Conclusion

The actual future course of the supplementary medical insurance program in the period immediately ahead depends on assumptions concerning inflation, as well as rates of utilization of medical services. The future experience is subject to important variations depending on administrative policy and the way that policy is carried out.

Actuarial estimates for the supplementary medical insurance program have been developed on the basis of various alternative assumptions concerning these factors. On the one hand, if inflation continues and the program recognizes most of the resulting increase in physicians' fees, the estimate showing an accrued cost of about $8.80 per month per capita would probably turn out to be correct. This estimate is based on the assumption that physicians' fees will rise and that benefit payments as compared to physicians' charges will continue at approximately the same ratio in fiscal year 1970 as in the past.

The lowest estimate, that which underlies the $4 standard premium rate that was promulgated, assumes that either no substantial increase in physicians' fees will actually take place during the period or, more realistically, that if they do rise, much more often than in the past reimbursement will be based on less than the full charge.

It is important to note that the rate of reduction in charges before reimbursement has been increasing. For the period July to December 1966, the reductions averaged 2.4 percent, and they have gradually risen to 3.2 percent for January to June 1968. The estimates underlying the $4 rate also assume that improved carrier administration of the program will result in some further reductions in the program recognition of services of doubtful validity which would compensate for the normal expected growth in the utilization of services.

If fees rise significantly, but the program fails to reimburse on the higher level, the result will be that the increase is borne by the beneficiary, even though not by the program. The Board of Trustees strongly believes for this reason, and also because we believe that there is little justification for further increases in physicians' income at this time, that physicians should exercise voluntary restraint in fee setting. We note that many leaders of the medical profession are also counseling restraint in fee setting. The Trustees believe that such restraint is important to the public and also to the medical profession itself.

The intermediate estimate, which would support a standard premium rate of $4.20, is also based on the assumption that the benefits-to-charges ratio will be substantially increased, but not as much as in the estimate underlying the $4 rate. The estimate underlying the $4.20 rate also assumes some increase in utilization.

It is important to note that all estimates of the progress of the trust fund show that, with a $4 premium rate promulgated for the period July 1969 through June 1970, the program will have sufficient funds, on a cash basis, to meet anticipated expenditures for benefits and administrative expenses during the period. If, on an accrual basis, the experience exceeds the $4 rate, there will, therefore, be ample time for action necessary to assure the continuing soundness of the program.

APPENDIXES

Appendix I. Statement of Actuarial Assumptions and Bases Employed in Arriving at Amount of Standard Premium Rate of Supplementary Medical Insurance Program for July 1969 Through June 1970*

On December 31, 1968, announcement was made of the promulgation of the standard premium rate of $4 a month necessary to finance benefits and related administrative expenses under part B of title XVIII of the Social Security Act for the period July 1969 through June 1970. The notice of this premium rate was published in the Federal Register for January 7, 1969 (34 F.R. 223).

There follows a statement of actuarial assumptions and bases employed in arriving at the amount of the standard premium rate for the supplementary medical insurance program beginning July 1969. The standard premium rate is that rate which is payable by those who enroll in their initial enrollment period and by those who enroll in a general enrollment period that terminates less than 12 months after the close of their initial enrollment period.

The actuarial determination has been made on the basis of both the actual operating experience under the program and the results of a current continuing sample survey of beneficiaries (which gives certain information more promptly than do the aggregate operations of the program). Operating figures for the 6 months of 1966 are virtually final, but because of the timelag in the submission of data noted below, figures for 1967 are not yet complete, and figures for 1968 are rather incomplete.

Current figures for cash expenditures under the program are available at all times, but such expenditures do not necessarily reflect accrued liabilities, especially in the early years of a new program and in times of rising prices because of the natural lag in benefit payments, which are not made until well after the date that services were received. Such delay is due to the tendency of enrollees to accumulate a number of bills before submitting a claim, the inherent delays by physicians and enrollees in making requests for payment, and the time required by the carriers to adjudicate and pay claims. There was a balance of $423 million in the supplementary medical insurance trust fund at the end of October 1968, and the balance at the end of December 1968 is estimated to be about $440 million (a decline from a peak of $570 million at the end of March 1967), but there were at that time substantial outstanding liabilities incurred for services rendered earlier in the program.

