applicable administrative expenses during that period. In fact, indications are that experience in this period has been more favorable than expected, due in part to favorable health experience and in part to measures placing tighter limits on program payments. Accordingly, the estimated net deficit will be reduced during the period. The rate promulgated for fiscal year 1972 is adequate, according to the expected estimates as to expenditures anticipated, and is expected to reduce the deficit further.

Conclusion

The future course of the supplementary medical insurance program over the period immediately ahead will depend largely on the adequacy of the $5.30 premium rate in effect for the remainder of the current fiscal year, and the $5.60 premium rate promulgated for fiscal 1972. Current indications are that these rates will prove to be adequate, and that the actuarial status of the program will improve.

The projected improvement is not a certainty. Any of several possible unfavorable developments or later discovered projection difficulties could result in the inadequacy of these premium rates, as has in fact happened in the past. On the other hand, favorable developments could act to reduce the accumulated deficit at a rate faster than now seems likely.

APPENDIX

Appendix I. Statement of Acturial Assumptions and Bases Employed in Arriving at the Amount of the Standard Premium Rate for the Supplementary Medical Insurance Program Beginning July 1971

This is a statement of actuarial assumptions and bases employed in arriving at the amount of the standard premium rate for the supplementary medical insurance program for the period July 1971 through June 1972. The standard premium rate is that rate which is payable by those who enroll in their initial enrollment period and by those who enroll in a general enrollment period that terminates less than 12 months after the close of their initial enrollment period.

The actuarial determination has been made on the basis of the actual operating experience under the program. Virtually complete operating-experience figures for July 1966 through December 1968 are now available, but because of the timelag in the submission of bills for this program, figures for 1969 are not quite complete, and only partial data for 1970 are available.

ANALYSIS OF DATA ON A CASH BASIS

Current figures for cash expenditures under the program are available on a relatively complete basis through fiscal year 1970, but these figures taken alone are misleading because they do not take into account the liabilities arising from the delay in paying for benefits, which on the average are not made until well after the date that services were received. Such delay is due to the tendency of enrollees to accumulate a number of bills before submitting a claim, the delays by physicians, other suppliers of services, and enrollees in making requests for payment, and the time required by the carriers and intermediaries to adjudicate and pay claims.

The balances in the supplementary medical insurance trust fund at the end of each fiscal year since the incention of the program and the most recent available month are as follows (in millions):

Month:	*Balance*
June 1967	$486
June 1968	307
June 1969	378
June 1970	57
October 1970	155

The liabilities outstanding on October 31, 1970. for claims incurred but not filed (or filed but not paid) are estimated to be $700 million, while the balance of the trust fund amounts to $155 million. On a cash basis, the fund is adequate to pay benefit claims and administrative expenses as they come due.

It is expected that the trust fund balance will continue to increase during the remainder of fiscal year 1971, because the premium rate of $5.30 per month which was promulgated in December 1969 has a margin of safety for severe adverse conditions. Current experience indicates that the income from the $5.30 premium rate together with equal matching from general revenues will not all be needed to cover costs. It is estimated that the trust fund balance will accumulate to over $200 million by the end of June 1971.

On the basis of claims and administrative expenses paid (cash basis), the average monthly per capita expenditures for the first 21 months of the program, July 1966 through March 1968, amounted to $5.12. Similarly, the average monthly per capita expenditures on a cash basis in the premium period, April 1968 through June 1969, amounted to $8.05. Finally, the average monthly per capita expenditures (cash basis) for the premium period, July 1969 through June 1970, amounted to $8.59.

ANALYSIS OF DATA ON AN INCURRED BASIS

Under the law, the premium rate must be set on an accrual basis, rather than a cash basis. Thus, the cash figures must be adjusted for the estimated increase in liability for benefits to be paid for services rendered during the period (and the accompanying administrative expenses), but that will not have been filed or filed but not paid at the end of the period.

Estimates on an incurred basis for the 18 months involved in the first premium period (July 1966 through December 1967), when the combined rate of $6 [1] applied, indicate that benefits and administrative expenses per capita exceeded income from premiums, interest, and matching Government contributions by $0.34 per month (i.e., 17 cents each), or by 6 percent relatively. During the extension of the premium period from January 1 through March 31, 1968, when the combined rate of $6 was continued by congressional action, the cost per capita was $8.22 compared to income from premiums, matching contributions, and interest of $6.11.

Estimates on an incurred basis for the 15 months involved in the second premium period (April 1968 through June 1969) indicate a total per capita cost of $8.45 which exceeded income from premiums, interest, and matching Government contributions by $0.45 per month, or by 6 percent of the combined rate of $8. These estimates are based on virtually complete experience data.

