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# 1975 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

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## COMMUNICATION

FROM

## THE BOARD OF TRUSTEES, FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

TRANSMITTING

THE 1975 ANNUAL REPORT OF THE BOARD, PURSUANT TO SECTION 1841(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

## LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

*Washington, D.C, May 2, 1975.*

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

SIR: We have the honor to transmit to you the 1975 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the tenth such report), in compliance with the provisions of Section 1841(b) of the Social Security Act.

Respectfully,

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

JOHN T.DUNLOP,
*Secretary of Labor.*

CASPAR W. WEINBERGER,
*Secretary of Health, Education, and Welfare.*

JAMES B. CARDWELL,
*Commissioner of Social Security*

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# 1975 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

## THE BOARD OF TRUSTEES

The Federal Supplementary Medical Insurance Trust Fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1841(b) of the Social Security Act, as amended. The Board is comprised of three members who serve in an ex-officio capacity. The members of the Board are the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Secretary of the Treasury is designated by law as the Managing Trustee. The Commissioner of Social Security is Secretary of the Board. The Board of Trustees reports to the Congress once each year, in compliance with Section 1841(b) (2) of the Social Security Act. This Report is the annual report for 1975, the tenth such report.

## HIGHLIGHTS

(a) In July 1973, persons entitled to disability insurance benefits for two years and persons suffering from chronic kidney disease became eligible to enroll in the supplementary medical insurance program. Based on the partial data now available, it appears that fiscal year 1974 outlays for these persons were close to that projected in the 1974 Report.

(b) The growth of the supplementary medical insurance trust fund during fiscal 1974 was somewhat higher than estimated in the 1974 Report. Income for fiscal 1974 of $3.8 billion was up about 31 percent from fiscal 1973. Expenditures for benefit payments and administration were $3.3 billion, an increase of about 24 percent over those for fiscal 1973. The cash balance of the trust fund grew by $526 million to reach $1,272 million by the end of fiscal 1974. Most of this increase was required to meet the liabilities for incurred but unpaid claims (and related administrative expenses) for disabled enrollees, first covered in July 1973.

(c) The solvency of the trust fund, which must be measured on an incurred basis, also improved during fiscal 1974. Although incurred data for the newly covered beneficiaries is too incomplete to permit a fully accurate assessment, it appears that the assets of the program exceeded the liabilities for incurred but unpaid services and administrative costs at the end of fiscal year 1974.

(d) In December 1974, adequate actuarial rates of $7.50 for aged enrollees and $18.50 for disabled enrollees were promulgated for fiscal year 1976. Due to a technical error in the law, it was necessary to continue the 1975 premium rate of $6.70 through 1976. Proposed legislation to correct this error has been submitted to the Congress. Appendix A gives a statement of the actuarial assumptions and bases employed by the Secretary of Health, Education, and Welfar0 in determining these rates.

(e) The number of aged enrollees had by July 1974 reached 21.2 million, about 95 percent of the totalpopulationaged65 and over. Disabled enrollment was 1.8 million in the same month.

## NATURE OF THE TRUST FUND

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

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

The premiums paid by participants are based on the standard monthly premium rate, which is the same for participants aged 65 and over and for disabled participants under age 65. Premiums paid for fiscal years 1967 through 1973 were matched by an equal amount of Government contributions. Beginning with fiscal year 1974, the amount of Government contributions corresponding to premiums paid by each of the two groups of participants is determined by applying a ratio, prescribed in the law for each group, to the amount of premiums received from that group of participants. The ratio is equal to (1) twice the amount of the adequate actuarial rate applicable to the particular group of participants, minus the amount of the standard monthly premium rate, divided by (2) the amount of the standard monthly premium rate.

Standard monthly premium rates and adequate actuarial rates are promulgated each year by the Secretary of Health, Education, and Welfare. The standard premium rates in effect since the beginning of the program, July 1966, through June 1975, and the rate promulgated for fiscal year 1976, are shown in table 1. Adequate actuarial rates in effect for fiscal years 1974 and 1975, and the rate" promulgated for fiscal year 1976, are also shown.

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

Section 201(i) of the Social Security Act authorizes the :Managing Trustee to accept and deposit in the trust fund unconditional money gift, or bequests made for the benefit of the fund or for any activity financed through the fund.

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

Hospitals, at their option, are permitted to combine their billing for both hospital costs and physician components of radiology and pathology

services rendered hospital inpatients by hospital-based physicians. Where hospitals elect this billing procedure, payments are made initially from the hospital insurance trust fund, with reimbursement later to it from the supplementary medical insurance trust fund. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.

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

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

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

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that such special public-debt obligations shall bear interest at a rate based on the average market yield (computed by the Managing Trustee on the basis of market quotations as of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States forming a part of the public-debt which are not due or callable until after the expiration of four years from the end of such calendar month.

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

| | Standard monthly premium rate | Adequate actuarial rate | |
|---|---|---|---|
| | | Participants aged 65 and over | Disabled participants under age 65 |
| July 1966 - March 1968 | $3.00 | | |
| April 1968 - June 1970 | 4.00 | | |
| Fiscal year:: | | | |
| 1971 | 5.30 | | |
| 1972 | 5.60 | | |
| 1973 | 5.80 | | |
| 1974[1] | 6.30 | $6.30 | $14.50 |
| 1975 | 6.70 | 6.70 | 18.00 |
| 1976 | 6.70 | 7.50 | 18.50 |

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

## SUMMARY OF THE OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1974

A statement of the income and disbursements of the Federal supplementary medical insurance trust fund during fiscal year 1974 and of the assets of the fund at the beginning and end of the fiscal year is presented in table 2. Comparable amounts for fiscal year 1973 are also shown in the table.

The total assets of the trust fund amounted to $746 million on June 30, 1973. During fiscal year 1974, total receipts amounted to $3,809 million and total disbursements were $3,283 million. Total assets thus increased $526 million during the year to a total of $1,272 million on June 30, 1974.

Of the total receipts, $1,579 million represented premium payments by (or on behalf of) participants aged 65 and over, and $125 million represented premium payments by (or on behalf of) disabled participants under age 65. Total premium payments amounted to $1,704 million, an increase of 19.5 percent over premium payments by participants in the preceding fiscal year. This increase in premiums from participants resulted primarily from (1) premiums paid by disabled participants under age 65, whose premiums first became payable in July 1973, (2) the increase from $5.80 to $6.30 per month in the standard premium rate that became effective during fiscal year 1974, and (3) the expected growth in the number of persons aged 65 and over enrolled in the supplementary medical insurance program.

Contributions received from the general fund of the Treasury amounted to $2,029 million. This amount consisted of $1,577 million representing contributions relating to premiums paid by participants aged 65 and over and $452 million representing contributions relating to premiums paid by disabled participants under aged 65.

Reference has been made in an earlier section to provisions under which money gifts or bequests may be deposited in the trust fund. In fiscal year 1974, the trust fund received gifts amounting to about $4,000.

The remaining $76 million of receipts consisted almost entirely of interest on the investments of the trust fund.

Of the $3,283 million in total disbursements, $2,868 million represented benefits paid directly from the trust fund for health services covered under Title XVIII of the Social Security Act. In addition,

transfers were made to the hospital insurance trust fund consisting of $6 million for inpatient professional radiology and pathology services that were paid initially from the hospital insurance trust fund but that are liabilities of the supplementary medical insurance trust fund. Total benefit payments from the trust fund in fiscal year 1974, therefore, amounted to $2,874 million, an increase of 20.2 percent over the corresponding amount paid in fiscal year 1973.

Reference has been made in an earlier section to provisions which authorize payment from the trust fund for costs of experiments and demonstration projects in providing health care services. In fiscal year 1974, payments for such costs amounted to about $47,000.

The remaining $409 million of disbursements was for net administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds-old-age and survivors insurance, disability insurance, hospital insurance, and supplementary medical insurance-on the basis of provisional estimates. Periodically, as actual experience develops and is analyzed, adjustments to the allocations of administrative expenses and costs of construction for prior periods are effected by interfund transfers, with appropriate interest allowances.

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

The assets of the trust fund at the end of fiscal year 1974 totaled $1,272 million, consisting of $1,231 million in the form of obligations of the United States Government and an undisbursed balance of $41 million. Table 4 shows a comparison of the total assets of the fund and their distribution at the end of fiscal years 1973 and 1974. A comparison of the assets of the trust fund with liabilities for incurred but unpaid benefits (and related administrative expenses) is shown in a later section.

The net increase in the par value of the investments held by the fund during fiscal year 1974 amounted to $531 million. New securities at a total par value of $4,316 million were acquired during the fiscal year, through the investment of receipts and reinvestment of funds made available from the redemption of securities. The par value of securities redeemed during the year was $3,785 million. Included in these amounts is $3,758 million in certificates of indebtedness that were acquired and redeemed within the fiscal year.

The effective annual rate of interest earned by the assets of the supplementary medical insurance trust fund during fiscal year 1974 was 6.8 percent. The interest rate on public-debt obligations issued for purchase by the trust fund in June 1974 was 7⅝ percent, payable semiannually.

