APPENDIXES

APPENDIX I. 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 1970*

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 for the period July 1970 through June 1971. The standard premium rate is that rate which is payable by those who enroll in their initial enrollment period and by those who enroll in a general enrollment period that terminates less than 12 months after the close of their initial enrollment period.

The actuarial determination has been made on the basis of the actual operating experience under the program. Virtually complete operating-experience figures for the 6 months of 1966 and for 1967 are now available, but because of the timelag in the submission of bills for this program, figures for 1968 are not quite complete, and only partial data for 1969 are available.

ANALYSIS OF DATA ON A CASH BASIS

Current figures for cash expenditures under the program are available on a complete, accurate basis, but these figures taken alone are misleading because they do not take into account the liabilities arising from the natural delay 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, other suppliers of services, and enrollees in making requests for payment, and the time required by the carriers and intermediaries to adjudicate and pay claims. The data on a "cash" basis are presented first, since they are the base from which the incurred figures needed for the premium-rate determination are developed.

The balances in the supplementary medical insurance trust fund at the end of various selected typical past months are as follows (in millions):

Month:	*Balance*
January 1967 [1]	$467
March 1967	570
December 1967	412
July 1968	403
December 1968	421
June 1969	378
October 1969	242

[1] Balances for months in 1966 were unduly low, because no federal matching payments were made until January 1967.

As compared with the balance of $242 million in the supplementary medical insurance trust fund at the end of October 1969, there were at that time substantial outstanding liabilities incurred for services rendered during the previous months of operation of the program, most of which had not yet been submitted for claims payment—an estimated $800 million approximately. It is expected that the trust-fund balance will continue to decrease during the remainder of fiscal year 1970, because the actuarially inadequate premium rate of $4 per month which was promulgated in December 1968 will still be in effect throughout this period. It is estimated that the trust fund balance will reach approximately $100 million on June 30, 1970.

*This statement was published in the Federal Register for December 31, 1969 (34 F.R. 249).

On the basis of claims and administrative expenses paid (cash basis), the average monthly per capita expenditures of the program for the 21 months in the first premium period, July 1966 through March 1968, amounted to $5.12. Similarly, the average monthly per capita expenditures on a cash basis in the second premium period, April 1968 through June 1969, amounted to $8.05. Finally, the average monthly per capita expenditures (cash basis) for the first 5 months of the third premium period, July 1969 through June 1970, amounted to $8.84.

ANALYSIS OF DATA ON AN INCURRED BASIS

The figures on a cash basis need to be adjusted for the estimated increase in liability that took place during the period for benefits that will be paid for services rendered during the period, but that had not been paid at the end of the period (and the accompanying administrative expenses). In other words, the premium rate must be set on an accrual or incurred basis, rather than a cash basis.

Estimates on an incurred basis for the 21 months involved in the first premium period (July 1966 through March 1968) indicate that benefits and administrative expenses per capita exceeded income from premiums and matching government contributions by $.65 per month (i.e., 32½ cents each), or by 11 percent relatively. These estimates are based on virtually complete experience data. If account is taken of the interest earnings of the trust fund, this deficit is reduced to $.57 per month, or 9½ percent relatively. If the comparison is made for the 18-month period, July 1966 through December 1967, for which the combined rate of $6 originally applied (having been extended 3 months by legislation in 1967), the differential under-estimate would have been 6 percent (taking into account the effect of the interest earnings of the trust fund).

Estimates on an incurred basis for the 15 months involved in the second premium period (April 1968 through June 1969), indicate that the total per capita cost exceeded income from premiums and matching government contributions by $.65 per month, or by 8 percent of the combined rate of $8. These estimates are based on moderately complete experience data. If account is taken of the interest earnings of the trust fund, this deficit is reduced to $.55 per month, or 7 percent relatively.