Estimates on an incurred basis for the third premium period (July 1969 through June 1970) indicate that benefits and administrative expenses per capita were $9.33 on the combined rate basis. The interest earnings on the trust fund amounted to 5 cents per month. Although the combined rate for this period recommended by the actuaries was $8.80, the Secretary promulgated the continuation of the rate of $8.

Estimates for the fourth premium period (July 1970 through June 1971), based on a very limited experience of 4 months, indicate that the total cost per capita will be about $10.08 per month (i.e., $5.04 when divided equally between the beneficiary and the Government).

BASIC ESTIMATE OF FUTURE EXPERIENCE ON AN INCURRED BASIS

In estimating the cost of the program for July 1971 through June 1972, it is necessary to provide for the long-term trend toward greater utilization of medical services and the long-term upward trend of physicians' fees, higher costs for covered institutional and other services, and higher administrative expenses. In the estimates in this section, reasonable assumption as to future increases have been made without allowing for the possibility of severe adverse events that might occur.

For the purpose of estimating the necessary premium rate for July 1971 through June 1972, the assumptions shown below were used.

[In percent]

Calendar year	Assumed increase over previous year		
	Physicians' fees [1]	Costs of other covered services	Utilization of pyysicians' services
1970	2.5	14.5	2.5
1971	6.8	15.0	2.0
1972	6.5	15.0	2.0

[1] As recognized by the program.

The small increase of physicians' fees in 1970 over 1969 reflects the continued deferment of recognition of increases in physicians' fees for reimbursement purposes that was put into effect at the end of 1968.

The rates of increase for calendar year 1971 are based on the assumption that such deferment will be moved forward by 1 year on January 1, 1971, and the prevailing level will be moved back to the 75th percentile by regulation at the

[1] $3 premium plus the matching Federal payment.

same time. Also, it is assumed that in the future, the deferment of recognition of increases in physicians' fees will be moved forward with an approximate average lag of 18 months.

It should also be noted that these assumed rates of increase take into account the fact that the costs of covered nonphysician services, such as hospital outpatient care and home health services, which represent only about 13 percent of the total cost of the program, have been increasing more rapidly than physicians' fees and have not been subject to a deferment of recognition of cost changes.

Administrative expenses are assumed to represent about 11½ percent of the benefit payments; this figure is based on the actual budget estimate for fiscal year 1972. The average interest rate on the invested assets of the trust fund is assumed to be about 7 percent.

It is estimated that the incurred monthly per capita *total* cost, on a calendar-year basis, would have been $8.98 for 1969 if there had not been the influenza epidemic in early 1969. This consists of $8.01 for benefits and $0.97 for administrative expenses. This approach has been taken in order to obtain a proper base on which to build estimates of future costs; the possibility of epidemics occurring is later taken into account by adding a contingency margin to the estimated costs for "normal" conditions.

On the basis of the foregoing assumptions, it is estimated that the monthly per capita *benefit* cost on a calendar-year basis will be $8.56 for 1970. The corresponding benefit-cost figures estimated for 1971 and 1972 are $9.48 and $10.51, respectively. To these must be added the monthly per capita costs for administrative expenses, which are estimated at $1.02 for 1970, $1.12 for 1971, and $1.21 for 1972. Thus, the monthly per capita *total* cost on an incurred basis is estimated at $9.58 for 1970, $10.60 for 1971, and $11.72 for 1972.

The monthly per capita total cost on an incurred basis for the premium period July 1971 through June 1972 is determined by averaging the corresponding total cost per capita for calendar years 1971 and 1972. This average is $11.16. When divided equally between the beneficiary and the Government, it supports a premium rate of $5.58 which under the law is rounded to the nearest 10 cents or $5.60. This methodology is used due to the fact that the estimated costs of this program can be properly determined only on a calendar year basis because of the deductible feature being on a calendar year basis.

EFFECT OF INTEREST EARNINGS ON THE CONTINGENCY MARGIN

In addition to the $0.04 contingency margin arising from the rounding procedure indicated above, the interest earnings of the trust fund are also available toward the margin for contingencies. If they are not needed to pay benefits and administrative expenses in the current period, they will reduce the unfunded liability for the past deficiency in the premium rate. Interest earnings for fiscal year 1972 are estimated to be the equivalent of about 8 cents per capita (i.e., 4 cents in terms of premium) in available income. Thus the total contingency margin amounts of $0.12 per capita.

SUMMARY AND RECOMMENDATION

Based on all available evidence and analyses, the standard premium rate for fiscal year 1972 should be promulgated at $5.60 per month. This recommended premium rate contains an estimated $.06 margin for contingencies—2 cents from the basic calculation and 4 cents from interest earnings. The rate is determined based on the assumptions that there will continue to be a deferment of recognition of increases in physicians' fees for reimbursement purposes and that this deferment will be advanced by 12 months on January 1, 1971 and thereafter maintain an approximate average lag of 18 months.