TABLE 2.—STATEMENT OF OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING FISCAL YEARS 1973 AND 1974

[In thousands of dollars]

| | Fiscal year 1973 | Fiscal year 1974 |
|---|---|---|
| Total assets of the trust fund, beginning of year | $480,709 | $745,722 |
| Receipts: | | |
| Premiums from participants: | | |
| Participants aged 65 and over | 1,426,607 | 1,578,919 |
| Disabled participants under age 65 | | 125,452 |
| Total premiums | 1,426,607 | 1,704,371 |
| Transfers from general fund of the Treasury: | | |
| Government contributions: | | |
| For premiums received from participants aged 65 and over | 1,430,652 | 1,577,045 |
| For premiums received from disabled participants under age 65 | | 451,880 |
| Total Government contributions | 1,430,652 | 2,028,926 |
| Less adjustment in interest received in prior fiscal year on delayed transfers of Government contributions | 201 | |
| Net transfers from general fund of the Treasury | 1,430,451 | 2,028,926 |
| Interest | | |
| Interest on Investments | 43,070 | 77,243 |
| Interest on amounts of interfund transfers due to adjustment in allocation of administrative expenses and construction costs[1] | 1,979 | −1,318 |
| Total interest | 45,049 | 75,924 |
| Gifts | | 4 |
| Total receipts | 2,902,106 | 3,809,225 |
| Disbursements: | | |
| Benefit payments | | |
| Paid directly from the trust fund for costs of health services | 2,385,128 | 2,867,602 |
| Transfers to the hospital insurance trust fund for reimbursement of payments made initially from that fund for costs of radiology and pathology services[2] | 6,000 | 6,000 |
| Total benefit payments | 2,391,128 | 2,873,602 |
| Costs of experiments and demonstration projects[2] | 104 | 47 |
| Administrative expenses: | | |
| Department of Health, Education and Welfare[3] | 269,887 | 379,319 |
| Treasury Department | 20 | 88 |
| Railroad Retirement Board | | 814 |
| Civil Service Commission | 72 | 78 |
| Construction of facilities for Social Security Administration | 1,064 | −72 |
| Interfund transfers due to adjustment in allocation of— | | |
| Administrative expenses[4] | −24,953 | 28,881 |
| Construction costs[4] | −223 | 42 |
| Gross administrative expenses | 245,867 | 409,150 |
| Less receipts from sale of surplus supplies, materials, etc. | 6 | 29 |
| Net administrative expenses | 245,861 | 409,121 |
| Total disbursements | 2,637,093 | 3,282,770 |
| Net addition to the trust fund | 265,014 | 526,455 |
| Total assets of the trust fund, end of year | 745,722 | 1,272,177 |

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

[2]For explanation, see text.

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

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

TABLE 3.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1974

[Dollar amounts in millions]

| Item | Actual amount | Estimated amount published in 1974 report | Actual as percentage of estimate |
|---|---|---|---|
| Premiums from Participants | $1,704 | $1,683 | 101 |
| Government Contributions | 2,029 | 2,008 | 101 |
| Benefit Payments | 2,874 | 2,900 | 99 |

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

TABLE 4.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, BY TYPE, AT THE END OF FISCAL YEARS 1973 AND 1974

| | June 30, 1973 | | June 30, 1974 | |
|---|---|---|---|---|
| | Par value | Book Value[1] | Par value | Book Value[1] |
| Investments in public-debt obligations sold only to this fund (special Issues): | | | | |
| Notes: | | | | |
| 5¾ percent, 1979 | $232,150,000 | $232,150,000.00 | $232,150,000 | $232,150,000.00 |
| 6⅛ percent, 1978 | 185,719,000 | 185,719,000.00 | 159,101,000 | 159,101,000.00 |
| 6⅝ percent, 1980 | 281,762,000 | 281,762,000.00 | 281,762,000 | 281,762,000.00 |
| Bonds: | | | | |
| 7⅛ percent, 1981 | | | 61,964,000 | 61,964,000.00 |
| 7⅛ percent, 1982 | | | 61,964,000 | 61,964,000.00 |
| 7⅛ percent, 1983 | | | 61,964,000 | 61,964,000.00 |
| 7⅛ percent, 1984 | | | 61,964,000 | 61,964,000.00 |
| 7⅛ percent, 1985 | | | 61,964,000 | 61,964,000.00 |
| 7⅛ percent, 1986 | | | 61,963,000 | 61,963,000.00 |
| 7⅛ percent, 1987 | | | 61,963,000 | 61,963,000.00 |
| 7⅛ percent, 1988 | | | 61,963,000 | 61,963,000.00 |
| 7⅛ percent, 1989 | | | 61,963,000 | 61,963,000.00 |
| Total investments in public-debt obligations | 699,631,000 | 699,631,000.00 | 1,230,685,000 | 1,230,685,000.00 |
| Undisbursed balance | | 46,091,485.58 | | 41,492,279.79 |
| Total assets | | 745,722,485.58 | | 1,272,177,279.79 |

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

## ADVISORY COUNCIL ON SOCIAL SECURITY

Pursuant to section 706 of the Social Security Act, an Advisory Council on Social Security was appointed by the Secretary of Health, Education, and Welfare in April 1974. The Council reports, submitted March 6, 1975, contained no recommendations regarding the supplementary medical insurance program.

## EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND DURING THE PERIOD JULY 1, 1974 TO SEPTEMBER 30, 1977

The projected cash income, disbursements, and balance of the trust fund during the period July 1, 1974 to September 30, 1977 are summarized in Table 5, along with a summary of the past transactions of the trust fund through June 30, 1974.

Income to the program is projected to increase by about 13% in fiscal year 1975 over fiscal 1974, due to the increase in the premium rate from $6.30 per month for fiscal 1974 to $6.70 per month for fiscal 1975, increased enrollment in the program, and increased government contributions for disabled enrollees. An increase of 16 percent is projected for fiscal 1976 over 1975.

Benefit expenditures for fiscal year 1975 are expected to increase by 27 percent over those for fiscal 1974. This increase is due partly to the

fact that outlays for disabled beneficiaries in fiscal l974 were depressed by normal first year payment lags. Benefit payments for fiscal year 1976 are expected to increase 16 percent over those for fiscal year 1975.

The estimate of benefit payments for fiscal year 1975 assume an average increase in reasonable charges of 8.5 percent above the 1974 level. Fiscal year 1976 reasonable charges are projected to increase 8.2 percent over 1975. This results from updating the reasonable and customary fees to the level charged in calendar year 1974 (as required by law) but with the restriction that prevailing fees not increase more than the increase of an economic: index of wage,; and costs (required by P.L. 92-603).

Trust fund withdrawals for administrative expenses are expected to increase to $420 million in fiscal year 1975. Fiscal 1976 administrative expenses are estimated to be $515 million.

The trust fund balance is projected to increase from $1,272 million at the beginning of fiscal1975 to $1,481 million at the end of that year, and to $1,664 million at the end of fiscal 1976.

The progress of the trust fund is shown on a calendar year basis in Table 5A.

TABLE 5.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) FISCAL YEARS 1975-1977 AND ACTUAL DATA FOR 1967-74

[In millions of dollars]

| Fiscal Year | Premiums from partici-pants | Govern-ment contribu-tions[1] | Benefit payments | Admin-istration expenses | Interest on fund | Total Income | Total expend-itures | Balance in fund at end of year[2] |
|---|---|---|---|---|---|---|---|---|
| Actual experience: | | | | | | | | |
| 1967 | $647 | $623 | $664 | [3] $134 | $15 | $1,285 | $799 | $486 |
| 1968 | 698 | 634 | 1,390 | 143 | 21 | 1,353 | 1,532 | 307 |
| 1969 | 903 | 984 | 1,645 | 195 | 24 | 1,911 | 1,840 | 378 |
| 1970 | 936 | 928 | 1,979 | 217 | 12 | 1,876 | 2,196 | 57 |
| 1971 | 1,253 | 1,245 | 2,035 | 248 | 17 | 2,516 | 2,283 | 290 |
| 1972 | 1,340 | 1,365 | 2,255 | 288 | 29 | 2,734 | 2,544 | 481 |
| 1973 | 1,427 | 1,430 | 2,391 | 246 | 45 | 2,902 | 2,637 | 746 |
| 1974 | 1,704 | 2,029 | 2,874 | 409 | 76 | 3,809 | 3,283 | 1,272 |
| Estimate of future experience: | | | | | | | | |
| 1975 | 1,868 | 2,329 | 3,661 | 420 | 93 | 4,290 | 4,081 | 1,481 |
| 1976 | 1,913 | 2,939 | 4,260 | 515 | 106 | 4,958 | 4,775 | 1,664 |
| Interim[4] | 489 | 953 | 1,253 | 126 | 30 | 1,472 | 1,379 | 1,757 |
| 1977[5] | 1,964 | 4,003 | 5,211 | 546 | 130 | 6,097 | 5,757 | 2,097 |

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

[2] Represents only a cash balance; financial status of the program depends on total net assets and liabilities of the program.

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

[4] Interim Period is period from July 1, 1976 to Sept. 30, 1976.

[5] Fiscal year 1977 is the period from Oct. 1, 1976 to Sept. 30, 1977.

TABLE 5A.— ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), CALENDAR YEARS 1975-1977 AND ACTUAL DATA FOR 1966-74

[In millions of dollars]

| Calendar Year | Premiums from partici-pants | Govern-ment contribu-tions[1] | Benefit payments | Admin-istration expenses | Interest on fund | Total Income | Total expend-itures | Balance in fund at end of year[2] |
|---|---|---|---|---|---|---|---|---|
| Historical Data: | | | | | | | | |
| 1966 | $322 | $0 | $128 | $75 | $3 | $324 | $203 | $122 |
| 1967 | 640 | 933 | 1,197 | 110 | 24 | 1,597 | 1,307 | 412 |
| 1968 | 832 | 858 | 1,518 | 183 | 21 | 1,711 | 1,702 | 421 |
| 1969 | 914 | 907 | 1,865 | 196 | 18 | 1,839 | 2,061 | 199 |
| 1970 | 1,096 | 1,093 | 1,975 | 238 | 12 | 2,201 | 2,212 | 188 |
| 1971 | 1,302 | 1,313 | 2,117 | 260 | 24 | 2,639 | 2,377 | 450 |
| 1972 | 1,382 | 1,389 | 2,325 | 290 | 37 | 2,808 | 2,614 | 643 |
| 1973 | 1,550 | 1,705 | 2,526 | 318 | 57 | 3,311 | 2,844 | 1,111 |
| 1974 | 1,804 | 2,225 | 3,318 | 410 | 95 | 4,124 | 3,728 | 1,506 |
| Projected: | | | | | | | | |
| 1975 | 1,890 | 2,634 | 3,960 | 468 | 109 | 4,633 | 4,428 | 1,711 |
| 1976 | 1,936 | 3,355 | 4,635 | 520 | 125 | 5,416 | 5,155 | 1,972 |
| 1977 | 1,974 | 4,198 | 5,412 | 556 | 145 | 6,317 | 5,968 | 2,321 |

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

[2] Represents only a cash balance; financial status of the program depends on total net assets and liabilities of the program.