Similar figures on an incurred basis for the third premium period (July 1969 through June 1970) necessarily must be based largely on estimates of the experience which will develop. Estimates for this period (which are described in more detail later, especially as to assumptions and methodology) indicate that the total per capita cost will exceed income from premiums and matching government contributions by about $1.28 per month, or by 16 percent relatively. If account is taken of the interest earnings of the trust fund, this estimated deficit is reduced to $1.22 per month, or 15 percent relatively.

It should be noted that this large deficit for the third premium period would not have occurred if the actuarially-determined and recommended premium rate of $4.40 had been promulgated, instead of the rate of $4 which was promulgated. If there had not been the administrative action to defer recognition of increases in physicians' fees for reimbursement purposes, a $4.40 rate would have resulted in an estimated deficit (after allowing for the higher interest receipts) of about $0.48 to $0.53 per capita per month, or about 6 percent relatively. Such estimated deficit takes into account the element that the costs of the program were apparently reduced by $0.10 to $0.15 per capita per month by such administrative action. It is possible—although not susceptible of proof—that the promulgation of the higher rate ($4.40) in itself would have led to higher program costs than were actually experienced, because of the psychological effect of having the Government predict a rise in physicians' fees.

In any event, it cannot be emphasized too strongly that the base for the estimate of the premium rate now to be promulgated for the fourth premium period (July 1970 through June 1971) is a presently-experienced cost requiring a standard premium rate of at least $4.60 and possibly $4.70 per month, and not the $4 which is currently being collected.

BASIC ESTIMATE OF FUTURE EXPERIENCE ON AN INCURRED BASIS

In estimating the cost of the program for July 1970 through June 1971 it is necessary to provide 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-term upward trend of the general earnings level and the general price level, which will be reflected in higher physicians' fees, higher costs for other covered services, and higher administrative

expenses. In the estimates in this section, the minimum reasonable assumptions as to future increases have been made. Certain other estimates based on somewhat higher cost assumptions are discussed in a later section.

For the purpose of estimating the necessary premium rate for July 1970 through June 1971 it was assumed that, in comparing calendar year 1969 with 1968, the combined effect of increases in physicians' fees and costs of other covered medical services and of increases in utilization would be an increase of 5½ percent. The corresponding figure for calendar year 1970 as compared with 1969 is 7½ percent, while the rate used for 1971 as compared with 1970 is 8½ percent. The breakdown of these aggregate increases into the three components is as follows:

[In percent]

Calendar year	Assumed increase over previous year		
	Physicians' fees [1]	Costs of other covered services [2]	Utilization of services
1969	2	15	3
1970	4	14	3
1971	6	13	2

[1] As recognized by the program.
[2] Including effect of increased utilization of such services which is in excess of assumed general increase in utilization.

It should be observed that the relatively low rate of increase for 1969 over 1968 reflects the deferment of recognition of increases in physicians' fees for reimbursement purposes that was put into effect by regulations at the end of 1968.

The rates of increase for calendar years 1970 and 1971 are based on the assumption that such deferment will be moved forward successively by 1 year—i.e., that the deferment applicable from July 1970 through June 1971 will be based on the situation as to physician fees during 1969. It should also be noted that these assumed rates of increase take into account the fact that the costs of covered nonphysician services, such as hospital outpatient care and home health services, which represent only about 10 percent of the total cost of the program, have been increasing more rapidly than physicians' fees and have not been subject to a deferment of recognition of cost changes.

Administrative expenses are assumed to represent about 11½ percent of the benefit payments; this figure is based on the actual operating results in 1969 and budget estimates for future years (all on an incurred basis). The average interest rate on the invested assets of the trust fund is assumed to be 6½ percent (the rate applicable to the entire portfolio as of September 30, 1969). This rate might be somewhat higher during the next premium period, but since the balance in the trust fund will not be very large, the effect of the interest-rate assumption is not significant; for example, if a 7-percent interest rate were assumed, the per capita cost would be reduced by less than one-half cent per month.

