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ANNUAL REPORT OF FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

LETTER

FROM

BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

TRANSMITTING

THE 1969 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (THE 4TH SUCH REPORT), IN COMPLIANCE WITH THE PROVISIONS OF SECTION 201(c) OF THE SOCIAL SECURITY ACT

JANUARY 16, 1969.—Referred to the Committee on Ways and Means, and ordered to be printed

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LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE FEDERAL
SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND,
Washington, D.C., January 16, 1969.

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

SIR: We have the honor to transmit to you the 1969 annual report of the Board of Trustees of the Federal supplementary medical insurance trust fund (the 4th such report), in compliance with the provisions of section 201(c) of the Social Security Act, as amended.

Respectfully,

JOSEPH W. BARR,
Secretary of the Treasury
and Managing Trustee of the Trust Funds.
WILLARD WIRTZ,
Secretary of Labor.
WILBUR J. COHEN,
Secretary of Health, Education, and Welfare.
ROBERT M. BALL,
Commissioner of Social Security
and Secretary, Board of Trustees.

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1969 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

The Board of Trustees

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

Fiscal Year Highlights

The fiscal year 1968 was the second full year of operation of the supplementary medical insurance program insofar as both premiums and benefit payments are concerned (benefits were first available on July 1, 1966, and premium collections started then).

Premiums collected in fiscal year 1968 amounted to $698 million, while the matching contributions from the general fund of the Treasury amounted to $634 million. The deficiency of $64 million in government matching funds for fiscal year 1968, as well as the similar deficiency of $24 million for fiscal year 1967, was made up by a transfer effective on July 1, 1968.

Total receipts of the trust fund amounted to $1,353 million in fiscal year 1968, an increase of 5 percent over the preceding fiscal year (primarily due to the increase in the premium rate that was effective in April 1968). In addition to contributions, receipts consisted of $21 million in interest on investments.

Total disbursements from the trust fund in fiscal year 1968 amounted to $1,532 million, an increase of 92 percent over the preceding year (primarily because of the increase in benefit payments as the inherent lag in beginning a new program of this type wore off). Of this amount, $1,390 million was paid out for benefits (this amount is based on Treasury statements; certain additional amounts have been identified by carriers as benefit withdrawals in fiscal year 1968 that did not clear through the Treasury before July 1, 1968). The benefit payments in fiscal year 1968 were just double those of the preceding fiscal year, when they amounted to $664 million. The remaining $143 million was for administrative expenses. The actual outgo for benefits

in this second year of operation was 6 percent lower than the estimate which was contained in the 1968 trustees report; this difference resulted primarily from the lag in the actual benefit disbursements being somewhat greater than had been estimated.

There was an excess of total outgo over total income, amounting to $179 million. Accordingly, the total assets of the trust fund decreased from $486 million on June 30, 1967 to $307 million on June 30, 1968, but by December 31, 1968, they had increased to about $446 million (as a result of the increased premium rate that became effective in April 1968 and the aforementioned Government matching contribution on July 1, 1968, which made up for past deficiencies).

After the close of the fiscal year—in December 1968—the standard premium rate for the period July 1969 through June 1970 was promulgated. This rate was retained at $4.00 per month. Appendix I gives a statement of the actuarial assumptions and bases employed by the Secretary of Health, Education, and Welfare in arriving at this premium rate. The law requires that this statement be made public at the time the promulgation of the premium rate is made.

Legislation in 1967–68

Public Law No. 90–97, approved September 30, 1967, extended the general enrollment period for the supplementary medical insurance program that had been scheduled for October through December 1967, so that it would run through March 1968. The initial $3 monthly premium rate was continued through March 1968, instead of through December 1967, and the promulgation by the Secretary of Health, Education, and Welfare of the new standard premium rate (for persons enrolling in the earliest possible enrollment period) was delayed so that it could occur any time before January 1, 1968—to be applicable for the period April 1968 through December 1969 (which period was changed by subsequent legislation).