## ACTUARIAL STATUS OF THE TRUST FUND

### 1. Actuarial Soundness of the Supplementary Medical Insurance Program

The concept of actuarial soundness, as it applies to the Supplementary Medical Insurance System, is closely related to the concept as it applies to private group insurance. The Supplementary Medical Insurance System is essentially yearly renewable term insurance; and in testing its actuarial soundness, it is not appropriate to look beyond the period for which the premium rate and the level of general revenue financing have been established.

The primary test of actuarial soundness relates to the adequacy of the income for fiscal years not yet completed, but for which the premium rate and the level of general revenue financing have been established. The income for such years should be sufficient to meet the benefits incurred and associated administrative expenses for the period. The law requires the Secretary of Health, Education, and Welfare to establish the income on this basis.

A second test of actuarial soundness is whether the trust fund assets, at the end of the period for which the premium rate and the level of general revenue financing have been established, will be as large as the liabilities-particularly those for services (and associated administrative expenses) that have been performed but for which reimbursement has not yet been made. This test will be met if the primary test of actuarial soundness has been met for all prior periods but it may not be met; even though the financing is currently adequate and the primary test is therefore met, if in the past the income was inadequate to meet incurred benefits and administrative expenses. In addition to the tests of actuarial soundness, a crucial consideration is that the trust fund never be in serious danger of becoming exhausted.

## 2. Incurred Experience of the Supplementary Medical Insurance Program

Both of the tests of actuarial soundness of the Supplementary Medical Insurance program noted above rely on the incurred experience of the program. Cash disbursements for benefits and administrative expenses by themselves are misleading, due to the relatively large liabilities outstanding at any time for benefits and processing costs that must be paid for services already performed. These liabilities result from the lag between the time that services are performed and the time that benefits for them are paid, due to 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. The 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 benefits incurred but unpaid as of the end of each fiscal year, and of the administrative expenses related to processing these benefits, appear in Table 6.

TABLE 6.—SUMMARY OF ESTIMATED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, AT THE END OF FISCAL YEARS 1967-76—PAST EXPERIENCE

[In millions of dollars]

| | As of June 30 | | | | | | | | Projected as of June 30 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 |
| A. Assets: | | | | | | | | | | |
| Balance in trust fund | 486 | 307 | 378 | 57 | 290 | 481 | 746 | 1,272 | 1,481 | 1,664 |
| Government contributions due and unpaid | 24 | 88 | 7 | 15 | 22 | −3 | −7 | −5 | 30 | −7 |
| Total assets | 510 | 395 | 385 | 72 | 312 | 478 | 739 | 1,267 | 1,511 | 1,657 |
| B. Liabilities: | | | | | | | | | | |
| Benefits incurred but unpaid | 499 | 599 | 702 | 619 | 656 | 700 | 763 | 1,073 | 1,228 | 1,442 |
| Administrative cost thereon | 56 | 65 | 81 | 71 | 77 | 85 | 90 | 131 | 148 | 174 |
| Total liabilities | 555 | 664 | 783 | 690 | 733 | 785 | 853 | 1,204 | 1,376 | 1,616 |
| C. Net surplus (or deficit): | −45 | −269 | −398 | −618 | −421 | −307 | −114 | 63 | 135 | 41 |
| D. Ratio of assets to liabilities: | .92 | .59 | .49 | .10 | .43 | .61 | .87 | 1.05 | 1.10 | 1.03 |

The incurred experience of the program for any period is obtained by adjusting the cash flow of premiums, matching government contributions, interest, benefit payments, and administrative expenses to an accrual basis by adding the net increase in each asset or liability item during that period to the corresponding item on a "cash" basis. This procedure produces the estimated incurred income and disbursements shown in Table 7.

## 3. Adequacy of income in fiscal years 1975-76

The financing for the supplementary medical insurance program has been set by promulgation of the adequate actuarial rates and the standard premium rates by the Secretary through fiscal 1976 as described in Appendix A. Since enrollment is voluntary and both income and outgo change directly with enrollment-it is appropriate to assess the adequacy of such financing on a monthly per capita basis. Table 8

compares the monthly income incurred per capita for fiscal years 1973-1976 with the estimated incurred expenditures. A minor deficiency is projected to occur in fiscal year 1976, which is acceptable in view of the anticipated surplus in the trust fund at the end of fiscal year 1975.

TABLE 7.—ESTIMATED INCOME AND DISBURSEMENTS INCURRED UNDER SUPPLEMENTARY PROGRAM MEDICAL INSURANCE PROGRAM, FISCAL YEARS 1967-76

[In millions of dollars]

| Fiscal Year | Premiums from participants | Government contributions | Benefit payments | Administrative expenses | Interest on fund | Net operations in year |
|---|---|---|---|---|---|---|
| Historical: | | | | | | |
| 1967 | $647 | $647 | $1,163 | [1] $190 | $15 | −$44 |
| 1968 | 699 | 699 | 1,490 | 152 | 21 | −223 |
| 1969 | 903 | 903 | 1,748 | 211 | 23 | −130 |
| 1970 | 936 | 936 | 1,896 | 207 | 12 | −219 |
| 1971 | 1,253 | 1,253 | 2,072 | 254 | 17 | +197 |
| 1972 | 1,340 | 1,340 | 2,299 | 296 | 29 | +114 |
| 1973 | 1,427 | 1,427 | 2,454 | 251 | 45 | +194 |
| 1974 | 1,704 | 2,031 | 3,184 | 450 | 76 | +177 |
| Projected: | | | | | | |
| 1975 | 1,868 | 2,364 | 3,816 | 437 | 93 | +72 |
| 1976 | 1,913 | 2,899 | 4,474 | 541 | 109 | −94 |

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

TABLE 8.—COMPARISON OF INCOME AND EXPENDITURES INCURRED PER CAPITA PER MONTH IN FISCAL YEARS 1973-76

| | Income | | | Expenditures | | | |
|---|---|---|---|---|---|---|---|
| Fiscal Year | Rate [1] | Interest | Total | Benefits | Adminis-trative | Total | Net |
| Aged: | | | | | | | |
| 1973 | $11.60 | $0.18 | $11.78 | $10.02 | $1.02 | $11.04 | +$0.74 |
| 1974 | 12.60 | .26 | 12.86 | 10.71 | 1.52 | 12.23 | +.63 |
| 1975 | 13.40 | .31 | 13.71 | 12.32 | 1.42 | 13.74 | −.03 |
| 1976 | 15.00 | .35 | 15.35 | 13.92 | 1.68 | 15.60 | −.25 |
| Disabled: | | | | | | | |
| 1974 | 29.00 | .54 | 29.54 | 24.58 | 3.49 | 28.07 | +1.47 |
| 1975 | 36.00 | .62 | 36.62 | 29.68 | 3.41 | 33.09 | +3.53 |
| 1976 | 37.00 | .75 | 37.75 | 34.70 | 4.20 | 38.90 | −1.15 |

[1] Combined monthly premium and general revenue matching payments.

## 4. Accumulated surplus or deficit of the program

Table 6 shows the accumulated surplus or deficit at the end of fiscal years 1967 through 1976 and the ratio of the total assets to the outstanding liabilities at the end of each of these fiscal years.

The program developed a relatively modest deficit of about $200 million during the first 1½ years due to an initial premium rate that proved to be about 8 percent low. The deficit increased further as a result of congressional action which retained the initial premium rate for an additional 3 months, through the first quarter of 1968. The deficit further increased by a relatively small amount during the next 15 months, during which the increased premium rate proved to be slightly low. The deficit accumulated by December 1969 was considered sufficiently manageable, so that the statutory provision for a contingency reserve available on a loan basis from the General Treasury that had been specifically authorized by Congress in view of the difficulties of forecasting the cost of the program was allowed to expire without being used.

The deficit grew substantially during fiscal year 1970 as a result of continuing the same premium rate as in the previous year, and as a result the trust fund was nearly exhausted. The adequate premium rates promulgated for the subsequent periods have substantially improved the financial position of the trust fund.

Reliable data on an incurred basis are not yet available for fiscal year 1974. Based on what is available, it appears that total assets exceeded total liabilities at the end of 1974. This surplus is projected to increase in 1975 and then be reduced slightly in 1976. Thus, under the current assumptions the program meets the second test of actuarial soundness described above during the period for which financing has been established.

### 5. Reliability of the estimates

Projections of the future income and disbursements of the SMI program are subject to forecasting errors. The principal reasons for errors are the uncertain nature of the trends in physicians' charges and institutional costs and the difficulty of predicting accurately changes in administrative policy. Over-all demand for covered services also fluctuates from year to year, as affected by epidemics, the weather, and many other causes. Further, due to inadequate data, the current cost of the program cannot be determined exactly, and the incurred cost as far back as 1972 must be estimated, with a possible error of a few percent.