On the basis of 1966 accrual figures, it is now estimated that, for the first 6 months of the program, benefits and administrative expenses per capita exceeded the income from premiums and matching Government contributions by 2 percent—that is, 10 cents per month (5 cents each). It is further estimated that the liability of the system for the entire 1½-year period, July 1966–December 1967, was about 7 percent higher than the income from the premiums and the matching Government contribution (as noted below, the subsequent rate increase took this factor into account). In other words, it appears that the $3 premium for the entire period for which this rate was initially established was about 22 cents short of meeting half the cost for benefits and administrative expenses. About 13 cents of this 22 cents can now be explained by the fact that physicians' fees were higher during this period than had been assumed in setting the premium; the remaining 9 cents arises from the fact that there had apparently been a somewhat greater utilization of services under the program than had been anticipated.

*This statement is to be published in the Federal Register for January 24, 1969 (34 F.R. 16).

RATE FOR APRIL 1968 THROUGH JUNE 1969

Projecting costs of the program for the 15-month period following March 1968 simply at the level of operation in 1966–67 would thus have required approximately an additional 22 cents in the premium rate. Further, in estimating the cost of the program for April 1968 through June 1969, provision was made for the long-term trend toward greater utilization of medical services (including the effects of the discovery and more frequent use of new, highly expensive medical techniques) and the long-range upward trend of the general earnings levels, which was being reflected in higher physicians' fees and administrative expenses.

It was assumed that, in comparing calendar year 1969 with 1968, physicians' fees would increase at an annual rate of 5 percent, and utilization of medical services by enrollees would increase at an annual rate of 2 percent. Administrative expenses were assumed to represent 9.5 percent of the benefit payments; this figure was based on the actual operating results in 1967, when the average per capita administrative expenses of $.56 per month (on a paid basis) represented 9.5 percent of the average per capita benefit costs on an incurred basis. The average interest rate on the invested assets of the trust fund was assumed to be 4.75 percent (the rate applicable to virtually the entire portfolio as of October 31, 1967).

It was estimated that the monthly per capita cost on a calendar-year basis would be $7.61 for 1968 and $8.28 for 1969 if the provisions of the 1967 amendments were in effect for this entire period. The cost for the 15-month period beginning April 1968 would average out at $7.89 a month (half of which is $3.95). Thus, the promulgated standard premium rate of $4 per month for the period April 1968 through June 1969 would, according to the estimate underlying the promulgation, allow a margin for contingencies, as required by law.

In addition, the interest earnings of the trust fund would be available as a margin for contingencies and, if not needed to pay benefits and administrative expenses in the current period, would reduce the unfunded liability for the past deficiency in the premium rate. Interest earnings were estimated to be the equivalent of another 10 cents per capita in available income.

RATE FOR JULY 1969 THROUGH JUNE 1970

In estimating the cost of the program for the new premium period ahead, there was an awareness of the long-term trend toward greater utilization of medical services (including the effects of the discovery and more frequent use of new, highly expensive medical techniques) and the long-range upward trend of the general earnings levels, which may be reflected in higher physicians' fees, charges and costs of other providers of services, and administrative expenses.

However, the assumption has been made by the Secretary of Health, Education, and Welfare that physician fees and the charges and costs of other providers of medical services which are recognized by the program for reimbursement purposes will not increase significantly in the next 18 months. It has also been assumed that increases in utilization of physician and other services will not increase significantly in that period. It is anticipated that this result will occur due to both the cooperation of the medical profession in exercising restraint in charges and the new administrative steps that the carriers are taking (*a*) to maintain physician fees and other cost elements that are considered for reimbursement purposes, as much as possible, at the level currently prevailing and (*b*) to secure more effective control of utilization.