The explanation of the $.30 increase in the standard monthly premium rate for the new premium period can be summarized as follows:

(*a*) The utilization of physicians' services is assumed to be higher in the new premium period than in the current period and so the program cost is higher—an increase of about 10 cents.

(*b*) The level of physicians' fees recognized by the program is assumed to be higher in the new premium period than in the current period, and so the program cost is higher—an increase of about 31 cents.

(*c*) The increase in unit cost and utilization of the institutional services covered by the program (13 percent of the total) is estimated to increase the cost of the program by 9 cents.

(*d*) The promulgated rate includes an allowance of 6 cents to provide a margin for contingencies, since the foregoing cost figures are based on reasonable cost projections and do not allow for any possible adverse morbidity experience (such as the influenza epidemic of 1968–69). The 6 cents for contingencies is a reduction of $0.18 from a planned contingency of $0.24 in the current $5.30 rate and a reduction of $0.20 from the $0.26 that is now estimated to be the actual margin over incurred costs during the current period. It is to be noted that this is the first period during which cost experience is expected to be more favorable than the estimates.

It should be noted that the $50 annual deductible in the program becomes a smaller proportion of the total incurred medical expenses for a beneficiary when there are increases in the unit price and utilization rate of covered services. Thus, the costs increases described in (*a*) and (*b*) above include an allowance for this fact and are higher than they would be if only the assumption of an increase in the utilization of services and an increase in the level of fees were considered.

Appendix II. Summary of Principal Provisions

Public Law 89–97, approved July 30, 1965, amended the Social Security Act by establishing the supplementary medical insurance program. A summary of its principal provisions, as amended by subsequent legislation up to and including Public Law 90–248, approved January 2, 1968, is as follows:

I. COVERAGE PROVISIONS (FOR CONTRIBUTION AND BENEFIT PURPOSES)

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

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

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

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

II. BENEFITS PROVIDED

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

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

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

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

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

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

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

III. FINANCING

(*a*) Participant premiums—flat monthly premium at a standard rate determined by Secretary of Health, Education, and Welfare. A rate of $4 has been promulgated for fiscal year 1970, and a rate of $5.30 has been promulgated for fiscal year 1971. 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 trust funds, with separate boards of trustees (same membership) and with same investment procedures. Premiums paid or deducted from benefits on the behalf

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

Appendix III. Nature of the Trust Fund

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

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

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

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

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

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 remibursement 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 previous sections of this report. The net worth of the resulting facilities—just as the net worth of all other capital assets—is not carried as an asset in such statements.

That portion of each trust fund which, in the judgment of the managing trustee, is not required to meet current expenditures for benefits and administra-

tion is invested in interest-bearing obligations of the U.S. Government, in obligations guaranteed as to both principal and interest by the United States, or in certain federally-sponsored agency obligations that are designated in the laws authorizing their issuance as lawful investments for fiduciary and trust funds under the control and authority of the United States or any officer of the United States. Obligations of these types may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price.

In addition, the Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall have maturities fixed with due regard for the needs of the trust fund and shall bear interest at a rate based on the average market yield (computed by the managing trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month. Where such average market yield is a multiple of one-eighth of 1 percent, this is taken as the rate of interest on such special obligations; otherwise, such rate is the multiple of one-eighth of 1 percent nearest such market yield.

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

Marketable public issues acquired by the fund may be sold at any time by the managing trustee at their market price. Special public-debt obligations issued for purchase by the trust fund may be redeemed at par plus accrued interest. Interest receipts and proceeds from the sale or redemption of obligations held in the trust fund are available for investment in the same manner as other receipts of the fund. Interest earned by the invested assets of the trust fund will provide income to meet a portion of future benefit disbursements. The role of interest in meeting future benefit payments is indicated in tables 7 and 8 of the main text.

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

Appendix IV.—Assumptions, Methodology, and Details of Cost Estimates

The basic assumptions 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 OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM: INCURRED BASIS OF PROGRAM, CASH BASIS OF BUDGET

The premium rate of 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 actually paid. Consequently, premium rates for any future period must be based on projections of the liability that will occur during that 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"[1] from the bank accounts of the Treasury to those of the various carriers and intermediaries,[2] and in the case of direct payments to certain providers, on actual disbursements by the Social Security Administration. The actual cash payments to beneficiaries and providers must necessarily lag a few days behind such

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

[2] 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."