The Social Security Amendments of 1967 (Public Law 90–248, approved January 2, 1968) affect significantly the future levels of income and disbursements under the supplementary medical insurance program. Benefit protection was expanded. Eligibility requirements for the payment of benefits were liberalized. Some modifications in the coverage provisions were made.

The more important changes, significant from an actuarial standpoint, are presented below:

1. Effective April 1, 1968, the outpatient diagnostic services which were previously covered under hospital insurance are covered for benefit purposes under the supplementary medical insurance program.

2. Effective April 1, 1968, the deductible and coinsurance provisions formerly applicable to the professional component of pathology and radiology services furnished to inpatients in hospitals are no longer applicable.

3. Effective July 1, 1968, broader coverage of outpatient physical therapy services is provided, primarily in instances where the individual is not homebound.

4. Effective April 1, 1968, the supplementary medical insurance program covers the costs of ancillary services furnished in hospitals that are not covered under the hospital insurance program (e.g. because the individual had exhausted his hospital benefits under that program or was not covered thereunder).

5. Claims now have to be filed no later than the end of the calendar year following the year when the services were rendered except that the limit for services furnished in October through December of any year is the end of the second calendar year following such year.

6. The standard premium rate is to be determined on an annual basis for periods beginning with each July (instead of a biennial calendar-year basis), except that the premium rate promulgated for the period beginning April 1968 is to be applicable through June 1969.

7. The general enrollment periods will be January through March of each year (instead of October through December of odd-numbered years). Enrollees will be permitted to disenroll at any time (effective at the end of the following quarter), instead of only during general enrollment periods.

8. Whenever the transfer of matching funds from the general fund of the Treasury is not made simultaneously with the enrollee contributions, an appropriate interest adjustment is to be made (applicable only to transactions after June 30, 1967).

9. The availability of the contingency reserve based on appropriations from the general fund of the Treasury, with any amounts used being repayable, was extended for 2 years (i.e. until December 31, 1969).

The effect of the foregoing benefit changes is to increase the cost of the program by about 6 percent relatively.

Appendix II gives a summary of the provisions of the supplementary medical insurance program as it is constituted following the enactment of the 1967 amendments.

Summary of the Operations of the Trust Fund, Fiscal Year 1968

A statement of the income and disbursements of the Federal supplementary medical insurance trust fund during fiscal year 1968 and of the assets of the fund at the beginning and end of the fiscal year is presented in table 1.

TABLE 1.—STATEMENT OF OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1968

Total assets of the trust fund, June 30, 1967		$485,791,145.46
Receipts, fiscal year 1968:		
Premiums from participants:		
Deducted from benefits [1]	$583,919,092.49	
Deposited by States	53,026,275.00	
Collected by Social Security Administration [2]	61,519,691.89	
Total premiums	698,465,059.38	
Contributions from general fund of the Treasury	634,000,000.00	
Interest:		
Interest on investments	20,103,173.15	
Interest on net amount of reimbursements for administrative expenses and construction from old-age and survivors insurance trust fund	574,000.00	
Total interest	20,677,173.15	
Total receipts	1,353,142,232.53	
Disbursements, fiscal year 1968:		
Benefit payments	1,389,622,232.27	
Administrative expenses:		
Department of Health, Education, and Welfare [3]	153,960,633.70	
Treasury Department	11,897.11	
Civil Service Commission	43,136.76	
Reimbursement to old-age and survivors insurance trust fund for costs of construction for fiscal year 1967	93,816.00	
Gross administrative expenses	154,109,483.57	
Less receipts from sale of surplus supplies, materials, etc	36,810.53	
Less reimbursement from old-age and survivors insurance trust fund due to adjustment in allocation of administrative expenses for fiscal year 1967	11,464,911.00	
Net administrative expenses	142,607,762.04	
Total disbursements	1,532,229,994.31	
Net addition to the trust fund		−179,087,761.78
Total assets of the trust fund, June 30, 1968		306,703,383.68

[1] Transferred from the old-age and survivors insurance and disability insurance trust funds, the railroad retirement account, and the civil service retirement and disability fund.
[2] With respect to uninsured persons and insured persons not receiving monthly benefits.
[3] Includes administrative expenses of the carriers.

