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1971 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 1971 ANNUAL REPORT OF THE BOARD (SIXTH REPORT, PURSUANT TO THE PROVISIONS OF SECTION 1841(b) OF THE SOCIAL SECURITY ACT, AS AMENDED

APRIL 19, 1971.—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 15, 1971.

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

SIR: We have the honor to transmit to you the 1971 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the sixth such report), in compliance with the provisions of section 201(c) of the Social Security Act, as amended.

Respectfully,

JOHN B. CONNALLY,
Secretary of the Treasury,
and Managing Trustee of the Trust Funds.
JAMES D. HODGSON,
Secretary of Labor.
ELLIOT L. RICHARDSON,
Secretary of Health, Education, and Welfare.
ROBERT M. BALL,
Commissioner of Social Security
and Secretary, Board of Trustees.

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1971 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 supplementary medical insurance program experienced a severe weakening in its financial position during fiscal year 1970. The balance in the trust fund dropped from $378 million at the beginning of fiscal year 1970 to $57 million at the end of fiscal year 1970. This drop occurred in spite of relatively favorable experience as to the level of services performed and hence in claims paid during this period. The estimate of claims incurred but not yet paid and administrative expenses related thereto decreased somewhat from $732 million at the beginning of fiscal year 1974 to $691 million at its end. Therefore, on an incurred basis the deficit for fiscal year 1970 is estimated as $280 million, resulting in an accumulated deficit, from the inception of the program through June 30, 1970, of $634 million. The accrued income of the program for fiscal year 1970 was $1,875 million, the incurred benefit payments and administrative expenses were $2,155 million.

The liabilities as of June 30, 1970, estimated to be $691 million, are for medical services already performed but for which no reimbursement has been made. They account for the difference between the $57 million positive cash position as of fiscal year end, and the $634 million deficit position on an incurred basis. Should the program be replaced by another social insurance program, any excess of this liability over the amount in the fund would have to be paid from special additional financing; otherwise these liabilities would fall back upon the insured beneficiaries.

The ability of the program to improve its financial position is limited. Enrollment is voluntary and Government matching is legally limited. Due to the substantial variation in medical costs throughout the country, many enrollees receive only the actuarial value of their benefits—despite the Government matching contribution. The premium rate can not be raised much above its actuarial value, since some

of the lower cost enrollees would find it to their advantage to drop out, raising the average cost of the remainder, and thus the premium rate required.

The deficit position of the supplementary medical insurance program results from a series of inadequate premium rates from the beginning of the program. To some extent, these premium rates were inadequate due to underestimates by the actuaries in predicting the increase in medical costs that would follow the beginning of the program, the level of administrative cost that would be required to enforce the provisions of the law relating to a reasonable fee screen, and the general inflation that has occurred in recent years—that has consistently exceeded virtually all economic projections. Further losses were incurred as a result of congressional action in maintaining the $3 premium rate during January through March 1968 and as a result of the action of the Secretary in December 1968 which maintained the $4 premium rate for fiscal year 1970.

During the fiscal year 1970, in December 1969, the standard premium rate for fiscal year 1971 was promulgated at $5.30 per month. As a result, the financial position of the program should improve during fiscal year 1971. Over the last 6 months of calendar year 1970 (the first 6 months of fiscal year 1971), the cash position improved by $131 million, bringing the trust fund balance to $188 million on December 31, 1970. The incurred position improved by approximately the same amount, reducing the estimated actuarial deficit as of December 31, 1970, to $515 million.

In December 1970, the standard premium rate for fiscal year 1972 was promulgated at $5.60 per month. Appendix I gives a statement of the actuarial assumptions and bases employed by the Secretary of Health, Education, and Welfare in determining this premium rate.

No amendments to the Social Security Act affecting this program were made in fiscal year 1970 or in the succeeding 6-month period. The Advisory Council on Social Security, appointed by the Secretary of Health, Education, and Welfare in May 1969, submitted its reports to the Secretary on March 31, 1971, who thereupon transmitted the reports to the Board of Trustees. The Board has not yet had an opportunity to study the reports thoroughly, and therefore, defers comments until the Board submits its next annual report.