Considering the apparent adequacy of the present premium rate of $4 for the period April 1968 through June 1969 and the interest earnings on the trust fund, then on the basis of the above assumptions the premium rate can be retained at a level of $4 a month for the period July 1969 through June 1970.

As indicated previously, the program has more than ample funds, on a cash basis, to meet its expected obligations for benefit payments and administrative expenses now and in the period to which the promulgated premium rate applies even if the experience should not be as favorable as the assumptions on which the promulgation is based—and, in fact, even if it is considerably worse than the experience which would result if past trends continued, rather than being altered by the administrative steps which have been announced. However, the resulting trust-fund balances would then be below the level necessary to meet the outstanding accrued obligations for claims, and an appropriate premium-rate increase would be required to restore the actuarial status of the program in accordance with the intent of the law.

APPENDIX II. SUMMARY OF PRINCIPAL PROVISIONS

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

I. COVERAGE PROVISIONS (FOR CONTRIBUTION AND BENEFIT PURPOSES)

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

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

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

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

II. BENEFITS PROVIDED

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

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

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

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

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

(*d*) Services not covered—self-administered drugs (only covered under hospital insurance, and then only when the individual is receiving covered hospital or extended care facility services and only when ordinarily furnished in and by such hospital or facility), private duty nursing, dental services, routine physical and eye examinations, elective cosmetic surgery, services performed

by a relative or household member, services performed by a governmental agency (except when it provides services to the public generally as a community institution or agency), eyeglasses and hearing aids, and cases eligible under workmen's compensation.

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

III. FINANCING

(*a*) Participant premiums—flat monthly premium at a standard rate determined by Secretary of Health, Education, and Welfare. A rate of $4 has been promulgated for the period from April 1968 through June 1969. The rate applicable to each fiscal year after June 1969 will be promulgated by the Secretary before the preceding January 1. Such rate for any period is intended to be adequate, along with other income of the system, to support the cost of the benefits and administration for services received by enrollees during the period on an accrual basis, plus a margin for contingencies. A higher rate than the standard one is to be paid by those enrolling late or reenrolling after terminating enrollment (a surcharge of 10 percent of the premium rate for each full year during which an individual enrolling late could have participated but did not).

(*b*) Government contributions—amount equal to total premiums paid by or on the behalf of participants. Further, an amount equal to 6 months' Government contributions for all eligible to participate on July 1, 1966, has been authorized to be made available as a contingency reserve on a non-interest-bearing loan basis until December 31, 1969. A sum of $100 million was appropriated for this purpose in 1966; this appropriation lapsed unused at the end of 1967. No further appropriations have been requested.

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

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

Appendix III. Nature of the Trust Fund

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

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

Under a decision of the Comptroller General of the United States (B–4906) dated October 11, 1951, receipts derived from the sale of surplus supplies and

materials are credited to and form a part of the trust fund, where the initial outlays therefore were paid from the trust fund.

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

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

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

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

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

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

Marketable public issues acquired by the fund may be sold at any time by the managing trustee at their market price. Special public-debt obligations issued for purchase by the trust fund may be redeemed at par plus accrued interest. Interest receipts and proceeds from the sale or redemption of obligations held in the trust fund are available for investment in the same manner as other re-

ceipts of the fund. Interest earned by the invested assets of the trust fund will provide income to meet a portion of future benefit disbursements. The role of interest in meeting future benefit payments is indicated in tables 6 and 7 of the main text.

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

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

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

(1) Basis of financing of supplementary medical insurance program

The financing of the supplementary medical insurance system is essentially different from that for the cash benefit and hospital insurance programs in several fundamental respects. First, the premium rate for any period is required by law to be set at such an amount that income from premiums and government matching contributions accrued in the period is estimated to be sufficient to cover the benefit payments and processing costs related to all services furnished during that period. In this way, those enrolled in the program during any period for which a particular premium rate is applicable will, as a group, pay for half the cost of the services that they as a group receive during that period.