Past experience demonstrates that cash expenditures for present enrollees can be estimated within a few percent for several future years. Due to incomplete data on an incurred basis, estimates of the future incurred experience for present enrollees are necessarily less reliable, and may vary from the actual experience. Estimates as to the cost of the new classes of beneficiaries are much less reliable because the data on which to establish historical costs are not yet available. Although a large relative error is possible in estimating the cost for these new beneficiaries, such an error would be relatively small compared to the overall size of the program.

## CONCLUSION

The financing for the supplementary medical insurance program for fiscal years 1975 and 1976 has been established by the promulgation of premium rates of $6.70 per month to be paid by enrollees and adequate actuarial rates which determine the amount to be contributed from general revenue on behalf of each enrollee. The income from these two sources plus interest earned on the investments of the fund is projected to exceed total outlays for benefits and administrative expenses in both fiscal 1975 and 1976 resulting in an increase in the trust fund of $392 million over the two year period.

The assets of the program exceeded the liabilities for incurred but unpaid benefits (and related administrative expenses) at the end of fiscal year 1974, according to the best information available at this time. This slight surplus of assets over liabilities is projected to be maintained through the end of fiscal year 1976 based on the financing provisions already promulgated.

# APPENDIXES

## APPENDIX A.—STATEMENT OF ACTUARIAL ASSUMPTIONS AND BASES EMPLOYED IN DETERMINING THE MONTHLY ADEQUATE ACTUARIAL RATES AND THE STANDARD MONTHLY PREMIUM RATE FOR THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM BEGINNING JULY 1975

This is a statement of actuarial assumptions and bases employed in determining the adequate actuarial rates and the standard monthly premium rate for the Supplementary Medical Insurance Program for the period July 1975 through June 1976. The adequate actuarial rate for enrollees age 65 and over is $7.50. The adequate actuarial rate for disabled enrollees is $18.50. The standard premium rate for both types of enrollees is $6.70.

### I. Analysis of Supplementary Medical Insurance Trust Fund

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

| Year ending June 30 | Monthly premium rate | Fund at end of period (millions) | Liability for incurred but unpaid services (millions) |
|---|---|---|---|
| 1972 | $5.60 | $481 | $917 |
| 1973 | 5.80 | 746 | 988 |
| 1974 | 6.30 | 1,272 | 1,315 |

Due to past deficiencies in the premium rate, the fund on June 30, 1974, was about 97% of the liability outstanding. The liabilities outstanding on June 30, 1974, for incurred but unpaid services, are estimated to have been $1,315 million, while the balance in the trust fund on the same date amounted to $1,272 million. It is expected that the trust fund balance will increase during fiscal year 1975. By the end of June 1975 the trust fund balance is estimated to be about $1,587 million, about 105% of the liability for incurred but unpaid services then outstanding. This slight surplus ($76 million) in the trust fund, if it materializes as projected, diminishes the size of required margins in the adequate rates for 1976. Approximately $75 million of this excess was generated by payments for the disabled and $1 million by payments for the aged.

### II. Adequate Actuarial Rate for Enrollees Age 65 and Older

The determination of an adequate actuarial rate for the aged has been made on the basis of the actual operating experience under the program,

projected through the year beginning July 1975. Virtually complete operating experience figures through June 30, 1974, are now available as to the cash income and disbursements under the program, and some data are available for the early months of fiscal 1975. The adequate actuarial rate, however, must be sufficient to cover benefits and related administrative costs for all services performed during the period from July 1975 through June 1976 (fiscal 1976). Experience on such a basis (hereafter called an "incurred" basis) is available for most components of the program through fiscal 1973; that for the other components must be estimated.

*Analysis of past experience*

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

| Fiscal year ending June 30 | Premium rate charged | Premium rate required for benefits and administrative expenses | |
|---|---|---|---|
| | | Cash basis | Incurred basis |
| 1972 | $5.60 | $5.29 | $5.43 |
| 1973 | 5.80 | 5.38 | 5.52 |
| 1974 | 6.30 | 5.85 | 6.06 |

*Basic estimates for future experience on an incurred basis*

In estimating the cost of the program for July 1975 through June 1976, it is necessary to project incurred results from fiscal year 1973. The actuarial assumptions used for the purpose of these projections are shown below:

AVERAGE INCREASE ASSUMED OVER PREVIOUS YEAR

[In percent]

| Fiscal year | Physicians' services | | Outpatient hospital | All other |
|---|---|---|---|---|
| | Fees [1] | Number and mix [2] | | |
| 1974 | 3.2 | 1.7 | 18 | 10 |
| 1975 | 7.2 | 1.7 | 18 | 10 |
| 1976 | 8.5 | 1.7 | 18 | 10 |

[1] As paid by the program.

[2] Increase in the number of services received per capita and greater relative use of more expensive services.

The increase in physician fees for fiscal year 1975 over 1974 of 7.2% results from an updating of customary and prevailing fees for fiscal 1975 to the calendar 1973 level of charges as provided in the law. This increase is larger than would normally have occurred because the fiscal year 1974 fees recognized by the program were held down by price controls. An increase in recognized fees of 8.5% is anticipated for fiscal year 1976 based on the progress in the consumer price index for physician fees through October 1974 and projected through December. Calendar year 1974 fees will form the basis for 1976 reimbursement as specified in the Law.

Both of these increase rates have been reduced to reflect the estimated impact of applying an economic index to prevailing fees as required by section 224 of P.L. 92-603. The estimated reduction in 1975 is 0.5% and in 1976, 1.0%. Administrative expenses incurred for the aged and disabled in fiscal 1976 will be 12.8% of incurred benefits paid under both programs, based on the amounts in the fiscal 1976 budget.

On the basis of the foregoing assumptions it is now estimated that the rate necessary so that income would cover both benefit payments and administrative expenses for aged enrollees on an incurred basis is $7.62 for fiscal 1976. The projection of the adequate actuarial rate is summarized as follows.

DERIVATION OF SMI AGED RATE REQUIRED IN FISCAL YEARS 1973-76

| | 1973 | 1974 | 1975 | 1976 |
|---|---|---|---|---|
| Covered services (at level recognized): | | | | |
| Physicians' reasonable charges | $6.50 | $6.82 | $7.44 | $8.21 |
| Radiology and pathology | .29 | .30 | .33 | .37 |
| Group practice plans | .12 | .13 | .15 | .16 |
| Independent laboratory | .05 | .06 | .07 | .07 |
| Home health agencies | .08 | .09 | .10 | .10 |
| Outpatient hospital and other institutions | .67 | .79 | .93 | 1.10 |
| Total services | 7.71 | 8.19 | 9.02 | 10.01 |
| Cost−sharing: | | | | |
| Deductible | −1.53 | −1.66 | −1.67 | −1.68 |
| Coinsurance | −1.17 | −1.23 | −1.38 | −1.57 |
| Total benefits | 5.01 | 5.30 | 5.97 | 6.76 |
| Administrative expenses | .51 | .76 | .79 | .86 |
| Incurred expenditures | 5.52 | 6.06 | 6.76 | 7.62 |
| Value of Interest on fund | −.09 | −.13 | −.16 | −.18 |
| Margin for contingencies and to amortize unfunded liabilities | .37 | .37 | .10 | .06 |
| Promulgated monthly rate | 5.80 | 6.30 | 6.70 | 7.50 |

*Calculation of actuarially adequate rate*

The $7.62 rate for fiscal year 1976 is decreased by $.18 to allow for interest earnings on the trust fund. Therefore the adequate rate before allowance for contingencies is $7.44. The margin of $.06 in the adequate actuarial rate of $7.50 will result in a surplus attributable to the aged of $32 million at the end of 1976 if all assumptions are exactly realized.

## III. Adequate Actuarial Rate for the Disabled

An adequate actuarial rate for disabled enrollees must take into account (i) enrollees eligible because they have been entitled to Disability Insurance for not less than 24 months, and (ii) enrollees meeting the chronic kidney disease provision. Only data on total cash flow of the SMI program is available on which to estimate the probable cost of these beneficiaries. This data is very incomplete because of the delay between the time expenses are incurred and the time bills are paid. As accrual data become available the error of the estimate should be substantially reduced.

Based on the data available, the rate required to pay benefits and administrative expenses for the disabled in FY 1976 less an allowance for interest is $19.33. In view of the anticipated surplus in the trust fund at the end of 1975 it is appropriate to decrease the adequate actuarial rate below that actually required to cover services rendered in fiscal year

1976. The adequate actuarial rate of $18.50 would result in a total surplus in funds contributed on behalf of the disabled of $38 million at the end of FY 1976, a decrease of $37 million during the fiscal year. Thus the total surplus for both the aged and disabled would be $70 million at the end of 1976 if all assumptions were realized exactly. This is about 1½ percent of anticipated outlays in fiscal year 1976.

## IV. Standard Premium Rate

Public Law 92-603, enacted October 30, 1972, provided that the standard premium rate to be paid by all enrollees is to be the smaller of:

A. The monthly adequate actuarial rate for enrollees age 65 and over, or

B. The premium rate most recently promulgated increased in proportion to any increases in the OASDI benefit table between June 1 immediately preceding the promulgation date and the June 1 immediately following the promulgation date.

At the time P.L. 92-603 was enacted, the law also provided that any automatic increase in OASDI benefits based on increases in the consumer price index would be announced before November 1 and would be effective the following January 1. Thus under the law in effect at that time, the table of benefits which would be in effect for the following June was provided in the law at the time the part B premium was to be promulgated—December of each year.