Summary of the Operations of the Trust Fund, Fiscal Year 1970

A statement of the income and disbursements of the Federal supplementary medical insurance trust fund during fiscal year 1970 and of the assets of the fund at the beginning and end of the fiscal year is presented in table 1.

TABLE 1.—STATEMENT OF OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1970

Total assets of the trust fund, June 30, 1969	$377,774,133.74
Receipts, fiscal year 1970:	
Premiums from participants:	
Deducted from monthly benefits [1]	763,515,823.79
Deposited by States	97,208,601.66
Paid to Social Security Administration [2]	75,275,522.48
Total premiums	935,999,947.93
Transfers from general fund of the Treasury:	

See footnote at end of table.

Government contributions:	
Matching of participants' premiums received in fiscal year 1970	918,870,000.00
Delayed matching of participants' premiums received in fiscal year 1969	7,822,000.00
Total matching contributions	926,692,000.00
Interest on delayed transfers of Government matching contributions	1,459,000.00
Total transfers from general fund of the Treasury	928,151,000.00
Interest:	
Interest on investments	16,141,780.33
Less interest on amount of transfer to hospital insurance trust fund for reimbursement of benefits paid initially therefrom [3]	4,511,000.00
Less interest on amounts of interfund transfers for reimbursement of administrative expenses and construction costs	94,707.00
Net interest	11,536,073.33
Total receipts	1,875,687,021.26
Disbursements, fiscal year 1970:	
Benefit payments:	
Paid directly from the trust fund	1,816,587,386.33
Transferred to hospital insurance trust fund for reimbursement of benefits paid initially therefrom [3]	162,700,000.00
Total benefit payments	1,979,287,386.33
Administrative expenses:	
Department of Health, Education, and Welfare [4]	219,325,525.00
Treasury Department	26,216.07
Civil Service Commission	22,098.00
Construction of facilities for Social Security Administration	683,860.89
Reimbursement to old-age and survivors insurance trust fund for:	
Administrative expenses [5]	765,000.00
Construction costs for fiscal year 1969	938,000.00
Gross administrative expenses	221,760,699.96
Less receipts from sale of surplus supplies, materials, etc	15,672.71
Less reimbursements from disability insurance and hospital insurance trust funds due to adjustment in allocation of administrative expenses for fiscal year 1969	4,751,782.00
Net administrative expenses	216,993,245.25
Total disbursements	2,196,280,631.58
Net addition to the trust fund	−320,593,610.32
Total assets of the trust fund, June 30, 1970	57,180,523.42

[1] Transferred from the old-age and survivors insurance and disability insurance trust funds, the railroad retiremen account, and the Civil Service retirement and disability fund.
[2] By certain persons not receiving monthly benefits.
[3] For explanation, see text.
[4] Includes administrative expenses of the carriers and intermediaries.
[5] Amount represents reimbursement for a payment made initially from the old-age and survivors insurance trust fund in fiscal year 1970 for expenses of the Public Health Service.

The total assets of the trust fund amounted to $378 million on June 30, 1969. By the end of fiscal year 1970, the assets amounted to $57 million, a decrease of $321 million.

Total receipts of the fund amounted to $1,876 million. Of this total, $936 million represented premium payments by (or on behalf of) the participants, an increase of 4 percent over premium payments by participants in the preceding fiscal year.

Matching contributions received from the general fund of the Treasury, plus interest on delayed transfers, amounted to $928 million. This amount consisted of $919 million in contributions matching participants' premiums received in fiscal year 1970, $8 million in contributions matching participants' premiums received in fiscal year 1969, and about $1.5 million in interest on delayed transfers of matching contributions.