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 the case of institutional benefits, however, advanced financing is possible; but even in this case, on the average there is a substantial lag between the incurred liability and the actual payment, even for interim payments. Further, virtually all advanced funding is currently made from the hospital insurance trust fund. In addition, there is a lag in the settlements with institutions for the differences between final and interim payments, which 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, so that 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, 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) COMPARISON OF INCURRED AND CASH PROJECTIONS

The principal economic variables involved—such as utilization and price increases, effects of influenza and other epidemics, changes in the operating philosophies of institutions or physicians, etc.—are in general, related to the services performed, rather than the cash payments made, which follow with a substantial lag. Consequently, the best way to project the cash payments is to first project the incurred services, and adjust for the expected lag with which the services will be paid.

On the other hand, administrative policy changes, especially policy changes related to the level of the reasonable cost screen, are applied on a cash basis. Thus a fee that is being processed is compared to the screen currently in effect, not that which would relate to the period in which a service was performed. Further, 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, adjustments 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 projections adjusted accordingly. For periods 3 to 5 years in the future, such projections should indicate the same general level of outgo as the more sophisticated projections on an incurred basis.

(C) PRINCIPAL COMPONENTS OF PROJECTIONS

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 purposes of estimating the present levels of program benefits, the benefits must be divided by types of payment mechanisms, 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 is required for each payment mechanism. Further, administrative policy is generally directed to benefits paid under a particular mechanism; e.g., the freeze on the prevailing fee level applied to services paid through the carriers and not to either the institutional or the direct payments. Finally, the currency and quality of the basic data—and consequently the accuracy of estimates made from it—varies substantially by source.

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 by payment records are broken into those for house visits, office visits, in-patient visits, surgery, X-ray, and laboratory, radiologists, and pathologists for care of in-patients, 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 in-patient 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 utilization increases separately only for (1) radiology and pathology for in-patients, (2) other physician services and miscellaneous services paid by carriers, (3) all institutional services, and (4) group practice plans.

(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 is incomplete and scarce, data concerning the variables that affect the difference in levels of utilization between the different types of program is particularly scarce and inconclusive. Much more reliable data is available for the cost of particular insured groups under particular insured programs 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. For example, an attempt to base estimates of the specific benefits on general estimates of the cost of medical services for the entire population would require a projection of the latter with problems similar to those of projecting the specific program costs, and an additional step—determining the proportion of each type of service used by covered persons. Not only is the data derived directly from the program of far superior accuracy and reliability, but the additional step introduces another nontrivial source of error, since reliable data is not available for either the level or trend of the proportions required.

Further, it is generally more helpful to estimate the change that will occur in a particular economic series as a result of the impact of any forecast events, rather than to ignore the series as a base for projecting the future. Thus, such items as the ratio or the expenditures of the program or a particular part of the program to, say, the gross national product, is very interesting, but not very helpful, in projecting the cost of the various components of the supplementary medical insurance program.

(E) PRINCIPAL SOURCES OF DATA

As discussed above, data from the program is available separately by the type of payment mechanism used. The principal components will be discussed in turn.

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

Approximately 86 percent of supplementary medical insurance benefits are paid by carriers; and carriers are required to submit payment records covering all payments made.

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, especially if the information submitted is incomplete or special handling is required to determine the reasonable fee or whether the services were covered. There may be a further delay before payment records are submitted. There is also the possibility 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 actuarial sample is based on those submitted, not those accepted. Currently, however, the proportion never returned is very small as monitored by statistical controls.)

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

For purposes of projecting the future, an allowance must be made for the effect of the very severe influenza epidemic that occurred during the winter of 1968–69. A study of some data from the national disease therapeutic index concerning nonhospital physician visits for influenza, and considerations of consistency required for feasible solutions to a number of relationships believed to hold concerning the data, indicate that the abnormal increase in cost due to the flu epidemic was approximately $0.75 per capita in 1969.

2. Inpatient radiology and pathology paid through hospital insurance

As a result of 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 and subsequently reimbursed from the supplementary medical insurance trust fund. Payments to hospitals are made on a basis of an estimated average cost of all inpatient radiology and pathology reimbursed by hospital insurance for that hospital. The actual liability of the program, however, depends on subsequent cost settlements with the hospitals.

Estimates have to be made of the liability of the program for such liability from the proportion of payment records that covered services for inpatient radiology and pathology prior to April 1968 when this payment mechanism became available. Prior to that date, payment records were submitted for all professional radiology and pathology. Payment records are not complete, however, due to the omission of payment records covering services where the deductible was not initially satisfied, but was later satisfied by a subsequent claim. Estimates were prepared on the basis of such information as was available.