It is estimated that the incurred monthly per capita *total* cost, on a calendar-year basis, would have been $8.28 for 1968 if the provisions of the 1967 amendments had been in effect for the entire year (instead of only part of it) and if there had not been the influenza epidemic in late 1968 and early 1969. This consists of $7.46 for benefits and $.82 for administrative expenses. This approach has been taken in order to obtain a proper base on which to build estimates of future costs; the possibility of epidemics occurring is later taken into account by adding a contingency margin to the estimated costs for "normal" conditions.

On the basis of the foregoing assumptions, it is estimated that the monthly per capita *benefit* cost on a calendar-year basis will be $7.95 for 1969 (again exclusive of the additional cost arising from the influenza epidemic in late 1968 and early 1969). The corresponding benefit-cost figures estimated for 1970 and 1971 are $8.65 and $9.50, respectively. To these must be added the monthly per capita costs for administrative expenses, which are estimated at $.93 for 1969, $1.03 for 1970, and $1.13 for 1971. Thus, the monthly per capita total cost on an incurred basis is estimated at $8.88 for 1969 (exclusive of the additional cost with respect to the influenza epidemic), $9.68 for 1970, and $10.63 for 1971.

The monthly per capita total cost for fiscal year 1969 averages out at $8.58; this is increased to $8.73 if the actual effect of the influenza epidemic is taken into account. The corresponding estimated costs for fiscal years 1970 and 1971 (assuming no influenza epidemic) are $9.28 and $10.16. Thus, as indicated previously, the standard premium rate for fiscal year 1970, promulgated at $4 per month in

December 1968, should have been at least $4.60, and quite possibly should have been $4.70. The figure of $10.16 for fiscal year 1971 (half of which is $5.08) indicates that, allowing even a small margin for contingencies (as required by law), the standard premium rate for the period July 1970 through June 1971 would need to be $5.20 per month at the very least. However, as indicated in the analysis which follows, the estimates presented up to this point (which are on a reasonable-minimum cost basis), the only safe course of procedure—considering the currently depleted state of the trust fund—is to set a rate of $5.30 per month.

OTHER ESTIMATES OF FUTURE EXPERIENCE

A similar analysis of the possible experience in 1969–1971 was made with more detailed and refined methodology and with somewhat higher assumptions as to future increases in medical costs and utilization, all under the assumption that the deferment of recognition of increases in physician fees for reimbursement purposes would be continued on the present lag basis moved up 1 year. This indicated monthly per capita total costs of $8.94 for fiscal year 1969 (including $.38 for the additional costs due to the influenza epidemic), $9.44 for fiscal year 1970, and $10.46 for fiscal year 1971. The last figure indicates that, according to this estimate, a standard premium rate of $5.30 per month should be promulgated for fiscal year 1971, if some reasonable margin for contingencies is to be included.

The level of benefit expenditures indicated by the foregoing estimate was confirmed by an independent calculation of the accrued benefits in 1969, starting with the cash expenditure in calendar year 1969 and adjusting for the benefits incurred but unpaid (due to the aforementioned lag) at the beginning and at the end of 1969, for the effect of the influenza epidemic, and for the liability of the program for certain payments for inpatient radiology and pathology services paid from the hospital insurance trust fund.

Still another type of analysis was made by using as a starting point the actual cash expenditures in fiscal year 1969. These data were adjusted downward for the nonrecurrent nature of the influenza epidemic and upward for certain payments attributable to the supplementary medical insurance program for inpatient radiology and pathology services but, during that time, paid from the hospital insurance trust fund. These calculations yielded a cash-basis per capita cost of $8.26 per month for fiscal year 1969. This figure was then projected to fiscal year 1970, yielding $8.86. Then, the latter figure was converted from a cash basis to an incurred basis, yielding $9.26. Finally, the latter figure was projected for 1 year, to fiscal year 1971, and the result was $10.26, so that on this basis the standard premium rate should be $5.20 with a small allowance for contingencies, and at least $5.30 with a sufficient allowance.