Public Law 93-233, enacted December 31, 1973, however, changed the effective date of any automatic OASDI increases to June 1 of a year and provided that the announcement of the increase would be made after the end of the first calendar quarter and prior to May 15 of that year. Since there can be no announcement of any automatic cash benefit increase until after the end of the first calendar quarter of 1975, the benefit rate now scheduled in the law for June 1975 is the same as that scheduled for June 1974 when the last benefit increase occurred.

Thus the $6.70 premium rate for fiscal year 1975 cannot be increased and must be promulgated as the premium rate for the twelve month period beginning July 1975. Because of the structure of current law, this situation will reoccur each year, and the $6.70 premium rate will remain in effect permanently unless remedial legislation is enacted.

## APPENDIX B.—ACTUARIAL METHODOLOGY AND PRINCIPAL ASSUMPTIONS FOR COST ESTIMATES FOR THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

### 1. ACTUARIAL ESTIMATES REQUIRED

Actuarial cost estimates of the SMI program are required for two purposes. First, the cost estimates form the base for the determination of the adequate actuarial rates and for the promulgation of the premium rates to be charged enrollees-on which the financing of the program is based. Second, they are needed for projecting the transactions of the trust fund and the accrued surplus (or deficit) of the program.

The estimates needed, although for the same program, take different forms. In order to determine adequate actuarial rates, cost estimates are needed on an incurred basis, and expressed per enrollee. The transactions related to the trust fund relate to the aggregate cash flow of the program. The accumulated surplus of the program is found by comparing the balance in the trust fund on any date with the assets and liabilities then outstanding, which form the difference between the cash and incurred status of the program.

The important difference between cash and incurred estimates is that in the former a transaction is assigned to the fiscal year in which an entry therefor is made to the trust fund account by the Secretary of the Treasury as Managing Trustee, and in the latter a benefit or premium payment is assigned to the fiscal year in which the service is performed or the premium falls due. Because there is a considerable time lag between the date a covered service is performed and the date that the corresponding cash transaction is charged against the trust fund, cash and incurred disbursement estimates can differ widely for any fiscal year. The principal reasons for this delay are the time taken by enrollees and providers to submit correctly documented claims, by carriers in processing and paying the amounts due, and by delays between payments and Treasury entries to the trust fund. In addition, the full payment for institutional services is not decided until the final cost settlement, which may be several years after the services were performed.

### 2. ESTABLISHING A SUITABLE BASE FOR PROJECTIONS

*a. Primary reliance on program data*

The actuarial cost estimates are based to the extent possible on accounting data from the program, and on such statistical information as can be derived from or reconciled with accounting data. Unconfirmed statistical data from the program is useful also, although less reliable.

Data from outside the program is less useful. There are many important but poorly understood factors that affect the level of services that will be sought and performed for a particular group of persons under a specific insurance program. Only in the absence of any program data, as in the case of new groups of beneficiaries or new types of benefits-is data from outside of the program relied upon to any significant extent.

*b. Establishing an incurred base*

Establishing an incurred base from which to project the future cost of the program requires reconstructing the incurred experience by adjusting the data for a number of sources of serious bias. A substantial part of the data for recent years is missing, due both to delays in receiving data and because statistical data are not tied to accounting procedures to insure accuracy. In addition, processing and classification errors are inevitable in any large scale data processing operation and overall corrections must be made. Finally, where reliance is made on sample data, corrections must be made for any sample bias present.

This reconstruction must be made separately for each payment route (through carriers[1], through intermediaries, through combined billing, etc.)—each of which involves a different set of lags in payment and receipt of data, other biases, and other peculiarities. Each requires a different set of adjustments to obtain reliable estimates of the actual incurred cost. Also, administrative policy, which may affect both the amount paid and the promptness of payment, is normally directed to a particular payment route (e.g. the reasonable charge screens apply only to benefits processed by carriers). Finally, the currency and quality of the basic data—and consequently the accuracy of estimates made from it—vary substantially by source of data.

The reconstruction of incurred experience has been done by fiscal years for this report since the fee screens are updated each fiscal year. The incurred experience is reconstructed for each payment route through the most recent fiscal year for which the data are sufficiently complete to permit a reasonable estimate of the total. Due to the delays in receiving data, projections must be made of the incurred experience for the most recent periods, as well as for future experience.

Payments are considered to be incurred when the service which makes payment due is performed. The increased reimbursements made in any year due to carryover of deductible from the prior year are thus assumed to be incurred in the year in which payable and not the year the service was performed, since if no further services had been performed or if enrollment had been terminated no payment would have been made.

The reconstruction of the incurred experience is accomplished principally by tying the incurred data to an accounting base by reconciling incurred data with cash flow by payment route. The total cash experience is complete by definition for any past fiscal year, but must be broken down by payment route (and whether interim or final).

It should be noted that the lag in the collection of data as well as the fact that only a sample is available on an incurred basis limit the accuracy with which the base year can be estimated. Any inadequacies in the base year data are compounded as the experience is projected to future years.

*c. Analysis of data by payment route*

*(1) Benefits paid through carriers (on payment records).*—All services reimbursed on the basis of reasonable charges are paid by carriers (Blue

[1] 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."

Shield plans and commercial insurance companies chosen to act as agents for the program). Approximately 87 percent of benefits are paid by carriers; and carriers are required to submit payment records covering all payments made. An actuarial sample of 0.1 percent of these payment records is tabulated by date of service rendered, which permits analysis of the program on an incurred basis. A number of corrections must be made to this data to eliminate biases resulting from the processing system and sampling procedure.

There is a substantial lag between the date on which services are performed, and the date on which payment records are posted to the samples. Payments lag from several months to a year or more behind services performed. There may be a further delay before payment records are submitted and a few are never submitted.[2] Finally, editing and processing of payment records by the Social Security Administration are required before tabulation, and if the editing produces any inconsistencies, a very long delay may result from returning the payment records to the carriers for correction.[3] Errors are often detected in the tabulations and delays of several months may be required to obtain corrections.

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

Further correction must be made to the sample data for the difference between the mean cost of enrollees in the sample and the average cost for all enrollees. This difference is due to statistical fluctuations from year to year, and to selection of a sample whose members are not fully representative of all enrollees by health and geographical distribution.

The appropriate corrections are made through controls to accounting data. Table B1 shows the cash paid and reconstructed reimbursement incurred for services for which payment records are submitted by fiscal year-both in total and per capita.

*(2) Institutional services reimbursed by intermediaries.*—Payments by intermediaries to hospitals for outpatient hospital services, to hospitals for covered services for beneficiaries who have exhausted their HI program benefits, to skilled nursing facilities for outpatient services, and to home health agencies for services not covered by the HI program are on an interim basis and adjusted by a subsequent settlement with the institution on the basis of an audited cost report. As in the case of benefits under the HI program, interim bills are submitted to support claims for interim payments. A 0.1 percent sample of these bills is tabulated by date of service, adjustments made for the lags in receiving bills,

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[2] Beginning with 1972 nearly all payment records submitted are reconciled with cash payments, so that incomplete data is no longer a problem.

[3] 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. Actuarial samples were maintained for all records processed as well as for those approved by the edit checks to overcome this problem. Currently, the proportion never returned is very small, as determined by actuarial controls.

and an estimate made of the interim payments incurred. These data are compared with accounting reports of cash payments to determine their reliability.

Finally, allowance must be made for the final cost settlements made with the institutions to bring interim payments up to full reimbursable costs. Table B2 summarizes the cash and reconstructed incurred experience for the institutional services by fiscal year.

*(3) Inpatient radiology and pathology paid initially through the hospital insurance program.*—As a result of the 1967 Amendments, hospital-based radiologists and pathologists have the option of making agreements with a hospital under which the hospital bills for their services. Where these agreements are in effect, payment is made initially from the hospital insurance trust fund by the hospital insurance intermediary. The HI trust fund is subsequently reimbursed from the SMI trust fund. Interim payments to hospitals are made on the basis of intermediary estimates, in theory based on the estimated average cost for all inpatient professional radiology and pathology services reimbursed by the HI program for that hospital. The actual liability, however, depends on subsequent cost settlements with the hospitals. No data as to the current cost of these services is available. Consequently, estimates of the liability of the program for these services must be based on cost settlement data. Presently there is little information on which to judge the completeness of this data. This inadequacy in the data available from the program gives rise to the possibility of substantial errors in estimating this component of the cost of the program.

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

*(5) Group practice plans dealing directly with the Social Security Administration.*—Group practice plans that deal directly with the Social Security Administration are reimbursed on a cost basis. They are financed on an interim payment basis designed to keep current the reimbursements for services performed. Final settlements are made after the close of the provider's fiscal year to reflect actual allowable cost during the period. Table B3 shows the reconstructed incurred per capita payments.