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 (negligible in amount), to extended care facilities for outpatient services, and to home health agencies for services not covered by hospital insurance—are reimbursed by the hospital insurance intermediary 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 can be tabulated by date of service, and an estimate thus made of the interim payments for these services on an incurred basis, the data available in the actuarial sample, however, contain substantial biases. Estimates of the level of the overall bias for the accumulated experience for the years 1966–69 are of the order of 10–15 percent (negative), but estimates of the specific bias applicable to a particular year, such as 1969, are not available. Further, study of

a very small sample indicates that on the average, final cost settlements result in increasing the interim payments for the outpatient institutional payments by about one third.

Finally, an adjustment must be made for the effect of the flu epidemic in 1968–69. The overall error possible in the estimates for the outpatient institutional services is of the order of 18 percent, or about 3 percent of the total supplementary medical insurance cost.

4. Group practice plans

Group practice plans are reimbursed on an interim payment system that is designed to reimburse currently for services performed. Consequently, cash payments for these services have been taken as the same as accrued benefits for these services.

5. Institutions reimbursed directly by Social Security Administration

The same basic procedures used by intermediaries is also followed by the Social Security Administration direct reimbursement group. Although data from this source should be analysed separately, the amount involved has been too small to merit priority compared to other sources of potential error. Consequently, direct institutional reimbursements were analysed jointly with other institutional benefits.

(F) ASSUMPTIONS CONCERNING INCREASES IN PRICES, UTILIZATION, AND THE EFFECT OF CONTROLS ON PHYSICIAN FEES

The experience under the program (as estimated from the actuarial samples and the current medicare survey) and assumptions concerning the future as to increases in average physician fees, utilization of physician services, and the effect of Social Security Administration policy with regard to prevailing fees—appears in table A.

The average price increases shown are based on 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 estimates for the effect of the fee screens for years 1966–70 are based on data from the Office of Research and Statistics 5-percent sample for 1966–68 and on the results of special surveys conducted during 1969–70 on a cash basis. Unfortunately, the latter are unreliable due to the presence of many obvious inconsistencies in the data. Utilization increases shown for 1966–69 are essentially residuals, smoothed to form an orderly progression.

Substantial errors are possible in any of these series, since no reliable program data is available that bears directly on price increases, utilization levels, or the effect of fee screens. Finally, substantial fluctuations are possible in the general level of health care costs.

(G) EFFECT OF ADMINISTRATIVE POLICY

Policy changes in the administration of the reasonable fee screen are of crucial importance in estimating future experience. Some changes have already been put into effect, and others are planned for the future. Although these actions are within the latitude permitted by the discretion delegated to the Secretary by Congress, these actions are in general coordinated with and in anticipation of action by Congress. Future policy will be set to conform to actual congressional action. Current estimates are based on the policy changes that would be anticipated assuming passage of H.R. 17550 of the 91st Congress.

The principal policy changes made or anticipated are as follows:

(1) Claims processed after January 1 and before July 1, 1971, will be subjected to a reasonable fee screen based on 1969 data, rather than on 1968 data as it has been (at least theoretically) since January 1969. The prevailing fee for any type of service will be set at the 75th percentile of the customary fees according to this data base, rather than the 83d percentile used in the past.

(2) Claims processed after July 1, 1971, will be subject to a reasonable fee screen based on data from 1970.

(3) After passage of legislation containing the provisions relating to the reasonable fee screen that were in H.R. 17550, the prevailing fees will be set each year at the level based on 1970 data projected to the year in question by an economic index, based partly on average earnings and partly on the cost of office practice.

(4) On July 1 of each succeeding year, the prevailing fee screen will be adjusted so as to be based on data from the prior calendar year, to be in effect during the next year. If the prevailing fees in that year are higher than that of 1970 projected to that year by an economic index of physician costs (including their own labor), the prevailing fee screen will be lowered accordingly.

The effect of these changes in policy is very difficult to assess due to insufficient information concerning the distributions of customary charges and the effect of price changes on these distributions through time—or even as to the actual effect of past changes in fee screen policy. Further, a change in policy affects only those services which are being reduced. At present, around 40 percent (by bills) of all services are reduced; so that adjustments to the screen have no influence on reimbursement for more than half of all services.

Using such data as is available and a large measure of a priori reasoning, the effect of the policy changes with regard to reasonable fees were estimated as shown in the column "Effect of the fee screen" in table A.

Another administrative policy decision that may have a significant impact on the level of benefits paid by the program was the proposed regulations which recognized as an inpatient service covered under hospital insurance diagnostic testing procedures during the seven days prior to admittance to a hospital. This policy change is consistent with provisions of H.R. 17550. The effect of this change was to transfer a significant portion of the supplementary medical insurance outpatient benefit to the hospital insurance program. Estimates of the cost of the institutional benefits was adjusted to take into account this transfer of liability.