Second, the financing of the program is set only for short periods into the future, so that no long-range projections of the experience of the program are prepared. (The premium rate for each fiscal-year period is promulgated before the January 1 that precedes the beginning of such year.) The cash income should exceed the cash disbursements in the period for which the experience is projected; the natural lag in the payment of benefits results in a cash surplus which provides some margin to insure enough assets on hand at any time to pay benefits should the premium prove inadequate by a moderate amount. In addition, a contingency reserve of approximately $342 million was authorized, to be available until December 31, 1969, as further assurance that there would be enough assets available to the program to be able to pay benefits if the premium rate is inadequate.

Because the supplementary medical insurance program is self-supporting, if there were no lag in payments or if there were no contingency fund available, the premium rate would have to contain a substantial margin to insure adequacy. The contingency fund was authorized so that the premium rate could be set without regard to providing for a large margin for contingencies and, therefore, the premium rate could be set in accordance with the actual accrued experience anticipated. Under these circumstances, the enrollees during the period to which a particular premium rate is applicable will, as a group, pay for half the cost of the services received by them during this period, instead of their being required to contribute to building surplus funds for the program.

As a result of the foregoing considerations, the actuarial status of the supplementary medical insurance system and the solvency of its trust fund can be assessed only on an accrual basis—that is, on the basis of all obligations for future payment of benefits, in addition to those already paid. The liability of the system that is outstanding at any time for benefits that will be paid as a result of services already performed is referred to as "benefits incurred but unpaid." This liability results from the delays in the program as between the date on which services are performed and the date benefits based on these services are paid from the trust fund. These delays are due to the tendency of enrollees to acccumulate a number of bills before submitting a claim, the time required by physicians and enrollees to complete the claim forms and submit them to the carriers, and the time required by the carriers to adjudicate and process the claims.

Further, the $50 deductible applicable to each calendar year tends to shift the benefits incurred toward the end of the calendar year, and encourages enrollees to wait until they have all bills relating to a calendar year before submitting a claim. Thus, the liability outstanding at the end of a calendar year for benefits incurred but unpaid tends to be especially large.

Since nearly all administrative costs of the program are initiated when a claim is filed, there is also outstanding at any time the liability of processing costs related to the benefits incurred but unpaid. To obtain the operating results of the system for any period, all cash income and disbursements must be adjusted by the increase in the corresponding asset or liability item during the period.

Another fundamental difference that may affect the financing methods is the voluntary enrollment provisions of the supplementary medical insurance program. As long as a large proportion (i.e., over 75 percent) of those eligible to participate do so, the level of average services per capita received by the group will not be significantly affected by the inclusion of a somewhat greater proportion of those in poor health than in the population aged 65 and over. Thus, both income and disbursements vary directly in proportion to the enrollment. Accordingly, the financial basis of the program depends solely on the relationship of the premium rate to the benefit payments and administrative expenses accrued per capita, and not on independent estimates of total income and disbursements (in contrast to the situation under the old-age, survivors, and disability insurance and the hospital insurance programs, under which income is not directly proportioned to disbursements).

It is believed that as long as the participation rate is at least 75 percent, there will be no significant adverse selection against the system by there being an excessive proportion of high-cost enrollees. However, if participation drops below that level, there might well be such antiselection.

Except for a very small group who may receive 3 months of free coverage because of the grace period, before being disenrolled for nonpayment of premiums, the premiums are collected and the government matching contributions are transferred for each enrollee for each month of enrollment. Thus, the premiums accrued for any period are very close to the product of the premium rate and the average enrollment in that period. Consequently, the premium rate can be based on the estimated benefit payments and administrative expenses expected to be accrued in the period divided by the average enrollment anticipated in that period. Such amounts are referred to as benefit payments and administrative expenses per capita.