The total assets of the trust fund amounted to $486 million on June 30, 1967. By the end of fiscal year 1968 the assets amounted to $307 million, a decrease of $179 million.

Total receipts of the fund amounted to $1,353 million. Of this total, $698 million represented premium payments by the enrollees, an increase of 8 percent over premium payments by enrollees in the preceding fiscal year. This growth is attributable to the increase in the standard premium rate from $3 to $4 per month that became effective in April 1968. Matching contributions received from the general fund of the Treasury amounted to $634 million. (The deficiencies of $64 million in fiscal year 1968 and $24 million in fiscal year 1967 were made up, along with appropriate interest on the fiscal year 1967 deficiency, in July 1968 after the close of fiscal year 1968.)

The remaining $21 million consisted of interest on the investments of the fund and on the net amount of reimbursements for administrative expenses and construction, which was received from the old-age and survivors insurance trust fund.

Disbursements from the fund during the fiscal year 1968 totaled $1,532 million. Of this total, $1,390 million was for benefit payments, an increase of 106 percent over the corresponding amount paid in the

fiscal year 1967. This large increase is primarily due to the newness of the program and the lag from the time that benefits are incurred to the time that benefits are actually paid. Since fiscal year 1967 was the first year of operation under the program, actual benefit payments in that year were much lower than the benefits incurred, while in fiscal year 1968 the difference between benefits incurred and benefits paid was considerably smaller.

The remaining disbursements, $143 million, were for net administrative expenses.

Table 2 compares the actual experience in the fiscal year 1968 with the estimates presented in the 1968 Annual Report of the Board of Trustees. The actual premium collections were 2 percent lower than the estimates, while the actual benefit payments were 6 percent lower than estimated.

TABLE 2.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1968

[Amounts in millions]

	Actual amount	Estimated amount published in 1968 report	Estimate as percentage of actual
Premiums from enrollees	$698	$714	102
Government contributions	634	739	117
Benefit payments	1,390	1,473	106
Assets, end of year	307	348	113

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

The assets of this fund at the end of fiscal year 1968, amounting to $307 million, consisted of $281 million in the form of obligations of the U.S. Government and $25 million in undisbursed balances. Table 3 shows the distribution of the total assets of the fund at the end of fiscal year 1968.

TABLE 3.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, BY TYPE, AT END OF FISCAL YEARS 1967 AND 1968

	June 30, 1967		June 30, 1968	
	Par value	Book value [1]	Par value	Book value [1]
Investments in public-debt obligations sold only to this fund (special issues):				
Certificates of indebtedness: 4¾-percent, 1968	$31,923,000	$31,923,000.00		
Notes:				
4¾-percent, 1969	31,923,000	31,923,000.00		
4¾-percent, 1970	31,923,000	31,923,000.00		
4¾-percent, 1971	31,923,000	31,923,000.00		
4¾-percent, 1972	31,923,000	31,923,000.00		
4¾-percent, 1973	31,923,000	31,923,000.00		
4¾-percent, 1974	287,311,000	287,311,000.00	$274,886,000	$274,886,000.00
5⅝-percent, 1975			6,527,000	6,527,000.00
Total investments in public-debt obligations	478,849,000	478,849,000.00	281,413,000	281,413,000.00
Undisbursed balances		6,942,145.46		25,290,383.68
Total assets		485,791,145.46		306,703,383.68

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

New securities at a total par value of $1,369 million were acquired during the fiscal year through the investment of receipts of the fund. The par value of securities redeemed during the year was $1,566 million. A summary of transactions for the fiscal year, by type of security, is presented in table 4.