H. PROJECTIONS OF FUTURE INCURRED EXPERIENCE

Details of the projection of future experience are summarized in "Appendix 1: 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, 1971." The basic method used was as follows. For projections of the experience for future calendar years, the average cost per capita of all covered benefits in 1969, adjusted for the flu epidemic, was projected to future years by weighted average factors which allowed for (1) increase in prices of covered services; (2) increase in utilization of covered services; and (3) an allowance for the leverage of the static $50 deductible.

Projections of fiscal year experience were made by averaging the projections on a calendar year basis, since the effect of the $50 deductible cannot be separated into the effects in the first half and the second half of a calendar year.

I. ACCOUNTING CHANGE WITH REGARD TO THE DEDUCTIBLE CARRIED OVER

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

Since these additional costs resulting from the deductible carried over result from services performed in the prior year, it can be argued if the program were superseded by some other program, or if an enrollee disenrolls at the end of a calendar year, there is no liability outstanding for such additional costs; this indicates that the liability for paying these additional costs arises from continuing the program and from the individual's continuing his enrollment. Also, in the case of any individual enrollee, there is no liability unless he receives enough services in the succeeding year to be eligible for benefits. Further, the additional costs are paid on the basis of services actually performed in the succeeding year, and the allocation of such costs to the year prior to that in which the services were performed appears inconsistent with the principle that all costs are accrued in the year in which the services giving rise to such costs were performed.

For calendar years beginning with 1968, the assumptions with regard to the deductable carried over will have negligible effect, since the additional costs paid as a result of deductibles carried over from the preceding year will be approximately equal to the deductibles carried over to the succeeding year. In 1966–67, however, due to the application of the full $50 deductible in a

6-month period for 1966, there was an unusually large amount of additional benefits paid in 1967 as a result of deductibles carried over from 1966. As a result, comparisons between the experience in 1967 and that of later years are difficult. Further, the experience in 1966 is artificially favorable not only because of the application of the full deductible in a short period, but also because there were no deductibles carried over from a prior period. Beginning with 1968, however, these problems disappear, since the deductible carried over from the previous year approximately offsets that carried over to the next.

(J) PROJECTIONS OF FUTURE CASH EXPERIENCE

The estimates contained in this report of cash expenditures are based on estimates used to prepare the budget, and agree with amounts shown therein. Since these estimates were submitted in August 1970, they are based on information available then as to the level of expenditures under the program and administrative policy decisions that had been made through that date, and not changed to reflect new information available since then other than a reduction ordered by the Office of Management and Budget to reflect an administration decision to request new legislation to put the deductible on a dynamic basis that would substantially reduce the cost of the program.

Two distinct approaches are followed in the projection of cash benefits. First, the estimates on an accrued basis are adjusted for the lags in actual payment, according to each payment mechanism. Estimates are also prepared by projecting the cash actually paid in the most recent year to future years, allowing indirectly for the effect of price increases, increases in utilization, etc. Reasonable agreement between the two methods of estimating future costs on a cash basis was achieved. Such cash projections provide a check on the general level of estimates prepared, on an incurred basis.

The cash figures used for each type of benefit in the latter calculations are derived from checks actually drawn to providers of services, not on the letter of credit payments which form the basis of the Treasury accounts. Consequently, a small discrepancy develops between the level of cash expenditure indicated by the Treasury statements and that actually paid for benefits. Additional discrepancies result from other accounting adjustments made by the Treasury.

(K) GENERAL LEVEL OF ACCURACY OF THE ESTIMATES

Due to the inadequacies in the data available from the program noted in the earlier discussion, the estimates of incurred costs for calendar year 1969 can only be regarded as within 5 percent of the actual liability. Further, substantial fluctuations in the level of cost from year to year must be anticipated, as a result of flu or other epidemics, and other fluctuations in the need for the services covered. Finally, the impact of projected administrative actions cannot be anticipated with certainty.[1] Thus the estimates are probably accurate only to within 5 to 10 percent depending on how far costs are projected into the future.

TABLE A.—INCREASES IN PHYSICIAN PRICES, UTILIZATION, AND EFFECT OF THE FEE SCREENS

(In percent)

Year	Prices	Utilization	Effect of change in screens [1]	Increases in charges
1967/1966	7.2	4.0	−1.5	9.7
1968/1967	6.6	3.0	0	9.6
1969/1968	7.7	2.0	−3.0	6.7
1970/1969	7.0	2.5	−4.5	5.0
1971/1970	6.0	2.0	0.8	8.8
1972/1971	5.6	2.0	0.9	8.5
1973/1972	5.2	2.0	−.2	7.0

[1] Difference between reductions in year y and y+1. Initial reductions in 1966 were about 1½ percent of payment records.

[1] In fact, policy on many aspects has not been determined. For example, the actual economic index to be used in projecting the maximum prevailing fee screen and the methodology to be followed have not been determined.