(2) INFORMATION AVAILABLE ON WHICH TO BASE ESTIMATES OF ACCRUED EXPERIENCE

The only fully reliable basis for an accurate assessment of the accrued experience of the program is the actual experience data developed from accounting information from the program (i.e., from the records of payments actually made). Accurate data from the program are available on a cash basis. However, due to the delays mentioned above, increased by the newness of the program and the unfamiliarity of many enrollees with reimbursement insurance, experience data from the program are not yet complete, except for 1966, for which virtually all the data are available.

In general, the estimates were based on data from the current medicare survey through December 1967 and on payment records for services performed in 1966–67 that were processed to the 0.1-percent actuarial sample before October 1968 (but not as yet reconciled with actual disbursements from the trust fund, to insure reliability). Estimates of the benefit payments accrued that were derived from these different sources were in reasonably close agreement.

The current medicare survey is a survey carried out in cooperation with the Bureau of the Census, in which a sample of 4,000 enrollees is picked for each year; interviewers make repeated visits to each member of the sample to determine the cost of medical services received by them. The actuarial sample consists of payment records for all benefit payments made with respect to members of a 0.1-percent random sample of enrollees and of copies of all bills and supporting documentation submitted with respect to such persons.

The current medicare survey provides an estimate of the total charges for services received by enrollees and the proportion potentially reimbursable; such data are available through December 1967. A number of estimates and assumptions are necessary, however, to derive from these data an estimate of the accrued

experience. For example, there are no data as to the proportion of enrollees who would satisfy the deductible in a 12-month period (since the source data available are for 6-month periods), or as to the proportion of enrollees with more than $50 in covered expenses who will not file claims including all covered services received.

As stated above, the many adjustments and assumptions required make these estimates subject to some variation from the actual experience in 1966 (as much as 10 percent), and to more variation in later years, since any errors in estimating the experience that has occurred during 1966–67 are necessarily incorporated into estimates for later years.

Further difficulties were encountered in estimating the effect of the benefit changes made by the 1967 amendments, because no information was available from the program as to the proportion of diagnostic services rendered in the outpatient department of hospitals and affiliated clinics or for the professional component of inpatient radiology and pathology services. No payment records are prepared for initial submissions of less than the deductible by enrollees who later submit enough additional expenses to qualify for reimbursements. Thus, any itemization of benefit payments in payment-record data by type of service is defective. (Such information will be available when the 0.1-percent actuarial sample receives data from the 5-percent statistical sample as to such services eliminated by the deductible.)

The only information currently available to the 0.1-percent actuarial sample is based on the payment records prepared by carriers to record benefit payments. Payment records for services performed during 1967 are still being received. Also, the reconciliation between payment records for the benefits paid for 1966 and the charges to the trust fund for such benefits, which is necessary to ensure that payment records were prepared covering all benefit payments, is only partially completed. Payment records for services performed during 1968 are only partially complete and are insufficient to serve as the basis of any estimate of the accrued experience in 1968, due to the absence of previous experience with a program similar to the supplementary medical insurance program.

(3) ASSUMPTIONS RELATING TO DEDUCTIBLE CARRIED OVER

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

Since these additional costs resulting from the deductible carried over result from services performed in the prior year, it can be argued that the additional costs were accrued in that year. On the other hand, if the program were discontinued (e.g., superseded by some other program), or if an enrollee disenrolls at the end of a calendar year, there is no liability outstanding for such additional costs; this indicates that the liability for paying these additional costs arises from continuing the program and from the individual's continuing his enrollment. Also, in the case of any individual enrollee, there is no liability unless he receives enough services in the succeeding year to be eligible for benefits.

From the latter point of view, the additional costs are accrued in the succeeding year. Further, the additional costs are paid on the basis of services actually performed in the succeeding year, and the assignment of benefit payments and administrative expenses to the year prior to that in which the services were performed appears inconsistent with the principle that all costs are accrued in the year in which the services giving rise to such costs were performed.