TABLE 4.—STATEMENT OF TRANSACTIONS IN PUBLIC-DEBT SECURITIES FOR THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1968

[All amounts represent par values]

	Acquisitions	Dispositions
Obligations sold only to this fund (special issues):		
Certificates of indebtedness:		
4¾-percent, 1968	0	$31,923,000
5-percent, 1968	$151,628,000	151,628,000
5⅛-percent, 1968	108,930,000	108,930,000
5¼-percent, 1968	122,634,000	122,634,000
5⅜-percent, 1968	214,063,000	214,063,000
5⅝-percent, 1968	765,206,000	765,206,000
Notes:		
4¾-percent, 1969	0	31,923,000
4¾-percent, 1970	0	31,923,000
4¾-percent, 1971	0	31,923,000
4¾-percent, 1972	0	31,923,000
4¾-percent, 1973	0	31,923,000
4¾-percent, 1974	0	12,425,000
5⅝-percent, 1975	6,527,000	0
Total transactions	1,368,988,000	1,566,424,000

Actuarial Status of the Trust Fund

In discussing the actuarial status of the supplementary medical insurance program, it is first necessary to consider the experience on an accrual basis and the limitations on the accuracy of the estimates before presenting and discussing the results of these estimates.

(1) *Actuarial status of program dependent on accrued experience*

The actuarial status of the program, and of the trust fund, can appropriately be measured only on an accrual basis; that is, the solvency of the trust fund depends on the services performed, on the basis of which benefits must be paid. 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 timelag between the time that services are performed and the time that benefits for them are paid. This lag is due to the $50 deductible which must be accumulated before any benefits are payable, the tendency of enrollees to accumulate bills and submit them together (especially at the end of the year), and the time required by carriers to process and adjudicate the bills received.

This liability outstanding at any time for benefits for services performed for which no payment has been made may be referred to as "benefits incurred but unpaid." Estimates of the amount of such benefits incurred but unpaid as of the end of each calendar year according to the "expected" estimates, and of the administrative expenses related to processing these benefits, appear in table 5. Also included in table 5 are estimates of the excess of premiums collected in advance over premiums due and uncollected, and of Government matching contributions due but not yet transferred to the trust fund.

The actuarial status of the program and the financial status of the trust fund at any time can be found by adjusting the balance in the trust fund account by the net of these asset and liability items on that date (as in item C of table 5). The actuarial experience of the program during any period can be obtained by adjusting the cash flow of premiums, matching Government contributions, benefit payments, and administrative expenses to an accrual basis by adding the net increase in each asset or liability item during the period to the corresponding item on a "cash" basis for that period.

TABLE 5.—SUMMARY OF PROJECTED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, ACCORDING TO "EXPECTED" ESTIMATE, AT END OF CALENDAR YEARS 1966–68

[In millions]

	As of Dec. 31—		
	1966	1967	1968
A. Assets:			
Premiums due and uncollected, less premiums collected in advance	—$7	—$3	—$8
Government matching contributions due and unpaid, less such contributions with respect to premiums paid in advance	315	25	—8
Actual balance in trust fund	122	412	446
Total assets	430	434	430
B. Liabilities outstanding:			
Benefits incurred but unpaid	407	500	526
Administrative cost for processing that are related to benefits incurred but unpaid	38	58	59
Total liabilities	445	558	585
C. Net actuarial surplus	—15	—124	—155

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

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

There are many difficulties in projecting the cost of a service benefit program that are not encountered in projecting the cost of cash benefit programs, due to the many economic and social factors involved. This is especially so as to the rate at which physicians may increase their fees and as to the increase in utilization of services that will gradually result from placing physician services within the financial means of over 95 percent of those aged 65 or older. Further difficulties result from the absence of firm estimates of the present and immediate past experience of the program, on which projections of future experience can be based (as discussed in appendix IV); and any errors in the former are necessarily incorporated into the latter. The "expected" estimates of the 1967 experience could vary as much as 10

percent from the actual experience, and estimates for later years could vary further from the actual experience.