EFFECT OF INTEREST EARNINGS OF TRUST FUND

The interest earnings of the trust fund are available toward the margin for contingencies. If they are not needed to pay benefits and administrative expenses in the current period, they will reduce the unfunded liability for the past deficiency in the premium rate. Interest earnings for fiscal year 1971 are estimated to be the equivalent of only about 5 cents per capita (i.e., 2½ cents as compared with the enrollee premium) in available income, thus providing income toward a contingency margin of only small magnitude.

SUMMARY AND RECOMMENDATION

Based on all available evidence and analyses, the standard premium rate for fiscal year 1971 should be promulgated at $5.30 per month. This is based on the assumptions that there will continue to be a deferment of recognition of increases in physicians' fees for reimbursement purposes and that this deferment will not be advanced more than 1 year (so that, in the new premium period, July 1970 through June 1971 generally speaking no recognition will be given of changes in fees after December 1969).

Although a rate of $5.30 is desirable to provide a sufficient margin for contingencies (as required by law), it should be noted that, even if this margin is not actually used for any contingencies arising in the premium period, it would nevertheless fill the very useful purpose of building up the trust-fund balance to a more desirable level, one which is more in keeping with the concept that the program should be operated on an incurred-cost basis.

It is particularly important to provide a reasonable and adequate contingency margin in the premium rate now being promulgated, since the balance in the trust fund at the beginning of the new premium period will be considerably less than 1 month's benefit outgo. A rate as low as $5.20 (the next lowest possible rate under the law, which requires rounding to $0.10 units) would make very little allowance for possible adverse experience, such as might result from another influenza epidemic or for higher rates of increase in utilization or physicians' fees than the minimum-reasonable rates assumed. If the trust-fund balance at the beginning of the new premium period were to be larger—as would have been the case if the premium rate had not been maintained at $4 by the promulgation made in December 1968, but rather had been increased to the actuarial recommendation of at least $4.40—it might now have been possible to promulgate a rate of $5.20. Such a rate, under these circumstances, would have been able to depend upon the interest earnings of the trust fund serving as a major part of the protection against unforeseen contingencies.

The explanation of the $1.30 increase in the monthly standard premium rate for the new premium period can be summarized in the following manner:

(a) The cost of the protection under the program as in effect in the current premium period is estimated to exceed income from premiums and matching government contributions by about 16 percent—an increase of about 64 cents.

(b) The utilization of medical services is assumed to be higher in the new premium period than in the current period, and so the program cost is higher—an increase of about 12 cents.

(c) The level of physicians' fees recognized by the program and of the costs and charges for other covered services is assumed to be higher in the new premium period than in the current period, and so the program cost is higher—an increase of about 26 cents.

(d) The $50 deductible represents a smaller proportion of the total covered reimbursable charges when these increase as a result of either higher charges or costs of providers of services or higher utilization—an increase of 6 cents.

(e) The promulgated rate includes a minimal allowance of about 4 percent so as to provide a margin for contingencies, especially since the foregoing cost figures are based on reasonable-minimum cost projections and do not allow for any possible adverse morbidity experience (such as the influenza epidemic of 1968–1969), and to provide for an adequate contingency reserve to be present in case of adverse experience, since the trust-fund balance at the beginning of the premium period will be very low—an increase of 22 cents.

APPENDIX II. SUMMARY OF PRINCIPAL PROVISIONS

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

I. COVERAGE PROVISIONS (FOR CONTRIBUTION AND BENEFIT PURPOSES)

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

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

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

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

II. BENEFITS PROVIDED

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

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

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

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

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

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

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

III. FINANCING

(*a*) Participant premiums—flat monthly premium at a standard rate determined by Secretary of Health, Education, and Welfare. A rate of $4 has been promulgated for fiscal year 1970, and a rate of $5.30 has been promulgated for fiscal year 1971. The rate applicable to each succeeding fiscal year will be promulgated by the Secretary before the preceding January 1. Such rate for any period is intended to be adequate, along with other income of the system, to support the cost of the benefits and administration for services received by enrollees during the period on an accrual basis, plus a margin for contingencies. A higher rate than the standard one is to be paid by those enrolling late or reenrolling after terminating enrollment (a surcharge of 10 percent of the premium rate for each full year during which an individual enrolling late could have participated but did not).

