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1970 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

LETTER

FROM

BOARD OF TRUSTEES
FEDERAL SUPPLEMENTARY MEDICAL
INSURANCE TRUST FUND

TRANSMITTING

THE 1970 ANNUAL REPORT OF THE BOARD (5TH REPORT), PURSUANT TO THE PROVISIONS OF SECTION 1841(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

APRIL 2, 1970.—Referred to the Committee on Ways and Means, and ordered to be printed

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LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE FEDERAL
SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND,
Washington, D.C., April 1, 1970.

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

SIR: We have the honor to transmit to you the 1970 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the 5th such report), in compliance with the provisions of section 1841(b) of the Social Security Act, as amended.

Respectfully,

DAVID M. KENNEDY,
Secretary of the Treasury,
and Managing Trustee of the Trust Funds.

GEORGE P. SHULTZ,
Secretary of Labor.

ROBERT H. FINCH
Secretary of Health, Education, and Welfare.

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

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1970 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 1969 was the third 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 1969 amounted to $903 million, while the matching contributions from the general fund of the Treasury amounted to $984 million. The excess of $81 million in Government matching funds for fiscal year 1969 resulted essentially from making up the deficiency in Government matching for the two prior fiscal years.

Total receipts of the trust fund amounted to $1,911 million in fiscal year 1969, an increase of 41 percent over the preceding fiscal year (primarily due to the increase in the premium rate that was effective in April 1968). In addition to premiums and Government contributions, receipts consisted of $23 million in interest on investments.

Total disbursements from the trust fund in fiscal year 1969 amounted to $1,840 million, an increase of 20 percent over the preceding year (primarily because of the increase in benefit payments due to greater utilization of medical services and higher costs thereof). Of this amount, $1,645 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 1969 that did not clear through the Treasury before July 1, 1969). The benefit payments in fiscal year 1969 were about 18 percent higher than those of the preceding fiscal year, when they amounted to $1,390 million. The remaining $195 million in fiscal year 1969 was for administrative expenses.

There was an excess of total income over total outgo amounting to $71 million. Accordingly, the total assets of the trust fund increased from $307 million on June 30, 1968, to $378 million on June 30, 1969,

but by December 31, 1969, they had decreased to $199 million (as a result of the inadequate premium rate that was promulgated for fiscal year 1970 and as a result of the transfer of $108 million to the hospital insurance trust fund with respect to certain costs for radiology and pathology services during April 1968 through September 1969 that were paid by that trust fund but that are liabilities of the supplementary medical insurance trust fund).

After the close of the fiscal year—in December 1969—the standard premium rate for the period July 1970 through June 1971 was promulgated, at $5.30 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, and such statement was published in the Federal Register for December 31, 1969.

No amendments to the Social Security Act affecting this program were made in fiscal year 1969 or in the succeeding 6-month period.

SUMMARY OF THE OPERATIONS OF THE TRUST FUND, FISCAL YEAR 1969

A statement of the income and disbursements of the Federal supplementary medical insurance trust fund during fiscal year 1969 and of the assets of the fund at the beginning and end of the fiscal year is presented in table 1.

The total assets of the trust fund amounted to $307 million on June 30, 1968. By the end of fiscal year 1969, the assets amounted to $378 million, an increase of $71 million.

Total receipts of the fund amounted to $1,911 million. Of this total, $903 million represented premium payments by—or on behalf of—the enrollees, an increase of 29 percent over premium payments by enrollees in the preceding fiscal year. This growth is largely attributable to the increase in the standard premium rate from $3 to $4 per month that became effective in April 1968. Since this increase in the standard premium rate became effective in the latter part of fiscal year 1968, fiscal year 1969 was the first full year during which it was operative.

TABLE 1.—STATEMENT OF OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1969

Total assets of the trust fund, June 30, 1968	$306,703,383.68
Receipts, fiscal year 1969:	
Premiums from participants:	
Deducted from benefits [1]	750,754,631.43
Deposited by States	75,852,109.60
Collected by Social Security Administration [2]	76,214,145.24
Total premiums	902,820,886.27
Transfers from general fund of the Treasury:	
Government matching contributions	983,145,978.58
Interest on delayed transfer of Government matching contributions	1,140,697.00
Total transfers from general fund of the Treasury	984,286,675.58
Interest:	
Interest on investments	23,514,663.20
Less interest on amounts of interfund transfers for reimbursement of administrative expenses and construction costs	48,865.00
Net interest	23,465,798.20
Total receipts	1,910,573,360.05