Final conclusions as to the accrued experience of the program for 1966–68 will not be possible until the deadline for filing claims based on services performed during 1966–68 has passed, all claims have been adjudicated and decided by carriers, payment records covering all benefit payments have been prepared by carriers and forwarded to the Social Security Administration, and the payment records pertaining to benefits paid through the deadline for filing claims based on services received during the period have been reconciled with the benefits actually paid from the trust fund for this period.

(3) "Expected" estimates

The financing of this program is essentially different from that for the cash benefit programs in that the premium is only set for a 1-year period (except for the period from April 1968 through June 1969); consequently, estimates are needed only for 1½ years into the future. Thus, there is not the same need for estimates of the highest cost and lowest cost experience that might be reasonably expected over many years into the future, so that the financing of the system can be set at the middle of the range between what would be necessary to finance the highest cost experience thought reasonably possible and the lowest cost experience thought reasonably possible. Further, the premium rate is required by law to be based on the estimate of the benefits and administrative expenses that can be expected to accrue for services performed during the period to which such rate is to be applicable.

The "expected" estimates of the cost per capita of benefits and administrative expenses that was accrued during calendar years 1966–68 and that anticipated for calendar years 1969–71 appear in table A in appendix IV. Since the $50 deductible applies to each calendar year, these costs can be developed only for calendar-year periods; however, the premium rate is to be determined for fiscal-year periods (except for the initial period July 1966 through March 1968 and the period from April 1968 through June 1969). The prorated average monthly rate of these costs for the periods to which a particular premium rate is applicable are as follows:

Period	Applicable premium rate	Benefit payments	Administrative costs	Total disbursements
July 1966 through March 1968	$3	$5.68	$0.76	$6.44
April 1968 through June 1969	4	7.21	.83	8.04

The premium rate for the period from July 1966 through March 1968 was about 7 percent lower than the combined benefits and administrative expenses accrued during this period. The slightly unfavorable experience during this period resulted primarily from an increase of approximately 13 percent in the average fees charged by physicians between July 1965 (when the premium rate was determined) and July 1967 (the approximate mid-point of the period in which the benefits were paid), as compared with the 6 percent increase assumed for this period. Further, the administrative expenses were higher than originally estimated (on a continuing basis)—the actual

ratio of administrative expenses to benefit payments on an accrual basis was 10 percent in 1967 and 11½ percent in 1968, as against the initial estimate of 8½ percent.

(4) Estimates of the past accrued experience

The estimates for the past accrued experience of the supplemental medical insurance program for calendar years 1966–68 appear in table 6.

The trust fund balances shown in the various tables presented in this report do not include the contingency reserve that is authorized to be available until December 31, 1969. The size of this reserve is to be $18 times the estimated number of persons who were eligible to participate in the program on July 1, 1966, if they had so elected. Any amount appropriated and drawn would be repayable without interest from future income of the program.

TABLE 6.—ESTIMATED INCOME AND DISBURSEMENTS PAYABLE (ACCRUAL BASIS) UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, CALENDAR YEARS 1966–68

[In millions]

Calendar years	Premiums from participants	Government contributions	Benefit payments	Administrative expenses	Interest on fund	Net of operations in year	Accumulated surplus at end of year
1966	$315	$315	$535	[1] $112	$2	−$15	−$15
1967	643	643	1,289	130	24	−109	−124
1968	830	830	1,536	177	22	−31	−155
Total, 1966–68	1,788	1,788	3,360	419	48	−155	−155

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

As can be seen by examination of table 5, the program netted an estimated deficit of $15 million on an accrual basis during calendar year 1966, an abnormal period due to the application of the full $50 deductible in a 6-month period and due to considerable nonrecurring startup expenses. Due to the inadequacy of the $3 premium rate (by about 7 percent), benefit payments and administrative expenses incurred exceeded accrued income during calendar year 1967 by an estimated $109 million, leaving an estimated deficit of $124 million on an accrual basis for the initial 1½-year period. The estimated accrued deficit increased during 1968 by $31 million to reach $155 million by December 31, 1968.