(*b*) Government contributions—amount equal to total premiums paid by or on the behalf of participants.

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

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

Appendix III. Nature of the Trust Fund

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

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

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

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

Expenditures for benefit payments and administrative expenses under the program are paid out of the trust fund. All expenses incurred by the Department of Health, Education, and Welfare and by the Treasury Department 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.

Section 1833 of the Social Security Act provides that pathology and radiology services rendered by physicians after March 1968 to hospital inpatients are not subject to the deductible and coinsurance provisions of the supplementary medical insurance program. Hospitals, at their option, are permitted to combine their billing for both hospital and physician components of radiology and pathology services rendered hospital inpatients by hospital-based physicians. Where hospitals elect this billing procedure, payments are made initially from the hospital insurance trust fund, with reimbursement from the supplementary medical insurance trust fund. The reimbursements so made are on a provisional basis and are subject to adjustment, with appropriate interest allowances, as the actual experience develops and is analyzed.

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

That portion of each trust fund which, in the judgment of the managing trustee, is not required to meet current expenditures for benefits and 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 semi-annually or at redemption, if earlier.

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

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

APPENDIX IV. ASSUMPTIONS, METHODOLOGY, AND DETAILS OF COST ESTIMATES

The basic assumptions and methodology used to prepare the actuarial cost estimates are described in this appendix, accompanied by more detailed data from these estimates.

(1) BASIS OF FINANCING OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

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.

Further, the financing of the program is set only for short periods into the future, so that no long-range projections of the experience of the program are prepared. (The premium rate for each fiscal-year period is promulgated before the January 1 that precedes the beginning of such year.) Under normal circumstances, the cash income should exceed the cash disbursements in the period for which the experience is projected, since the natural lag in the payment of benefits results in a cash surplus. Such surplus provides some margin to insure enough assets on hand at any time to pay benefits should the premium prove inadequate by a moderate amount.

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 proved inadequate; however, no funds were drawn and the contingency reserve has now expired.

The actual cost of the program depends on a number of economic and medical variables. Because the program is intended by law to be self-supporting, if there were not the lag in payments, which produces a cash surplus in the trust fund, or if there were no surplus accumulated from past premium periods, the premium rate would have to contain a substantial margin to insure payment of all benefits under all circumstances. An additional element of uncertainty is introduced by the absence of firm data concerning the present cost of the program (as discussed subsequently). A substantial margin for contingencies would result in the enrollees for a particular premium-rate period paying more than half of the cost of the benefits and administrative expenses resulting from services performed for them.

Under normal circumstances, the natural lag between dates of services and dates of payment results in a cash surplus sufficiently large that the margin for contingencies over a "best estimate" of the accrued claims and administrative expenses need be only large enough to build up some surplus for influenza epidemics and the like, which can be expected to occur every few years.

Due to the promulgation of a substantially inadequate premium rate by the Secretary of Health, Education, and Welfare in December 1968, however, the cash surplus in the trust fund has become so low that it has become necessary to include a moderate contingency margin in the premium rate, rather than the relatively small amounts that have been included for contingencies in the past.

Thus, 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 accumulate 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).

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 (which are increased by the newness of the program and the unfamiliarity of many enrollees with reimbursement insurance), experience data from the program are complete only for 1966 and 1967.