TABLE 1.—STATEMENT OF OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1969—Continued

Disbursements, fiscal year 1969:	
Benefit payments	1,644,842,355.93
Administrative expenses:	
Department of Health, Education, and Welfare[3]	193,726,117.00
Treasury Department	12,022.03
Civil Service Commission	73,987.00
Reimbursement to old-age and survivors insurance trust fund due to adjustment in allocation of administrative expenses for fiscal year 1968	325,099.00
Reimbursement to old-age and survivors insurance and disability insurance trust funds for costs of construction for fiscal year 1968	550,000.00
Gross administrative expenses	194,687,225.03
Less receipts from sale of surplus supplies, materials, etc	26,970.97
Net administrative expenses	194,660,254.06
Total disbursements	1,839,502,609.99
Net addition to the trust fund	71,070,750.06
Total assets of the trust fund, June 30, 1969	377,774,133.74

[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.

Matching contributions received from the general fund of the Treasury, plus interest on part of such transfers that were delayed, amounted to $984 million. This amount included $24 million for the deficiency in Government matching contributions in fiscal year 1967, along with $1 million interest thereon, and $64 million for the deficiency in fiscal year 1968—all of which was transferred to the trust fund in July 1968. (An amount covering the deficiency in fiscal year 1969, some $8 million, along with interest thereon, and interest on the deficiency in fiscal year 1968 was transferred to the trust fund after the close of fiscal year 1969, in February 1970.)

The remaining $23 million consisted of the interest on the investments of the trust fund less the interest on amounts of interfund transfers between this trust fund and the other three trust funds, old-age and survivors insurance, disability insurance, and hospital insurance.

Disbursements from the fund during fiscal year 1969 totaled $1,840 million. Of this total, $1,645 million was for benefit payments, and $195 million was for net administrative expenses. Administrative expenses are allocated and charged directly to each of the four trust funds on the basis of provisional estimates. Periodically, as actual experience develops and is analyzed, adjustments to the allocations of administrative expenses for prior periods are effected by interfund transfers, with appropriate interest allowances.

Table 2 compares the actual experience in the fiscal year 1969 with the estimates presented in the 1969 Annual Report of the Board of Trustees. The estimated premium collections and Government matching contributions were very close to the actual experience. The estimated benefit payments were 6 percent lower than the actual experience. Estimated assets at the end of the fiscal year were 37 percent higher than the actual assets, largely because of the difference between estimated and actual benefit payments.

The assets of this fund at the end of fiscal year 1969, amounting to $378 million, consisted of $358 million in the form of obligations

of the U.S. Government and $20 million in undisbursed balances. Table 3 shows a comparison of the total assets of the fund and their distribution at the end of fiscal years 1968 and 1969.

New securities at a total par value of $2,109 million were acquired during the fiscal year, through the investment of receipts and the reinvestment of funds made available from the maturity of securities. The par value of securities redeemed during the year was $2,032 million. A summary of transactions for the fiscal year, by type of security, is presented in table 4.

TABLE 2.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1969

[Amounts in millions]

Item	Actual amount	Estimated amount published in 1969 report	Estimate as percentage of actual
Premiums from enrollees	$903	$905	100
Government matching contributions	983	983	100
Benefit payments [1]	1,714	1,606	94
Assets, end of year [1]	309	424	137

[1] The actual amounts have been adjusted to take into account the effect of the transfer (in October 1969) made from this trust fund to the hospital insurance trust fund to reimburse for the cost of certain physician radiology and pathology services which were paid at first from the latter trust fund, but were an obligation of the supplementary medical insurance trust fund. The amount of such transfer that related to services rendered in fiscal year 1969 was $69,000,000. This adjustment was made so that the actual experience would be presented on a basis consistent with the basis on which the estimates shown in the 1969 annual report were prepared.