For calendar years beginning with 1968, the assumptions with regard to the deductible carried over will have negligible effect, since the additional costs paid as a result of deductibles carried over from the preceding year will approximately equal the deductibles carried over to the succeeding year. In 1966–67, however, due to the application of the full $50 deductible in a 6-month period for 1966, there was an unusually large amount of additional benefits paid in 1967 as a result of deductibles carried over from 1966. As a result, comparisons between the experience in 1967 and that of later years are difficult. Further, the experience in 1966 is artificially favorable, not only because of the application of the full deductible in a short period, but also because there were no deductibles carried over from a prior period.

Beginning with 1968, however, these problems disappear. It may be noted that the assignment of additional costs resulting from the deductibles carried over to the year in which the services on the basis of which benefits were paid were performed eliminates one important adjustment required to obtain cash outlays from accrued outlays (or vice versa). Also, if the program were terminated, the trust fund would be liable for all benefit payments and administrative expenses for services performed prior to termination, but not for the deductibles that would have been carried over if the program had continued.

The calculations in table A assume that the additional costs resulting from the deductibles carried over are accrued in the year from which the deductible is carried over.

(4) BENEFITS AND ADMINISTRATIVE EXPENSES PER CAPITA ACCORDING TO THE ESTIMATES

The estimates of benefits and administrative expenses per calendar year per capita appear in table A. These estimates are based on the projection of physician fees (and costs and charges of other providers of services) and of utilization of covered medical services which does not make any allowance for the effect of the revised instructions to the carriers and intermediaries to hold down increases in physician fees insofar as they are recognized for benefit purposes and to improve the professional review of the utilization of physicians' services. The estimates presented in the main body of this report which are based on the alternative assumptions (*a*) that such instructions are fully successful in keeping payments for services in line with the income that will be derived from a standard premium rate of $4 per month for periods after June 1969 and (*b*) that such instructions are partially successful therein were derived in a similar manner. The last-mentioned estimate falls approximately midway between the other two estimates.

TABLE A.—ESTIMATES OF ACCRUED BENEFITS AND ADMINISTRATIVE EXPENSES PER CAPITA IN CALENDAR YEARS 1966–70, WITH DEDUCTIBLE CARRIED OVER CHARGED TO PREVIOUS YEAR[1]

[In millions]

Calendar year	Reasonable charges for covered services	Net effect of deductible [1]	Amount of coinsurance	Benefit payments	Administrative expenses	Total per capita annual cost
1966 [2]	$55.90	$18.05	$7.57	$30.27	$6.35	$36.62
1967	122.70	32.50	18.04	72.16	7.29	79.43
1968 [3]	135.44	32.32	19.85	83.27	9.59	92.86
1969	145.53	32.74	21.43	91.36	10.43	101.79
1970	154.26	33.00	23.04	98.22	11.20	109.42
1971	161.97	33.35	24.44	104.18	11.88	116.06

[1] Including effect of allowance made for underfiling of claims.
[2] Data are for last 6 months of year only.
[3] Includes effect of new benefits effective after March 1968, as a result of the 1967 amendments.

The first column in table A, "Reasonable charges for covered services," refers to the total reasonable charges as determined by the carriers (for noninstitutional services) and the total reasonable costs as determined by the fiscal intermediaries (for institutional services) for all covered services received during the calendar year, divided by the average enrollment in that year. The column "Net effect of the deductible" refers to the total amount deducted from total reasonable charges, including the reasonable charges for any services received by enrollees who did not have enough reasonable charges to be eligible for some reimbursement (i.e., who did not have more than $50 in such charges less the amount of deductible carried over from the previous year), divided by the average enrollment.

It may be noted that benefit payments are low in 1966 due to the relatively greater effect of the full $50 deductible (without any carryover deductible) in a 6-month period. As a result, benefit payments per capita in 1967 are increased by the unusually high carryover deductible that results in 1967.

Administrative costs were unusually high in 1966 due to the inclusion of startup expenses. Part of the increase in total costs in 1968 over 1967 is due to the new benefits that become effective on April 1, 1968 (approximately a 6-percent cost increase relatively).