TABLE B1.—BENEFITS PAID FOR SERVICES ON PAYMENT RECORDS

| Fiscal year | Average enrollment (millions) | Incurred | | Cash | |
|---|---|---|---|---|---|
| | | Total (millions) | Per capita | Total (millions) | Per capita |
| 1967 | 17.750 | $1,109 | $62.47 | $632 | $35.61 |
| 1968 | 18.038 | 1,375 | 76.24 | 1,312 | 72.74 |
| 1969 | 18.833 | 1,546 | 82.08 | 1,523 | 80.87 |
| 1970 | 19.312 | 1,671 | 86.53 | 1,652 | 85.54 |
| 1971 | 19.664 | 1,827 | 92.89 | 1,780 | 90.52 |
| 1972 | 20.043 | 2,008 | 100.20 | 1,959 | 97.74 |
| 1973 | 20.428 | 2,129 | 104.24 | 2,075 | 101.58 |

TABLE B2.—AGED BENEFITS PAID FOR INSTITUTIONAL SERVICES

| Fiscal year | Services— | Incurred | | Cash | | | |
|---|---|---|---|---|---|---|---|
| | Average enrollment (millions) | Total (millions) | Per capita | Interim | Final | Total | Per capita |
| 1967 | 17.750 | $40 | $2.25 | $18.1 | $0.1 | $18.2 | $1.03 |
| 1968 | 18.038 | 70 | 3.88 | 55.4 | 1.0 | 56.4 | 3.13 |
| 1969 | 18.833 | 105 | 5.58 | 91.5 | 4.7 | 96.2 | 5.11 |
| 1970 | 19.312 | 120 | 6.21 | 102.3 | 26.2 | 128.5 | 6.65 |
| 1971 | 19.664 | 150 | 7.63 | 111.9 | 50.4 | 162.3 | 8.25 |
| 1972 | 20.043 | 200 | 9.98 | 140.4 | 71.8 | 212.2 | 10.59 |
| 1973 | 20.428 | 234 | 11.45 | 160.3 | 71.2 | 231.5 | 11.33 |

TABLE B3.—SUMMARY OF AGED INCURRED BENEFITS PER CAPITA

| Fiscal year | All services | Physician services [1] | Inpatient radiology and pathology [2] | Outpatient hospital | Home health agencies | Group practice plan |
|---|---|---|---|---|---|---|
| 1967 | $62.53 | $62.47 | | $1.37 | $0.88 | $0.81 |
| 1968 | 82.61 | 75.60 | 1.89 | 2.48 | 1.40 | 1.24 |
| 1969 | 92.82 | 79.26 | 6.57 | 3.81 | 1.77 | 1.41 |
| 1970 | 98.17 | 83.39 | 7.14 | 5.12 | 1.09 | 1.43 |
| 1971 | 105.35 | 89.16 | 7.21 | 6.61 | 1.02 | 1.35 |
| 1972 | 114.70 | 96.32 | 6.77 | 8.78 | 1.20 | 1.63 |
| 1973 | 120.14 | 99.85 | 6.99 | 10.25 | 1.20 | 1.85 |

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

## 3. PROJECTION OF' COSTS FOR AGED ENROLLEES

### *a. Basis of projection*

Projection of future costs requires ascertaining stable relationships among the payments for services in past periods and projecting these into the future. The pattern of services rendered changes relatively slowly and in similar ways from year to year. Abrupt changes in payments under the program are caused primarily by administrative policy. The most 1mportant among other influences on costs are price increases, especially the average increase in physician fees (as affected by administrative policy) and in the average reasonable cost for the institutional services. Most other relationships are stable, or apply only to a small portion of covered services. To obtain these relationships, the reasonable charges (or costs) of services rendered must be reconstructed from the reimbursements incurred and the effect of administrative policy and price changes on the increases in the per capita amounts must be eliminated. Projections can then be made with specific assumptions as to price increases and administrative policy judged most likely to occur, assuming that most other relationships remain stable.

*b. Trends in reasonable charges and costs incurred.*—(1) Reasonable charges and costs incurred per capita through 1973:

After allowing for the effect of the coinsurance and deductible (including the tendency not to submit claims for all services for which reimbursement would be paid), the reasonable charges and costs incurred per capita for periods for which adequate data are available are as shown in Table B4. In allowing for the effect of the deductible and coinsurance, inpatient radiology and pathology on payment records are separated from other services on payment records. To facilitate projections, institutional services are divided into those for home health agencies and those for outpatient hospital services and group practice plans. Projections are made separately for each of these broad categories of services.

(2) Past effects of administrative policy:

Administrative policy has had a substantial impact on amounts paid by carriers-especially as to payment for services not covered by the program (e.g. custodial care, routine physicals, etc.) and the reasonable charge screens. Establishing the trends that have been experienced in recognized charges requires allowances for the effect of any changes in policy that have occurred in the past. Similarly, projections require assumptions as to the policies most likely to be followed in the future.

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

| Fiscal year | All services | Physician services [1] | Inpatient radiology and pathology [2] | Outpatient hospital | Home health agencies | Group practice plans |
|---|---|---|---|---|---|---|
| 1967 | $114.45 | $109.11 | | $2.39 | $1.54 | $1.41 |
| 1968 | 133.59 | 123.35 | 1.89 | 4.05 | 2.28 | 2.02 |
| 1969 | 147.05 | 129.09 | 6.57 | 6.21 | 2.88 | 2.30 |
| 1970 | 154.62 | 135.10 | 7.14 | 8.30 | 1.77 | 2.32 |
| 1971 | 163.90 | 142.35 | 7.21 | 10.55 | 1.63 | 2.16 |
| 1972 | 176.24 | 151.24 | 6.77 | 13.79 | 1.88 | 2.56 |
| 1973 | 185.15 | 157.24 | 6.99 | 16.16 | 1.89 | 2.91 |

[1] Includes all services paid on the basis of reasonable charges (except those for inpatient radiology and pathology after 1967).
[2] Includes services on payment records and those using combined billing; amounts shown are for April 1968 and later when combined billings are authorized and inpatient radiology and pathology charges are reimbursed at 100%.

*(a) Payment for noncovered services*

Currently, 11½ percent of the amounts claimed are denied by carriers as services not covered by the program. The level of denied claims has risen gradually from around 2-3 percent in the first year of the program, and reached the present level in 1971. Thus if the pattern of claims submitted has not changed, around 9 percent of payments during the early years of the program were made for noncovered services, and such payments have been gradually reduced. Such payments were probably somewhat in excess of 9 percent initially, however, since many claimants have learned through denials not to submit certain types of claims, and are not currently contributing to the 11½ percent that are denied. The effect has been to inflate payments in the early years by around 10 percent and reduce the rate of increase experienced in the cost per capita of physicians and miscellaneous service.

*(b) Reasonable charge screens*

The "reasonable charge" for any service covered by the program is the lower of the "customary charge" by the particular physician for the type of service in question and the "prevailing charge" by physicians in the geographical area for that type of service. Reimbursement under the program is based on the lower of the reasonable and actual charge.

The policy of the Social Security Administration in implementing the requirement for paying at most reasonable charges has consisted of the following components:

(i) A reasonable charge is determined for each service reimbursed by carriers.[4]

(ii) The "customary charge" for a physician for any type of service is defined to be the median charge used by that physician for that type of service for enrollees in the program during the calendar year preceding the fiscal year in which the claim is processed. Thus there is on the average a delay of l½ years in recognizing any increase in customary charges and such charges are determined solely from services performed for enrollees in the program.[5]

(iii) The "prevailing charge" for any type of service in a geographical area is defined to be the 75th percentile of the customary fees for that service by the physicians in that area.[6]

(iv) Decisions as to how to group services rendered in combination or to patients with complications (a large proportion of services for persons over age 65) and as to the number of observations required to form a distribution for purposes of determining a customary or a prevailing charge-are left to the individual carriers.

(v) Payment is made on the basis of the bill submitted by the physician or enrollee. The burden of proof is placed on physicians or patients in appealing any disagreement over the classification of services for reasonable charge determinations.

Due to the large number of services that are infrequently performed, there are many covered services for which there is no customary or prevailing charge.

Use of relative value scales permits use of estimates for many of these, but there are many that cannot be established in this way. Further, many physicians charge less than the customary charge for some patients. For both these reasons, about 35 percent of charges are not affected by the screens.

The increases that have taken place in reimbursements per capita under the program can only be understood after an analysis of the effect of changes in fee screen policy. In the early years of the program, each carrier was allowed to determine much of its own policy with regard to reasonable charge, following very general guidelines. The policies that followed ranged from use of Blue Shield fee schedules to reducing

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[4] This policy contrasts with that followed by Insurance companies operating under similar contractual language, who in general examined only unusually large bills or bills from particular physicians.

[5] The delay in recognition of customary charges was explicitly authorized by the 1972 Amendments.

[6] Use of the 75th percentile for defining prevailing fees was mandated by the 1972 Amendments.

payment only when a joint insurance company-medical society review committee agreed that a charge was out of line.

In 1969, the Social Security Administration instructed the carriers to adopt policies similar to those now followed but with the prevailing fee set at the 83rd percentile of customary charges. Data from the program indicate that these policies were introduced gradually over three years. The level of prevailing fees was reduced to the 75th percentile of customary charge distributions in early 1971 (conforming with pending legislation). Also, introduction of fee screens based on 1969 data was delayed until early 1971. The data, however, indicate delays between policy changes and actual implementation that most likely varied substantially by carrier.

(3) Price increases:

Data concerning the trends in the average price of health care are available for some of the types of services covered by the program and estimates of the trends of the others can be based on data for similar types of services.

(4) Residual factors:

In addition to administrative policy and price increases, the cost per capita for each type of covered service is affected by a number of other factors. For example, total physician charges for covered services increase due to (a) changes in the mix of services rendered (reflecting trends to use new, more complex, and more expensive techniques) and pattern of specialists (reflecting increased specialization); (b) changes in the level of use of physician services, including chance fluctuations in health (e.g. epidemics): (c) changes in the manner in which physicians bill for their services; (d) any change in the composition of the enrollment by age, sex, geographical distribution—other significant actuarial variables, and (c) any difference between the actual and estimated increase in reasonable charges (i.e. any error in actuarial estimates of price increases and of the effect of the fee screens). No data bearing directly on any · of these components is available. The overall effect appears to be relatively stable from year to year, however, and can be estimated as a residual through examination of historical data.

(5) Analysis of increases in reasonable charges and costs per capita.

Table B5 summarizes the effects of the principal factors which have produced increases in reasonable charges per capita for services paid by carriers, which comprise 87% of benefits paid. Price increases are estimated from the physicians services component of the CPI. The effect of a price increase is reduced by any increase in fee screen reductions. Similarly, the residual increases are reduced by the effect of reductions in payments for noncovered services. The compound increase due to the recognized fee increase and the residual increase net of the effect of increased denials is the increase in reasonable charges per capita. A similar analysis (not shown) is required for the other types of covered services. The increases that have been experienced in the recognized charges and costs per capita are summarized in Table B6.