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

TABLE 3.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, BY TYPE, AT END OF FISCAL YEARS 1968 AND 1969

	June 30, 1968		June 30, 1969	
	Par value	Book value [1]	Par value	Book value [1]
Investments in public-debt obligations sold only to this fund (special issues):				
Notes:				
4¾ percent, 1974	$274,886,000	$274,886,000.00	$134,238,000	$134,238,000.00
5⅝ percent, 1975	6,527,000	6,527,000.00	6,527,000	6,527,000.00
6½ percent, 1976			217,206,000	217,206,000.00
Total investments in public-debt obligations	281,413,000	281,413,000.00	357,971,000	357,971,000.00
Undisbursed balances		25,290,383.68		19,803,133.74
Total assets		306,703,383.68		377,774,133.74

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

TABLE 4.—STATEMENT OF TRANSACTIONS IN PUBLIC-DEBT SECURITIES FOR THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1969

[All amounts represent par values]

	Acquisitions	Dispositions
Obligations sold only to this fund (special issues):		
Certificates of indebtedness:		
5¼ percent, 1969	$144,905,000	$144,905,000
5⅜ percent, 1969	316,165,000	316,165,000
5½ percent, 1969	380,071,000	380,071,000
5⅝ percent, 1969	144,206,000	144,206,000
6 percent, 1969	170,399,000	170,399,000
6⅛ percent, 1969	282,987,000	382,987,000
6¼ percent, 1969	314,419,000	314,419,000
6½ percent, 1969	138,403,000	138,403,000
Notes:		
4¾ percent, 1974		140,648,000
6½ percent, 1976	217,206,000	
Total transactions	2,108,761,000	2,032,203,000

Expected Operations and Status of the Trust Fund During the Period July 1, 1969, to June 30, 1972

The actual progress of the supplementary medical insurance trust fund on a cash basis during fiscal years 1967 through 1969 appears in table 5. Cash income during those fiscal years exceeded cash disbursements by $378 million, leaving a balance in the trust fund of this amount as of June 30, 1969. This amount was about $350 million less than the benefit payments and processing costs related thereto based on services furnished prior to June 30, 1969, that would subsequently be claimed, adjudicated, and paid.

Disbursements for benefits and administrative costs in fiscal year 1970 are now estimated at $2,165 million—on an accrual basis—somewhat higher than the actuarial projections for fiscal year 1970, made in December 1968, of $1,967 million.[1] About $85 million of this difference is due to the retroactive reimbursement to the hospital insurance trust fund for certain radiology and pathology services rendered prior to fiscal year 1970.

TABLE 5.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), FISCAL YEARS 1970–72, AND ACTUAL DATA FOR 1967–69

[In millions]

Fiscal year	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses	Interest on fund [1]	Balance in fund at end of year
Actual experience:						
1967	$647	$623	$664	[2] $134	$15	$486
1968	699	634	1,390	142	20	307
1969	903	984	1,645	195	23	378
Estimate of future experience:						
1970	922	928	1,949	216	4	66
1971	1,242	1,245	2,078	236	10	250
1972 [3]	1,257	1,257	2,243	278	15	258

[1] The payments shown as being from the General Fund of the Treasury do not include any interest-adjustment items (which are included in the interest column).
[2] Administrative expenses shown include those incurred in fiscal 1966 and 1967.
[3] Experience that would result if the standard premium rate remained at $5.30 per month after June 1971.

[1] See table 8 of the 1969 Trustees Report, according to "estimates based on projections of physician fees and utilization of services."

In contrast, income in fiscal year 1971 will probably more than cover cash disbursements, resulting in a small cash surplus in that period, although there will continue to be a large deficit, on an accrual basis, resulting from previous inadequate premium rates. If the standard premium rate of $5.30 per month that has been promulgated for fiscal year 1971 is continued in fiscal year 1972, this estimate shows an almost exact balance between income and outgo for fiscal year 1972; however, if that is to be the experience expected, a higher premium rate than $5.30 would be required, since the rate is to be determined on an accrual basis, thus reflecting the larger incurred costs arising, so that the incurred but unpaid amounts will be increased.

Actuarial Status of the Trust Fund

(1) Actuarial status of program dependent on accrued experience

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

This liability outstanding at any time for benefits for services performed for which no payment has been made may be referred to as "benefits incurred but unpaid." Estimates of the amount of such benefits incurred but unpaid as of the end of each calendar year, and of the administrative expenses related to processing these benefits, appear in table 6. Also included in table 6 are estimates of 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 for any period can be obtained by adjusting the cash flow of premiums, matching Government contributions, benefit payments, and administrative expenses to an accrual basis by adding the net increase in each asset or liability item during the period to the corresponding item on a cash basis for that period.