Interest earnings of about $20 million per year have been earned during the 1967–68 period. As explained previously, the large positive balance in the trust fund is a result of the natural delay between the date that services are performed and benefits accrued and the date on which benefit payments made on the basis of the services are paid. The balance in the fund during 1966–68 was unusually large due to the newness of the program and the lack of familiarity of many enrollees with reimbursement insurance. The interest earned on these unusually large balances will contribute toward meeting the net accrued deficit in the future. Thus, income derived from those enrolled during 1966–67 will contribute substantially toward reducing the deficit incurred in that period.

(5) *Past experience on a cash basis*

The income and disbursements of the trust fund on a "cash" basis for calendar years 1966–68 appear in table 7. Cash income exceeded cash disbursements during 1966–67 by a large margin, resulting in a cash balance in the trust fund at the end of 1967 of $412 million, although the program actually had an estimated net deficit of $124 million on that date, due to the large liabilities outstanding on account of incurred but unpaid claims. Cash disbursements were slightly lower than cash income during calendar year 1968 despite the inadequacy of the $3 premium rate during the first quarter of the year, and the balance in the trust fund increased to about $446 million at the end of the year (figure partially estimated).

TABLE 7.—ACTUAL PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, CALENDAR YEARS 1966–68

[In millions]

Calendar years	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses [2]	Interest on fund [1]	Balance in fund at end of year
1966	$322	----------	$128	[3] $74	$2	$122
1967	640	$933	1,197	110	24	412
1968 [4]	834	863	1,509	176	22	446
Total, 1966–68	1,796	1,796	2,834	360	48	446

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

[2] These figures fluctuate in a nonsignificant manner from year to year because of the method of reimbursement between this trust fund and the old-age and survivors insurance trust fund.

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

[4] Estimated on the basis of actual experience for January through November.

(6) *Summary of actuarial status of program*

The actuarial status of the program and the financial status of the trust fund depend on the determination and measurement of the accrued income and benefit payments and administrative expenses accrued under the program. Due to the small inadequacy of the initial $3 rate, there was an estimated net deficit in the operations of the program from July 1966 through March 1967 of about 7 percent and hence in the estimated accrued balance at the end of this period. However, due to the normal delay between the time that services were furnished and the time at which benefits were claimed on the basis of these services, there was an adequate cash balance in the trust fund, and this balance will continue to be adequate through fiscal year 1969, even if the experience follows high-cost assumptions.

The premium rate of $4 that is set for the period April 1968 through June 1969 will, in combination with the interest earnings of the trust fund, probably be sufficient to meet the benefit costs and applicable administrative expenses during that period. Accordingly, the estimated net deficit will be slightly reduced during the period, and as of June 30, 1969, will be somewhat lower than it was on March 30, 1968 (but will nonetheless be of a large size).

Expected Operations and Status of the Trust Fund During the Period July 1, 1968 to June 30, 1971

The actual progress of the supplementary medical insurance trust fund on a "cash" basis during fiscal years 1967 and 1968 appears in table 8. Cash income during those fiscal years exceeded cash disburse-

ments by $307 million, leaving a balance in the trust fund of this amount as of June 30, 1968. This amount plus the Government contribution of $89 million made on July 1, 1968 (to make up for past deficiencies in the matching contributions), a total of $396 million, was about $150 million less than the benefit payments and processing costs related thereto based on services furnished prior to June 30, 1968, that would subsequently be claimed, adjudicated, and paid. Such liabilities outstanding as of June 30, 1968, for benefit payments and administrative expenses incurred but unpaid were unusually large due to the newness of the program and the lack of familiarity of many enrollees with reimbursement insurance.

Three estimates for the future period after June 1968 have been made and are presented in table 8. One estimate is based on an actuarial projection of past trends in physician fees (and in charges and costs for other covered services) and in utilization of covered services. The specific assumptions are described in detail in appendix I.