In general, the estimates are based on data from payment records for services performed in 1966–68 that were processed to the 0.1 percent actuarial sample before October 1969 (but not as yet reconciled with actual disbursements from the trust fund, to ensure reliability) and the cash expenditures of the trust fund for benefits and administrative expenses. 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 many adjustments and assumptions required make these estimates subject to some variation from the actual experience in 1968 (as much as 5 percent), and to more variation in later years, since any errors in estimating the experience that has occurred during previous years 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 medical expenses leading to benefit payments as shown in payment-record data by type of service is defective. (Such information is available in the 0.1 percent actuarial sample to the limited extent that the 5 percent statistical sample as to such services eliminated by the deductible has been received from the carriers.)

(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. 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.

If the program were terminated at the end of a calendar year, 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 discussed in appendix I and in the main text assume that the additional costs resulting from the deductibles carried over are accrued in the year from which the deductible is carried over.

(4) 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) 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 increases in the unit prices of these services have, in the past, been highly correlated with the increases in earnings from all 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 A, together with the increases in the average wages in manufacturing and in the Consumer Price Index of Services (less rents).

TABLE A.—AVERAGE ANNUAL RATES OF INCREASE IN PHYSICIANS' FEES, IN AVERAGE WAGES, AND IN THE CONSUMER PRICE INDEX OF SERVICES, 1960–69

[In percent]

Year	Physicians' fees [1]	Average earnings in employment covered by social security	Wages in manufacturing (less overtime)	Consumer price index of services (less rent)
1960	1.8	4.3	3.8	3.7
1961	2.6	3.1	2.3	2.4
1962	3.1	4.2	2.7	1.9
1963	2.2	2.4	2.6	2.1
1964	2.3	3.1	3.0	2.2
1965	3.3	1.6	2.5	2.6
1966	5.9	4.4	3.6	4.2
1967	7.3	6.3	5.0	4.9
1968	5.5	7.0	5.9	5.7
1969	7.3	6.0	5.2	7.6
Average 1960–69	4.1	4.2	3.1	3.7

[1] As measured by Consumer Price Index of physician fees.

Physicians' fees had been increasing by an average of 2.6 percent per year during 1960–65 or at a rate slightly lower than that for all earnings (3.1 percent). During 1966–69, however, physicians' fees increased at a rate of 6.5 percent per year, somewhat higher than the average rate of increase for all earnings (5.9 percent). Over the last decade, however, physicians' fees increased 4.1 percent per year, and the average earnings in employment covered by the social security program increased 4.2 percent per year. Thus, it appears reasonable to assume that physicians' fees will continue to increase at the annual rate projected for the average earnings of persons covered by social security.

The average fees charged by physicians are assumed to increase by 6 percent in calendar years 1970 and 1971—in line with the anticipated increases of earnings in employment covered by the social security program. However, the program is assumed to recognize increases of 4 percent in calander year 1970 and of 6 percent in calendar year 1971.

(b) Rate of increase in costs of covered nonphysician services

The cost of outpatient hospital and clinic services and of home health agency services has been increasing in excess of 10 percent per year, with the result that these services are accounting for an increasing proportion of the cost of the program. It is assumed that these costs will increase at a rate of 10 percent per year.

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

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

During 1969, 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).

Premiums collected in cash for years beyond 1969 are assumed to equal those accrued. Government matching contributions transferred are expected to be equal to those accrued.

Administrative expenses for fiscal years 1970 and 1971, on a cash basis, were obtained from the Budget Document of the United States for fiscal year 1971. The liability outstanding at the end of each period for the administrative expenses for processing benefit payments incurred but unpaid was assumed to be 11.5 percent of such benefit payments, which proportion is based on the budget figures.

An interest rate of 6 percent was used in developing the progress of the trust fund. As of December 31, 1969, the average yield of the total investments of the trust fund was 6.59 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, 1969, 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 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 fund and shall bear interest at a rate equal to the average market yield (computed by the managing trustee on the basis of market quotations as of the end of the calendar month next 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 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The managing trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he 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 deductions shall be made in such manner and at such times as the Secretary shall by regulation 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.—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 sur-

vivors 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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