TABLE 6.—SUMMARY OF PROJECTED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, AT END OF CALENDAR YEARS 1966–69

[In millions]

	As of December 31			
	1966	1967	1968	1969
A. Assets:				
Premiums due and uncollected, less premiums collected in advance	−$3	$1	$3	$3
Government matching contributions due and unpaid, less such contributions with respect to premiums paid in advance	319	30	5	12
Actual balance in trust fund	122	412	421	199
Total assets	438	443	429	214
B. Liabilities outstanding:				
Benefits incurred but unpaid	395	508	667	648
Administrative cost for processing that are related to benefits incurred but unpaid	38	55	71	81
Total liabilities	433	563	738	729
C. Net actuarial surplus	5	−120	−309	−515

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

The accrual basis of measuring the actuarial status of the supplementary medical insurance program is a reasonable, even essential, procedure. This approach, if successfully carried out, assures that the benefit costs actually incurred in a particular premium period will be met by the premiums paid by the enrollees during that period. Thus, since the enrollee group is not the same from year to year, there would otherwise be the inequity of some persons paying for other person's costs.

(*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 physician fee increases will be recognized by the program and as to the increase in utilization of services that continues to result from having placed 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 app. IV); and any errors in the former are necessarily incorporated into the latter. The resulting estimates of the 1969 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 1968 or 1969 will not be possible until the deadlines for filing claims based on services performed then have passed, all claims have been adjudicated and decided by carriers, and payment records covering all benefit payments have been prepared by carriers and forwarded to the Social Security Administration.

(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 in December of each year for a 1-year period beginning the following July; consequently, estimates are needed only for 1½ years into the future (although due to the lags mentioned and the difficulties in obtaining reliable data from the program, the forecasting period is really 2½ to 3½ years). 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 that are used in considering the cost of the old-age, survivors, and disability insurance and hospital insurance programs, so that the financing of the system can be set at the level thought most likely to be actually required (i.e. a "maximum likelihood" estimate).

The "expected" estimates of the per capita costs of benefits and administrative expenses that were accrued during calendar years 1966–69 and those anticipated for calendar years 1970–72 are given in Appendix I. Since the $50 deductible applies to each calendar year, these costs can be developed only for calendar-year periods; however, the premium rate is 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 for which a particular premium rate was forecast are as follows:

Period	Applicable premium rate	Benefit payments[1]	Administrative costs[1]	Total disbursements[1]
July 1966 to December 1967	$3	$5.71	$0.74	$6.45
January 1968 to March 1968[2]	3	6.75	.81	7.56
April 1968 to June 1969	4	7.76	.89	8.65
July 1969 to June 1970	4	8.30	.98	9.28

[1] Assuming disbursements paid due to the carryover deductible are accrued in the year paid (see app. IV for explanation).
[2] The premium-rate forecast was not implemented due to action of Congress.

Although the law requires that the promulgated premium rate should be determined by considering only the estimated incurred benefit costs and administrative expenses, interest is normally earned on the trust fund assets as a result of the lag between payment of premiums and settlement of claims. For example, if the premium rate is exactly adequate to meet the benefit costs and administrative expenses on an accrual basis, the program will show a surplus due to these interest earnings. It was intended that such earnings would provide a small additional margin for contingencies or to build a modest contingency reserve.

When interest earnings on an accrual basis are taken into consideration, the deficiencies indicated—on a monthly per capita basis—are reduced slightly, as indicated in the following table:

Period	Gross deficiency	Effect of interest	Net deficiency
July 1966 to December 1967	$0.45	$0.11	$0.34
January 1968 to March 1968	1.56	.16	1.40
April 1968 to June 1969	.65	.17	.48
July 1969 to June 1970	1.28	.20	1.08

These estimates are based on the assumptions that there is a lag of 5 months between the payment of premiums and the settlement of claims, that benefit payments for each month in the period in question are equal to the average for the period, and that the interest earnings are those of special issues during such period. Interest earned in the first period was reduced somewhat due to the failure of the General Fund to make the matching payments during the first 6 months of the program. Although these payments were made up subsequently—by a lump-sum payment in January 1967—no interest was earned by the program with respect to this delay. It should be emphasized that this concept of the effect of interest contains certain artificialities, because no account is taken of the fact that there are deficits on an incurred basis which are never paid off and which will reduce the interest income in future years below the amounts shown. However, the method does provide a useful index of the relative value of the interest that is earned on the funds from each period.

The premium rate for the period from July 1966 through December 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; the actual ratio of administrative expenses to benefit payments on an accrual basis was 10 percent in 1967 and 12 percent in 1968, as against the initial estimate of 8 percent.