TABLE 8.—PRICE AND UTILIZATION INCREASE ASSUMPTIONS COMBINED (AS RECOGNIZED BY PROGRAM) INCREASE OVER PRIOR YEAR

[In percent]

Year	Physician services records	Inpatient radiology and pathology	Group practice plans	Institutions
1970	5.0	7.0	9.0	14.5
1971	8.8	10.8	8.0	15.0
1972	8.5	10.5	7.6	15.0
1973	7.0	9.0	7.2	15.0

TABLE 1.—REIMBURSEMENT FOR SERVICES ON PAYMENT RECORDS

Year	Enrollment (millions)	Reimbursement (millions)		Reimbursement per capita	
		Accrued	Cash	Accrued	Cash
1966	17.7	$452.2	$120.3	$25.55	$6.80
1967	17.9	1,254.4	1,117.5	70.21	62.43
1968	18.4	1,465.5	1,420.8	79.63	77.22
1969	19.0	1,633.0	1,592.5	85.97	83.82
1970	19.4	.....	1,699.4	.....	87.60

TABLE 2.—REIMBURSEMENT FOR INSTITUTIONAL SERVICES

[In millions]

Year	Enrollment	Interim reimbursement		Final settlements, cash	Interim reimbursement per capita	
		Actuarial sample	cash		Actuarial sample	Cash
1966	17.7	$15.8	$2.6	0	$0.89	$0.15
1967	17.9	50.0	41.3	$0.4	2.79	2.31
1968	18.4	75.3	67.4	2.0	4.09	3.66
1969	19.0	107.5	98.5	11.0	5.66	5.18
1970	19.4	.....	104.5	59.4	.....	5.39

TABLE 3.—SUMMARY OF BENEFITS PER CAPITA BY TYPE OF BENEFIT

Year	Payment records	Direct inpatient R. & P.	G.P.P.P.	Institutions		Total
				Interim	Adjustment	
1966	$25.55	.....	$0.34	$1.07	$0.35	$27.31
1967	70.21	.....	1.05	2.79	0.92	74.97
1968	79.65	$0.92	1.27	4.89	1.61	88.34
1969	85.97	1.25	1.45	6.43	2.12	97.22

Appendix V.—Legislative History Affecting the Trust Fund

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

Premium rates.—The Social Security Amendments of 1965, which established the supplementary medical insurance program, fixed the premium rate for indi-

viduals enrolling under the program at $3 per month for the 18-month period, July 1966 to December 1967. The 1965 amendments also provided that between July 1 and October 1, 1967 (and every 2 years thereafter), the Secretary of Health, Education, and Welfare could adjust the standard premium rate so that income to the program would be in balance with outgo for benefit payments and administrative expenses (with inclusion of an appropriate contingency margin in the premium rate). Because the 1967 amendments were then pending and their final form indeterminate, on September 30, 1967, Public Law 90-97 was enacted to permit the promulgation to be deferred until December 31, 1967, with the adjusted premium rate to become effective for April 1968. The rate so promulgated was $4. The 1967 amendments provide that the premium rate is to be determined annually, during December of each year, and is to apply initially for April 1968 through June 1969, and beginning with July 1969 for 12-month periods. The standard premium rate applies to persons who enroll in their initial enrollment period. The premium rate for persons who enroll later than the first period when enrollment was open to them or who re-enroll after their enrollment was terminated is the standard premium rate increased by 10 percent for each full year during which they could have been but were not enrolled.

Government contributions.—The 1965 amendments provide for payments from general funds of the Treasury to be made in amounts equal to the aggregate premiums paid by enrollees. The 1967 amendments provide for payment of interest, after June 30, 1967, when the Government contribution is not made promptly.

Contingency reserve.—An appropriation from general funds of the Treasury is authorized by the 1965 amendments, to provide an operating fund at the beginning of the program—i.e., a contingency reserve. The amount of the authorization is $18 times the estimated number of individuals who would be covered by the program on July 1, 1966, if all persons eligible to so elect had done so. This authorization, which would have expired at the end of 1967, was extended to the end of 1969 by the 1967 amendments. Any amounts actually used by the supplementary medical insurance trust fund are repayable (without interest) to the Treasury.

Investments.—Since the inception of the program, provision has been made for the investment of funds which are not required to meet current disbursements. As provided in the Social Security Act, the funds may be invested only in interest-bearing obligations of the U.S. Government or in obligations guaranteed as to both principal and interest by the United States; or the funds may be invested in certain federally-sponsored agency obligations that are designed in the laws authorizing their issuance as lawful investments for fiduciary and trust funds under the control and authority of the United States or any officer of the United States. These obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at their market price. In addition, the Social Security Act authorizes the issuance of public-debt obligation for purchase by the trust funds.