A weighted average of the benefit payments and administrative expenses for the period from April 1, 1968, through June 1969 (the period for which a $4 standard premium rate is applicable), produces a monthly per capita cost for benefit payments and administrative expenses of $8.04. The total income from the $4 premium rate, the matching Government contribution, and the interest earnings of the trust fund is slightly more than $8.04 per capita per month.

(5) PRINCIPAL ASSUMPTIONS REQUIRED IN ESTIMATES

The principal factors which have a major impact on costs, concerning which it has been necessary to make assumptions without fully adequate information, are as follows:

(a) Proportion of enrollees who will have "reasonable charges" for covered services in excess of the deductible in a full 12-month period

Data from the current medicare survey and from the 0.1-percent actuarial sample show that, in the 6-month period from July through December 1966, approximately 23 percent of those enrolled at any time during this period accumulated more than $50 in charges for covered services and that about 21 percent actually claimed benefits. The "expected" estimate projected that 42 percent of those enrolled at any time would have more than $50 in "reasonable charges" and that, on the average, these persons would not file claims for all covered services, resulting in an average decrease in benefit payments of $7.50 per capita per year.

(b) Rate of increase in average fees charged by physicians

Nearly all benefits under the program are for professional services, primarily for those of physicians. The unit prices of these services has, in the past, risen at a slightly lower rate than all earnings from employment in the United States. The annual increases in physicians' fees, as measured by the Consumer Price Index for physician fees, and the annual increases in average earnings, as measured by the average increases in the average earnings in employment under the social security program, appear in table B.

As can be seen from table B, physicians' fees had been increasing by an average of 3 percent per year during the decade 1955–65, or at a rate slightly lower than that for all earnings (3.6 percent). During 1966–68, however, physicians' fees increased at a rate of 6.2 percent per year, somewhat higher than the average rate of increase for all earnings (5.9 percent). Over the 13-year period, however, physicians' fees increased 3.7 percent per year, and the average earnings in employment covered by social security increased 4.2 percent per year. Thus, it appears reasonable to assume that physicians' fees will continue to increase at an annual rate slightly below that projected for the average earnings of persons covered by social security.

The average fees charged by physicians were assumed, for the "expected" estimate, to increase by 5 percent per year for calendar years 1968 and 1969, by 4½ percent for calendar year 1970, and by 3½ percent for calendar year 1971—in line with the anticipated increases of earnings in employment covered by the social security program.

TABLE B.—AVERAGE ANNUAL RATE OF INCREASE IN PHYSICIANS' FEES AND IN AVERAGE EARNINGS IN EMPLOYMENT COVERED BY SOCIAL SECURITY, 1955-68

[In percent]

Year [1]	Physicians' fees [2]	Average earnings in employment covered by social security	Year [1]	Physicians' fees [2]	Average earnings in employment covered by social security
1956	3.1	5.7	1964	2.3	3.1
1957	4.4	5.5	1965	3.3	1.6
1958	3.4	3.3	Average, 1955-65 [3]	3.0	3.6
1959	3.9	3.3	1966	5.9	4.4
1960	1.8	4.3	1967	7.3	6.3
1961	2.6	3.1	1968	5.5	7.0
1962	3.1	4.2	Average, 1955-68 [3]	3.7	4.2
1963	2.2	2.4			

[1] Increase from June of previous year to June of year listed for 1st column and from 1st quarter of previous year to 1st quarter of year listed for last column.
[2] As measured by Consumer Price Index of physician fees.
[3] Arithmetic average of increases for years included in period.

(c) *Rate of increase in utilization of services*

There is a long-term trend in the United States of increasing use of physician services per capita that amounts to somewhat less than 1 percent per year. The increase in use of physician services by enrollees who were not insured for these services prior to coverage under the program is much higher. Further, there were no major epidemics of respiratory diseases during 1966–67 and the first half of 1968; the assumptions used in the cost estimates should contain an allowance for the possibility of an occasional epidemic.

The "expected" estimates assume an increase in utilization of 2 percent per year for calendar years 1968 and 1969 and of 1½ percent per year thereafter.