No specific premium rate was promulgated for the period January through March 1968, due to a special action of Congress continuing the $3 rate until the 1967 amendments went into effect on April 1, 1968. Consequently, a much larger deficit occurred in this period.

A premium rate of $4 was promulgated for the 15-month period April 1968 through June 1969. This rate proved to be inadequate by 11 percent, due to the following factors:

(*a*) A severe influenza epidemic in November 1968 through January 1969 added, for the entire premium-rate period, an estimated 30 cents per capita per month to disbursements.

(*b*) Physician fees, utilization of physician services, and the cost and utilization of institutional services covered by the program continued to rise more than estimated, due partially to

continuing inflationary conditions. The rise in cost and utilization of outpatient hospital and clinic services and of home-health agency services was especially pronounced (and has continued).

(*c*) Administrative costs continued to rise faster than benefit costs, and to exceed those estimated.

A premium rate of $4 was also promulgated for fiscal year 1970, despite actuarial recommendations that a premium rate of at least $4.40 would be required. Actually, it now appears that the estimate of the fiscal year 1969 base which was used to estimate the premium rate for fiscal year 1970 was too low, in part because of the influenza epidemic that occurred in the middle of fiscal year 1969. In other words, the per capita cost for fiscal year 1969—instead of being somewhat less than $8 per month, as was thought to be the case in December 1968—is now estimated to be $8.73 per month. Similarly, the per capita cost for fiscal year 1970 is now estimated to be about $9.28 per month (instead of $8.80), or about 6 percent higher than for fiscal year 1969. This relative increase of 6 percent would, of course, be somewhat higher—actually 8 percent—if the effect of the influenza epidemic in fiscal year 1969, which caused unusually high experience, were eliminated.

(*4*) *Effect of administrative action to contain rising costs*

In December 1968, the decision was made by the Secretary to hold the standard premium rate for the supplementary medical insurance program at the $4 level through fiscal year 1970. On the basis of information then available, it was thought that the cost for benefit payments and administrative expenses for fiscal year 1969 would be slightly less than $8 per month per capita, although it is now clear that, when all bills for services furnished in that period have been paid, the cost is more likely to be about $8.73 (see appendix I), although it would have been about $8.58 if there had not been the significant influenza epidemic then. A variety of steps were taken at that time by the Social Security Administration designed, insofar as possible, to hold the benefit cost to as low a point as possible.

Increases in allowed charges were restricted, starting with January 1969, as follows:

(*a*) Customary charge to be increased only in individually identified highly unusual situations where equity clearly requires such an adjustment.

(*b*) Until July 1970, prevailing charges to be increased only on the approval of the Social Security Administration.

The administrative steps taken at that time also included new standards of carrier performance (developed during 1968 with the aid of consultant experts and the Health Insurance Benefits Advisory Council). Under these new standards, the definition of prevailing charges was refined (i) to place further restrictions on the proportion of charges that would be covered in full, and (ii) generally to preclude changes in these limits more often than annually after June 1970. In addition, the definition of the customary charge of a physician was refined to preclude upward adjustments unless there is adequate evidence that the new higher fees have been in effect for a substantial period of time, and to relate physician charges for purchased laboratory services to the charges made by laboratories to physicians.

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

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

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

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

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

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

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

While the administrative actions that were taken did not contain the cost of the protection provided under the program to a level that could be met by a $4 standard premium rate, they appear to have mitigated the increase in cost that might otherwise have been expected. One indication of the effect of the policies adopted with respect to recognition of increases in physician fees is that, during fiscal year 1969, the program recognized only a 3-percent increase in the general level of physician fees, although nationwide the actual increases in physician fees averaged between 6 and 7 percent. Furthermore, during that fiscal year, there was an increase in the rate of denial of claims.

Efforts to administer the program in a way that will constrain overutilization and fee escalation have continued through the current fiscal year. By December 1969, about 30 percent of the claims [1] submitted were reduced or denied. The resulting savings to the program are estimated, on the basis of data submitted by the carriers, to be at a rate of about $155 million a year (these savings include both those arising under the previous procedure for determining reasonable charges and those arising under the new procedures described earlier in this section). At the same time, about 6½ percent of claims submitted were being denied as noncovered.

(*5*) *Estimates of the past accrued experience*

The estimates for the past accrued experience of the supplementary medical insurance program for calendar years 1966–69 appear in table 7.

The trust fund balances shown in the various tables presented in this report do not include the contingency reserve that was authorized to be available until December 31, 1969, and has now expired. The size of this reserve was $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 have been repayable without interest from future income of the program.