TABLE 8.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEARS 1969–71, AND ACTUAL DATA FOR 1967–68

[In millions]

Fiscal year	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses [2]	Interest on fund [1]	Balance in fund at end of year
Actual experience						
1967	$647	$623	$664	[3] $134	$14	$486
1968	698	634	1,390	142	21	307
Estimate based on projections of physician fees and utilization of services						
1969	$905	$983	$1,606	$184	$19	$424
1970	917	927	1,758	209	19	320
1971 [4]	930	930	1,913	218	9	58
Estimate based on recognition of only moderate increases in physician fees and utilization of services						
1969	$905	$983	$1,586	$184	$20	$445
1970	917	927	1,678	209	20	422
1971 [4]	930	930	1,768	216	18	316
Estimate based on recognition of no substantial increases in physician fees or utilization of services during next premium period						
1969	$905	$983	$1,567	$184	$22	$466
1970	917	927	1,598	209	20	523
1971	([5])	([5])	([5])	([5])	([5])	([5])

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

[2] These figures fluctuate in a nonsignificant manner from year to year, because of the method of reimbursement between this trust fund and the old-age and survivors insurance trust fund.

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

[4] Experience that would result if the standard premium rate remained at $4 per month after June 1969.

[5] No estimate for 1971 was prepared on this set of assumptions because they seem completely unrealistic when carried this far into the future.

Note: See text for description of the three different bases for the estimates.

Another estimate is based on the assumption that physician fees (and charges and costs for other covered services) and utilization of medical services will be reimbursed by the program in the future period covered by the estimate at approximately the level prevailing in the latter part of 1968. This result is hypothesized to occur because of the

cooperation of the medical profession in exercising restraint in increasing charges and new administrative steps that the carriers are expected to take so as to give only very limited recognition to any increase in physician fees and other cost elements that do occur and in regard to improved monitoring of the utilization of services. This estimate, appears in the Budget of the United States for fiscal year 1970.

The third estimate is intermediate to the other two estimates and is based on the assumption that the administrative steps that can be taken will, in practice, result in recognition by the program of moderate increases in physician fees and other cost elements and not a nearly complete maintenance of present levels.

None of the foregoing estimates is a high-cost one, such as could arise under circumstances of the highest cost assumptions that appear reasonable (but substantially more adverse than expected). Any such estimate prepared on high-cost assumptions would naturally show less favorable results in comparing outgo with income and in the developing size of the trust fund.

As would be expected—and as would necessarily have to occur under the assumptions made—the trust fund increases moderately under the estimate based on the assumption of no substantial recognition of increases in physician fees or utilization in the next premium period. The balance in the trust fund as of June 30, 1970 is shown to be $523 million, which amount closely approximates the estimate incurred but unpaid benefit payments at that time. It has not been assumed that such a static situation could be continued into the following fiscal year. Quite clearly, by that time, it would be necessary to recognize physician-fee increases, at least to the extent of increases in their own costs. A specific estimate for fiscal year 1971 has not, therefore, been made under this assumption.

When the estimate based on the actuarial projection of past trends is considered, an entirely different picture emerges. Under the assumptions made as to future trends of physician fees and utilization of services, the premium rate (assumed to remain at the $4 rate throughout the period considered) would obviously be inadequate. The balance in the trust fund is shown to decrease from $424 million on June 30, 1969 to $320 million on June 30, 1970 and to $58 million on June 30, 1971. Under these conditions, the standard premium rate for the period July 1970 through June 1971 would have to be increased substantially—both to meet the costs accruing in that year and to make up, at least in part, for the deficit incurred in the preceding year, when the premium rate was too low.

The estimate which is intermediate to the foregoing two estimates, naturally shows results that fall in between them. The balance in the trust fund decreases after June 1969, thus giving indication that the premium rate in effect is not adequate. Accordingly, if these conditions should prevail, the premium rate for the period July 1970 through June 1971 would have to be significantly higher than $4, although, of course, not as much so as if the conditions assumed in the estimate based on an actuarial projection of past trends were to eventuate.