This estimate of increased utilization does not take into account the fact that, to some extent, the present level of utilization may contain some unnecessary services which could be eliminated by improved claims administration. Thus, although there is a long-term trend to increase utilization, in the short term this might be compensated for by the elimination (from the standpoint of the liability of the program) of some services in the near future that were comparable to those paid for in the past, even though not strictly necessary or in accord with good medical practice.

(6) ESTIMATES OF ACCRUED COSTS, LIABILITIES OUTSTANDING AT THE END OF EACH CALENDAR YEAR, AND FUTURE CASH FLOW UNDER THE PROGRAM

During the second half of 1968, approximately 95 percent of all persons aged 65 or over in the country were enrolled in the program. This percentage of participation was assumed to continue in the future (for reasons given earlier, a large variation in the number enrolled would not affect the financial soundness of the program). The premiums, Government matching contributions, and benefit payments accrued were obtained by multiplying the corresponding rate per capita by the projected enrollment. Interest earnings were calculated from the anticipated experience of the trust fund on a cash basis (projected as explained below).

The cash benefits estimated to be paid during 1968 were projected from the actual experience for the first 11 months of the year. Benefit payments beyond 1968 were calculated from the corresponding accrued item, under the assumption that the total benefit payments incurred but unpaid at the end of each period would be a constant proportion of the accrued benefits for the preceding 12 months. As a percentage of benefit payments accrued in the preceding year, benefit payments incurred but unpaid are thus assumed to decrease from about 39 percent on December 31, 1967, to 34 percent on December 31, 1968, and to 33 percent for later periods.

Premiums collected in cash for years beyond 1968 are assumed to equal those accrued. Government matching contributions transferred very closely caught up with the premiums collected in July 1968 and are expected to continue thereafter at virtually the same rate as premiums collected.

Administrative expenses for fiscal years 1969 and 1970 on a cash basis were obtained from the budget document of the United States for fiscal year 1970. The liability outstanding at the end of each period for the administrative expenses for processing benefit payments incurred but unpaid was assumed to be 11.4 percent of such benefit payments, which proportion is based on the budget figures.

An interest rate of 5 percent was used in developing the progress of the trust fund. As of December 31, 1968, the average yield of the total investments of the trust fund was 5.29 percent.

Appendix V. Legislative History Affecting the Trust Fund

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

Premium rates.—The Social Security Amendments of 1965, which established the supplementary medical insurance program, fixed the premium rate for individuals enrolling under the program at $3 per month for the 18-month period, July 1966 to December 1967. The 1965 amendments also provided that between

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

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

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

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

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

Appendix VI. Statutory Provisions, as of December 31, 1968, Creating the Trust Fund, Defining the Duties of the Board of Trustees, and Providing for Advisory Councils on Social Security

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

Federal supplementary medical insurance trust fund.—Section 1841. (*a*) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal supplementary medical insurance trust fund" (hereinafter in this section referred to as the "trust fund"). The trust fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

(*b*) With respect to the trust fund, there is hereby created a body to be known as the Board of Trustees of the trust fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of the Health, Education, and Welfare, all

ex officio. The Secretary of the Treasury shall be the managing trustee of the Board of Trustees (hereinafter in this section referred to as the "managing trustee"). The Commissioner of social security shall serve as the secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the trust fund;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(*e*) (1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5, United States Code, or any other law administered by the Civil Service Commission providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Civil Service Commission may determine. The Civil Service Commission shall furnish such information as the Secretary of Health, Education, and Welfare may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies.

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the civil service retirement and disability fund, or the account (if any) applicable in the case of such other law administered by

the Civil Service Commission, to the Federal supplementary medical insurance trust fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Civil Service Commission and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

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

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

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

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

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

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

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

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

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

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

(2) Appointed members of any such council, while serving on business of the council (inclusive of traveltime), shall receive compensation at rates fixed by the

Secretary, but not exceeding $100 per day and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

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

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

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

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

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

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