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

TABLE 7.—ESTIMATED INCOME AND DISBURSEMENTS PAYABLE (ACCRUAL BASIS) UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, CALENDAR YEARS 1966–69

[In millions]

Calendar year	Premiums from participants	Government contributions	Benefit payments [1]	Administrative expenses [1]	Interest on fund	Net of operations in year	Accumulated surplus at end of year
1966	$319	$319	$523	[2] $112	$2	$5	$5
1967	644	644	1,310	127	24	−125	−120
1968	834	834	1,678	199	20	−189	−309
1969	914	914	1,846	206	18	−206	−515
Total 1966–69	2,711	2,711	5,357	644	64	−515	−515

[1] Assuming disbursements paid due to the carryover deductible were accrued during the year paid.
[2] Administrative expenses shown include those incurred in 1965 and 1966.

As can be seen by examination of table 6, the program netted an estimated surplus of $5 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 in the initial premium period, July 1966 through December 1967 (by about 7 percent), the benefit payments and administrative expenses incurred exceeded accrued income during calendar year 1967 by an estimated $125 million, leaving an estimated deficit of $120 million on an accrual basis for the initial 1½-year period. The estimated accrued deficit increased during 1968 by $189 million to reach $309 million by December 31, 1968, and increased by $206 million during 1969 to reach an estimated $515 million as of December 31, 1969. Interest earnings of about $20 million per year have been earned during the 1967–69 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 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, interest income derived from the balances built up by those enrolled during 1966–67 will contribute toward reducing the deficit incurred in that period.

(6) Past experience on a cash basis

The income and disbursements of the trust fund on a "cash" basis for calendar years 1966–69 appear in table 8. Cash income exceeded cash disbursements during 1966–67 by a large margin, resulting in a cash balance in the trust fund at the end of 1967 of $412 million, although the program actually had an estimated net deficit of $125 million on that date, due to the large liabilities outstanding on account of incurred but unpaid claims (as shown in table 5). Cash disbursements were slightly lower than cash income during calendar year 1968 despite the inadequacy of the $3 premium rate during the first quarter of the year, and the balance in the trust fund increased to $421 million at the end of the year. In 1969, however, due to the promulgation of an actuarially inadequate rate, disbursements ex-

ceeded income by a large margin, resulting in a reduction of 50 percent in the trust fund, to $199 million as of December 31, 1969. Further, interest receipts in succeeding years will be reduced as a result, requiring higher premium rates.

TABLE 8.—PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), CALENDAR YEARS 1966-69

[In millions]

Calendar year	Premiums from participants	Government contributions [1]	Benefit payments	Administrative expenses	Interest on fund [1]	Balance in fund at end of year
1966	$322	----------	$128	[2] $74	$2	$122
1967	640	$933	1,197	110	24	412
1968	832	859	1,519	183	20	421
1969	914	907	1,865	196	18	199
Total, 1966-69	2,708	2,699	4,709	563	64	199

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

(7) Summary of actuarial status of program

The actuarial status of the program and the financial status of the trust fund depend on the determination and measurement of the accrued income and benefit payments and administrative expenses 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 December 1967 of about 7 percent, and hence in the estimated accrued balance at the end of this period. However, due to the normal delay between the time that services were furnished and the time at which benefits were claimed on the basis of these services, there was an adequate cash balance in the trust fund, and this balance was adequate through fiscal year 1969.

The premium rate of $5.30 that is set for the period July 1970 through June 1971 will 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 (but will nonetheless be of a large size).

Due to the promulgation of an actuarially inadequate rate for fiscal year 1970, however, the balance in the trust fund has been decreasing at a rapid rate during fiscal year 1970. Provided that experience is not very unfavorable, however, the trust fund should prove adequate to cover the deficit in current operations through June 1970, when a premium rate of $5.30, which is estimated to be actuarially adequate, will take effect.

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 (with a 1-year delay), the estimate showing an accrued cost of $10.20 per month per capita will 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 1971 as in the past.

It is important to note that the rate of reduction in charges before reimbursement has been increasing. For the period July 1966 through June 1967, the reductions averaged 2.6 percent, and they gradually rose to 3.1 percent for July 1967 through June 1968, and to 5.2 percent for July 1968 through June 1969. The estimates underlying the promulgated $5.30 rate, which includes a small margin for contingencies, also assume that improved carrier administration of the program will result in some further increases in the rate of reduction of charges, and also that there will be 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.