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

| Fiscal year | CPI for physician's fees | Effect of screens[2] | Recognized fees | Residual causes | Effect of denials[3] | Net residual | Recognized charge |
|---|---|---|---|---|---|---|---|
| 1968 | 5.9 | −0.7 | 5.2 | 9.3 | −1.4 | 7.9 | 13.1 |
| 1969 | 6.2 | −1.5 | 4.7 | .4 | −.4 | .0 | 4.7 |
| 1970 | 6.7 | −2.8 | 3.9 | 3.9 | −3.1 | .8 | 4.7 |
| 1971 | 7.5 | −3.0 | 4.5 | 4.1 | −3.2 | .9 | 5.4 |
| 1972 | 5.2 | −1.2 | 4.0 | 1.8 | +.4 | 2.2 | 6.2 |
| 1974 | 2.6 | −.6 | 2.0 | 2.6 | −.6 | 2.0 | 4.0 |

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

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

[In percent]

| Year ending June 30— | Physician services[2] | Inpatient radiology and pathology | Outpatient hospital | Home health agencies | Group practice plan |
|---|---|---|---|---|---|
| 1968 | 13.1 | | 69.5 | 48.1 | 43.3 |
| 1969 | 4.7 | −13.2 | 53.3 | 26.3 | 13.9 |
| 1970 | 4.7 | 8.7 | 33.7 | −38.5 | .9 |
| 1971 | 5.4 | 1.0 | 27.1 | −7.9 | −6.9 |
| 1972 | 6.2 | −6.1 | 30.7 | 15.4 | 18.5 |
| 1973 | 4.0 | 3.2 | 17.2 | .5 | 13.7 |

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

*(c) Projection of future increases in reasonable charges and costs per capita*

The rates of increase assumed in projecting the incurred costs of the program are summarized by broad category of service in Table B7, and the resulting reasonable charges and costs per capita in Table B8. More detail concerning the assumptions used in projecting physicians' and miscellaneous services, which account for most of the increase in costs is provided in Table B9.

TABLE B7.—PROJECTED INCREASES IN RECOGNIZED CHARGES AND COSTS INCURRED PER CAPITA FOR THE AGED[1]

[In percent]

| Year ending June 30 | Physician services[2] | Inpatient radiology and pathology | Outpatient hospital | Home health agencies | Group practice plans |
|---|---|---|---|---|---|
| 1974 | 5.9 | 4.1 | 18 | 10 | 10 |
| 1975 | 11.7 | 10.0 | 18 | 10 | 10 |
| 1976 | 10.0 | 10.0 | 18 | 10 | 10 |
| 1977 | 11.6 | 10.0 | 18 | 10 | 10 |
| 1978 | 9.4 | 10.0 | 18 | 10 | 10 |

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

TABLE B8.—INCURRED REASONABLE CHARGES AND COSTS PER CAPITA FOR THE AGED: PROJECTION

| Year ending June 30 | All services | Physician services [1] | Inpatient radiology and pathology | Outpatient hospital | Home health agencies | Group practice plans |
|---|---|---|---|---|---|---|
| 1974 | $198.07 | $166.49 | $7.28 | $19.02 | $2.08 | $3.20 |
| 1975 | 222.29 | 186.03 | 8.01 | 22.44 | 2.29 | 3.52 |
| 1976 | 246.39 | 204.71 | 8.81 | 26.48 | 2.52 | 3.87 |
| 1977 | 276.53 | 228.56 | 9.69 | 31.25 | 2.77 | 4.26 |
| 1978 | 305.40 | 250.12 | 10.66 | 36.88 | 3.05 | 4.69 |

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

TABLE B9.—COMPONENTS OF INCREASES IN REASONABLE CHARGES PER CAPITA FOR PHYSICIAN AND MISCELLANEOUS SERVICES [1]

[In percent]

| Year ending June 30 | Actual fees with fee screens | Effect of economic index [2] | Recognized fees | Net residual | Recognized charges |
|---|---|---|---|---|---|
| 1974 | 3.2 | 0 | 3.2 | 2.7 | 5.9 |
| 1975 | 8.5 | 0 | 8.5 | 3.2 | 11.7 |
| 1976 | 9.2 | −1.0 | 8.2 | 1.8 | 10.0 |
| 1977 | 11.0 | −1.2 | 9.8 | 1.8 | 11.6 |
| 1978 | 9.0 | −1.4 | 7.6 | 1.8 | 9.4 |

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

The fiscal year 1975 screens were updated to the calendar 1973 level resulting in an increase of approximately 8.5 percent in average recognized fees over the fiscal 1974 level. This increase is larger than would have normally occurred because the fee screens for 1973 and 1974 were held down in compliance with price stabilization policy. The fiscal year 1976 screens are to be updated in the usual manner to the calendar 1974 level of fees which is estimated to produce a 9.2 percent increase in reasonable charges. P.L. 92-603 requires that increases in prevailing fees be restricted to increases in a suitable economic index reflecting increases in general wages and the physician's cost of doing business. The application of such an index in fiscal year 1976 is assumed to reduce the average increase in fees from 9.2 percent to 8.2 percent.

Increases in charges per capita for physicians and miscellaneous services from causes other than price increases are projected at approximately the same rate as occurred during recent years. Denied claims are assumed to have no further impact, i.e. it is assumed that no significant payments are now made for noncovered services which will not be paid during the period projected.

Use of physicians' and miscellaneous services is affected by the amount of cost sharing. Reductions in payment due to the fee screens become in effect additional cost sharing, borne by the provider or the patient—either financially or through reduced services. In the case of assigned claims, the differential between reasonable and actual charges is borne entirely by the physician. The proportion of claims on which physicians accept assignments is to some extent an index of the willingness of physicians to accept enrollees as patients who provide adequate compensation. The rate of acceptance of assignments has decreased slightly recently from around 58 percent of all bills submitted for payment in fiscal 1973 to around 56 percent in fiscal l974.

*(d) Benefit payments per capita*

The benefits incurred per capita are obtained from the recognized charges and costs by allowing for the effect of the $60 deductible and 20 percent coinsurance rate. The resulting benefits incurred per capita for aged beneficiaries appear in Table B10.

*(e) Aggregate incurred estimates for fiscal years 1975-77*

Aggregate benefits incurred by the aged in years ending June 30, 1975 through 1977 are estimated by multiplying the incurred rates per capita for these years by the estimated enrollment during the year. The aged enrollment is projected to be 95 percent of the population over age 65. The projected aggregate incurred benefits are summarized in Table B11.

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

| Year ending June 30 | Benefits | Adminis-tration | Total |
|---|---|---|---|
| 1974 | $128.48 | $18.24 | $146.72 |
| 1975 | 147.85 | 17.04 | 164.89 |
| 1976 | 167.07 | 20.16 | 187.23 |
| 1977 | 191.12 | 20.88 | 212.00 |
| 1978 | 214.19 | 21.60 | 235.79 |

[1] For aged beneficiaries only.

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

| | | Benefits incurred | | | |
|---|---|---|---|---|---|
| Year ending June 30 | Average enrollment (millions) | Per capita | Aggregate (millions)l | Fiscal year | Aggregate benefits paid (millions) |
| 1974 | 20.988 | 128.48 | 2,697 | 1974 | 2,569 |
| 1975 | 21.408 | 147.85 | 3,165 | 1975 | 3,064 |
| 1976 | 21.793 | 167.07 | 3,641 | 1976 | 3,486 |
| 1977 | 22.142 | 191.12 | 4,232 | Interim | 1,010 |
| 1978 | 22.496 | 214.19 | 4,818 | 1977 | 4,187 |

*(f) Aggregate cash estimates for fiscal years 1975-77.*

The estimates of aggregate cash benefits paid in fiscal years 1975 through 1977 are obtained by projecting the lag structure between the dates on which services are performed and the dates on which corresponding entries are made to the SMI trust fund account. Separate estimates are prepared for each payment route, which requires that benefits incurred be broken down accordingly. The projected aggregate cash benefits are summarized in Table B11.

Estimates of the cash disbursements for benefits by payment route are also prepared by projecting the cash disbursements in the most recent fiscal year, 1973. The two sets of projected estimates of cash expenditures are compared and adjustments made until the projections agree. These adjustments depend on the relative strength and weaknesses of incurred and cash projections. The projected aggregate cash benefits paid are summarized in Table B11.

The principal advantage of a cash projection is the currency of the data base. At the time the projections are made, the final results for the preceding fiscal year are known precisely. Data on an incurred basis, however, are only partially available at that time for the preceding calendar year. Consequently, projections on an incurred basis must he adjusted for incomplete data and projected over a longer period of time,

in some cases as much as several years. All incurred items must be controlled to corresponding cash items to insure completeness and currency of the data base.

On the other hand, projections of the cash expenditures can only be made under the assumption that all of the set of complex relationships between cash and incurred expenditures do not change during the projection period or under the assumption that any changes have offsetting impact. In the absence of significant changes in program policy, such changes tend to take place very slowly, so that very accurate projections of the short run cash outlays can be made, using actuarial assumptions appropriate to the periods in which the services were performed. Administrative policy of the HMI program has been frequently changed, making reliable cash projections difficult. Major adjustments must be made in the estimating process to offset the effect of such changes. An additional problem posed for cash projections is the leverage of a fixed deductible.