Special issues acquired after enactment bear interest at a rate equal to the average market yield (computed on the basis of market quotations as of the end of the calendar month next preceding their issue) on all marketable interest-bearing obligations of the United States forming a part of the public debt which are not due or callable for 4 or more years from the time the special obligations are issued, such average market yield being rounded to the nearest one-eighth of 1 percent.

Appendix VI. Statutory Provisions, as of December 31, 1970, Creating the Trust Fund, Defining the Duties of the Board of Trustees, and Providing For Advisory Councils on Social Security

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

Federal supplementary medical insurance trust fund.—Section 1841. (*a*) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal supplementary medical insurance trust fund" (hereinafter in this section referred to as the "trust fund"). The trust fund shall con-

sist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

(*b*) With respect to the trust fund, there is hereby created a body to be known as the Board of Trustees of the trust fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the manag ng trustee of the Board of Trustees (hereinafter in this section refererred to as the "managing trustee"). The Commissioner of social security shall serve as the secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the trust fund;

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

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

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

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

(*c*) It shall be the duty of the managing trustee to invest such port'on of the trust fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and 'nterest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the trust fund. Such obligations issued for purchase by the trust fund shall have maturities fixed with due regard for the needs of the trust fund and shall bear interest at a rate equal to the average market yield (computed by the managing trustee on the basis of market quotations as of the end of the calendar month next preced'ng the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligat'ons shall be the multiple of one-eighth of 1 per centum nearest such market yield. The managing trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determ'nes that the purchase of such other obligations is in the public interest.

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

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

(*f*) There shall be transferred periodically (but not less often than once each fiscal year) to the trust fund from the Federal old-age and survivors insurance trust fund and from the Federal disability insurance trust fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this act. There shall be transferred periodically (but not less often than once each

fiscal year) to the trust fund from the railroad retirement account amounts, equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this act.

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

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

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

(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal old-age and survivors insurance trust fund or the Federal disability insurance trust fund to the Federal supplementary medical insurance trust fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 which are payable from such trust fund. Such transfer shall be made on the basis of a certification by the Secretary of Health, Education, and Welfare and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

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

(2) The Secretary of the Treasury shall, from time to time, transfer from the railroad retirement account to the Federal supplementary medical insurance trust fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

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

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

(*e*)(1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5, United States Code, or any other law administered by the Civil Service Commission providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the amount thereof from each installment of such annuity. Such deduction

shall be made in such manner and at such times as the Civil Service Commission may determine. The Civil Service Commission shall furnish such information as the Secretary of Health, Education, and Welfare may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies.

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the civil service retirement and disability fund, or the account (if any) applicable in the case of such other law administered by the Civil Service Commission, to the Federal supplementary medical insurance trust fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Civil Service Commission and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

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

(*g*) Amounts paid to the Secretary under subsection (d) or (f) shall be deposited in the Treasury to the credit of the Federal supplementary medical insurance trust fund.

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

Appropriations to cover Government contributions and contigency reserve.—Section 1844. (*a*) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal supplementary medical insurance trust fund—

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

(2) Such sums as the Secretary deems necessary to place the trust fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the trust fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the trust fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the trust fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

(*b*) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the trust fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

Advisory Council on Social Security.—Section 706(a). During 1969 (but not before February 1, 1969) and every fourth year thereafter (but not before February 1 of such fourth year), the Secretary shall appoint an Advisory Council on Social Security for the purpose of reviewing the status of the Federal old-age and survivors insurance trust fund, the Federal disability insurance trust fund, the Federal hospital insurance trust fund, and the Federal supplementary medical insurance trust fund in relation to the long-term commitments of the old-age, survivors, and disability insurance program and the programs under parts A and B of title XVIII, and of reviewing the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs under this act.

(*b*) Each such council shall consist of a chairman and 12 other persons, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public.

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

(2) Appointed members of any such council, while seving on business of the council (inclusive of traveltime), shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

(d) Each such council shall submit reports (including any interim reports such council may have issued) of its findings and recommendations to the Secretary not later than January 1 of the second year after the year in which it is appointed, and such reports and recommendations shall thereupon be transmitted to the Congress and to the Board of Trustees of each of the trust funds. The reports required by this subsection shall include—

(1) A separate report with respect to the old-age survivors, and disability insurance program under title II and of the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954,

(2) A separate report with respect to the hospital insurance program under part A of title XVIII and of the taxes imposed by sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, and

(3) A separate report with respect to the supplementary medical insurance program established by part B of title XVIII and of the financing thereof.

After the date of the transmittal to the Congress of the reports required by this subsection, the council shall cease to exist.

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