### 4. Cost Estimates for the Disabled and Persons Suffering from Chronic Kidney Disease

Persons who have been entitled to Disability Insurance Benefits for at least two years and certain persons suffering from chronic kidney disease have been eligible for part B coverage since July 1973. Because of the time required for bills to clear the payment and data collection systems, it is not yet possible to establish their benefit costs on an accrual basis.

Aggregate cash expenditures for all beneficiaries are available and it is possible to make a reasonable estimate of what portion of that was spent for the aged as described above. The remainder is allocated between disabled and chronic renal disease beneficiaries using data from those carriers and intermediaries who have reported their benefit payments segregated by type of beneficiary.

Unfortunately this cash data does not provide as reliable a base for projection as docs the accrual base used for the aged. This is true because cash flows tend to be especially erratic in the first year of a program and because there is no historical series in which to observe trends in utilization. Also, the first year cash outlays are probably only about % the incurred costs in that year.

However, errors in allocating benefits by type of beneficiary are not expected to have a major impact on the estimate of overall program expenditures since understatement of the cost of the disabled, for example, would result in a somewhat offsetting overstatement of the cost of the aged.

It appears at this time that the per capita costs for the disabled (and thus the adequate rates upon which general revenue financing are based) were slightly over estimated in the preceding two reports. Thus only a modest increase in the adequate rate for the disabled will be necessary for fiscal year 1976, drawing down the surplus that is believed to have been accumulated in the first two years of coverage. As more reliable data become available on an accrual basis, more accurate determinations of the required financing and benefit outlays should be

possible. The projected aggregate incurred and cash expenditures for new groups of enrollees appear in Table B12.

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

| | | Benefits incurred | | | |
|---|---|---|---|---|---|
| Year ending June 30 | Average enrollment (thousands) | Per capita | Aggregate (millions)l | Fiscal year | Aggregate benefits paid (millions) |
| A. Disabled enrollees: | | | | | |
| 1974 | 1,642 | 229.10 | 376 | 1974 | 251 |
| 1975 | 1,815 | 263.61 | 478 | 1975 | 445 |
| 1976 | 1,985 | 299.70 | 595 | 1976 | 557 |
| 1977 | 2,149 | 343.95 | 739 | Inter1m | 173 |
| 1978 | 2,290 | 389.20 | 891 | 1977 | 730 |
| B. Enrollees with chronic kidney disease: | | | | | |
| 1974 | 9 | 12,333.33 | 111 | 1974 | 54 |
| 1975 | 13 | 13,307.69 | 173 | 1975 | 152 |
| 1976 | 16 | 14,875.00 | 238 | 1976 | 217 |
| 1977 | 18 | 16,555.56 | 298 | Inter1m | 70 |
| 1978 | 20 | 18,300.00 | 366 | 1977 | 294 |

## 5. Administrative Expenses

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

TABLE B13.—PROJECTED ADMINISTRATIVE EXPENSES PAID IN FISCAL YEARS, 1974-77

| Fiscal year | Amount (millions) |
|---|---|
| 1974 | $409 |
| 1975 | 420 |
| 1976 | 515 |
| Interim | 126 |
| 1977 | 546 |

TABLE B14.—RATIO OF ADMINISTRATIVE EXPENSES TO BENEFIT PAYMENTS

| Fiscal year | Cash basis |
|---|---|
| Actual experience: | |
| 1967 | 0.202 |
| 1968 | .103 |
| 1969 | .119 |
| 1970 | .110 |
| 1971 | .122 |
| 1972 | .128 |
| 1973 | .103 |
| 1974 | .142 |
| Projected (for all enrollees) | |
| 1975 | .115 |
| 1976 | .121 |
| Interim | .101 |
| 1977 | .105 |

## APPENDIX C.—SUMMARY OF PRINCIPAL PROVISIONS

Public Law 89-97, enacted July 30, 1965, amended the Social Security Act by establishing the Supplementary Medical Insurance Program. A summary of its principal provisions, as amended by subsequent legislation up to and including the date of this report, is as follows:

### 1. ELIGIBLE INDIVIDUALS

Almost all persons age 65 and over are eligible to enroll.

Beginning July 1, 1973 eligibility is extended to disabled persons under 65, who have been entitled to disability insurance benefits for 24 months or more, and to persons who have been receiving hemodialysis for three months or more and persons receiving kidney transplants (coverage terminated one year after a successful kidney transplant).

### 2. ENROLLMENT PROVISIONS

(a) Persons aged 65 and over on December 31, 1965-voluntary individual election of coverage during period through May 31, 1966, effective July 1, 1966.

(b) Persons attaining age 65 after 1965 whose initial enrollment period begins on or before March 31, 1973-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 whose initial enrollment period begins after March 31, 1973— automatic enrollment (unless coverage is specifically declined) for those individuals entitled to hospital insurance benefits with coverage beginning in month first eligible (month of attaining age 65, 25th month of eligibility for disability insurance benefits, three months after the beginning of hemodialysis or upon receiving a kidney transplant). In the case of an individual who would otherwise be entitled to hospital insurance benefits but does not establish his entitlement until after the last day of his initial enrollment period, his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period.

(d) Termination of enrollment-either by failure to pay premiums (for premiums not deducted from retirement benefits) or by election to terminate enrollment at any time (to be effective at the end of the following calendar quarter). An individual who terminated coverage or who failed to enroll in an initial period may reenroll in a general enrollment period (January to March of each year). However, reenrollment is permitted only once.

### 3. BENEFITS PROVIDED

a. Types of benefits—(1) physicians (including surgeons and the professional component of anesthesiology, pathology, radiology, and physical medicine in a hospital), (2) services and supplies normally furnished in a physician's office incident to his professional services

(including drugs which cannot be self-administered), (3) outpatient hospital services, (4) services of independent clinics, (5) home health services, (6) diagnostic x-ray and laboratory tests, (7) x-ray, radium, and radioactive isotope therapy, (8) surgical dressings and splints and other devices used for reduction of fractures and dislocations, (9) rental of durable medical equipment (or purchase thereof if not more expensive), (10) ambulance services in certain circumstances, (11) prosthetic devices, (12) braces and artificial limbs where required due to a change in the patient's physical condition, and (13) manual manipulation of the spine to correct a subluxation (demonstrated by x-rays to exist) by a chiropractor.

b. Amount of reimbursement—program pays:

(i) In the case of the professional component of inpatient radiology and pathology, 100% of reasonable costs for those electing to have the hospital reimbursed for their services and 100% of reasonable charges; otherwise, (ii) in the case of home health services, 100% of reasonable costs after the $60 deductible has been met; (iii) in the case of services received from a group practice prepayment plan electing reimbursement based on costs, 80% of the excess of the reasonable costs of furnishing services to enrollees over the average value of the deductible; (iv) for all other services, 80% of the excess of reasonable charges (or in the case of institutional services, 80% of reasonable costs) over a deductible of $60 in each calendar year (reduced by any amount applied to meet the deductible during the last quarter of the preceding year). Special limits apply to outpatient care for mental illness (50% coinsurance and $250 maximum on 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.

The reasonable charge for any service is the lower of the "customary charge" of the provider of the service for the type of service rendered and the "prevailing charge" of all providers of the same type in a geographical area. The customary charge is the median rate charged for a particular type of service by a particular supplier to enrollees during the calendar year prior to the fiscal year in which the claim is processed. The prevailing charge for any type of service is the 75th percentile of the distribution of customary charges for that service in an area. Payment is made on the basis of the lowest of the customary, the prevailing, and the actual charge. 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.

d. Services not covered-any service not certified by a physician (and approved upon carrier review) to be necessary for the diagnosis or treatment of an illness, routine procedures followed in eye examinations, routine foot care (including the removal of corns, warts, calluses), elective cosmetic surgery, glasses and hearing aids, 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), cases eligible under workmen's compensation, prescription drugs, and services of providers not covered (e.g. private duty nursing, and dental services).

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.

## 4. FINANCING

The Supplementary Medical Insurance system is self-supporting through combined income to the trust fund from premiums paid by enrollees and general revenue payments intended to be equal to the incurred cost of benefits and administration, with such margin for contingencies as the Secretary deems appropriate. The incurred cost of the program in any period is the sum of all payments that will be made for services performed in that period, including the administrative cost of making such payments, regardless of when payments are actually made.

a. The rate of income to the trust fund per month of coverage for which a beneficiary is enrolled is determined by two "adequate actuarial rates," one for the aged and one for the disabled. The trust fund receives twice the applicable adequate actuarial rate for each monthly premium collected, the excess over the premiums coming from general revenues.

b. The adequate actuarial rates are promulgated by the Secretary of Health, Education, and Welfare before the January 1st preceding each fiscal year-separately for (i) enrollees over age 65 and (ii) enrollees eligible as a result of disability or chronic kidney disease. Each of these rates is the sum of (i) half of the estimated monthly incurred cost per capita for benefits and administration of the applicable enrollees and (ii) a margin for contingencies.

c. Premiums from enrollees-A standard premium rate for each fiscal year is also promulgated by the Secretary of Health, Education, and Welfare before the preceding January 1st. The standard premium rate is the lessor of (i) the adequate actuarial rate for the aged for that fiscal year and (ii) the standard premium rate for the prior fiscal year increased by the rate at which benefits under the OASDI program have increased (or will increase by law) during such prior fiscal year.

Persons who elected not to enroll until more than 3 months after the date of eligibility must pay premiums that are 10 percent higher for each year not enrolled while eligible.

d. Government contributions—For each premium payment deposited in the

Supplementary Medical Insurance Trust Fund, the excess of (i) twice the appropriate adequate actuarial rate (adjusted if higher than standard premiums are paid) over (ii) the amount of the premium, is transferred to the Trust Fund from General Revenues. If transfers are not made on a timely basis, interest is accrued and paid.

e. 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, 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 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.