The remaining $12 million of receipts consisted of interest on the investments of the trust fund less 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 1970 totaled $2,196 million. Of this total, $1,817 million represented benefits that were paid directly from the trust fund and $163 million was transferred to the hospital insurance trust fund with respect to certain costs for radiology and pathology services that were paid by that trust fund but that are liabilities of the supplementary medical insurance trust fund. (Interest of this latter amount was also transferred to the hospital insurance trust fund.) Total benefit payments from the trust fund in fiscal year 1970, therefore, amounted to $1,979 million. The remaining $217 million of disbursements 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 1970 with the estimates presented in the 1970 annual report of the board of trustees. The estimated amounts of participants' premiums, Government matching contributions, and benefit payments were quite close to the actual experience. Estimated assets at the end of the fiscal year were $9 million higher than the actual assets.

TABLE 2.—COMPARISON OF ACTUAL AND ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, FISCAL YEAR 1970

[Amounts in millions of dollars]

Item	Actual amount	Estimated amount published in 1970 report	Estimate as percentage of actual
Premiums from participants	$936	$922	99
Government matching contributions	928	928	100
Benefit payments	1,979	1,949	98
Assets, end of year	57	66	

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

The assets of this fund at the end of fiscal year 1970, amounting to $57 million, consisted of $13 million in the form of obligations of the U.S. Government and $44 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 1969 and 1970.

TABLE 3.—ASSETS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, BY TYPE, AT END OF FISCAL YEARS 1969 AND 1970

	June 30, 1969		June 30, 1970	
	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	$134,238,000	$134,238,000.00		
5⅝-percent, 1975	6,527,000	6,527,000.00		
6½-percent, 1976	217,206,000	217,206,000.00	$10,562,000	$10,562,000.00
7⅝-percent, 1977			2,855,000	2,855,000.00
Total investments in public-debt obligations	357,971,000	357,971,000.00	13,417,000	13,417,000.00
Undisbursed balances		19,803,133.74		43,763,523.42
Total assets		377,774,133.74		57,180,523.42

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

New securities at a total par value of $1,880 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 $2,225 million. A summary of transactions for the fiscal year, by type of security, is presented in table 4.

TABLE 4.—STATEMENT OF TRANSACTIONS IN PUBLIC-DEBT SECURITIES FOR THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING THE FISCAL YEAR 1970

[All amounts represent par values]

	Acquisitions	Dispositions
Obligations sold only to this fund (special issues):		
Certificates of indebtedness:		
6⅝-percent, 1970	$306,081,000	$306,081,000
6¾-percent, 1970	153,098,000	153,098,000
7-percent, 1970	463,353,000	463,353,000
7¼-percent, 1970	153,744,000	153,744,000
7⅝-percent, 1970	469,053,000	469,053,000
7¾-percent, 1970	166,542,000	166,542,000
7⅞-percent, 1970	165,613,000	165,613,000
Notes:		
4¾-percent, 1974		134,238,000
5⅝-percent, 1975		6,527,000
6½-percent, 1976		206,644,000
7⅝-percent, 1977	2,855,000	
Total transactions	1,880,339,000	2,224,893,000

Expected Operations and Status of the Trust Fund During the Period July 1, 1970, to June 30, 1973

The expected operation and status of the Trust Fund during the period July 1, 1970, to June 30, 1973 (fiscal years 1971–73) are summarized in table 5. Also in table 5, to serve as a base for comparison, is a summary of the actual operations of the program and the trust fund through June 30, 1970.

As can be seen by an examination of table 5, income for the program is projected to increase by approximately a third in fiscal year 1971 over fiscal 1970, due to the increase in the premium rate to $5.30 per month at the beginning of that fiscal year. A further increase is projected for fiscal 1972 over fiscal 1971, as a result of the new premium rate of $5.60 per month promulgated by the Secretary for that fiscal year. Since the premium rate for fiscal year 1973 will not be promulgated by the Secretary until December 31, 1971, income has been projected for fiscal year 1973 under the assumption that the $5.60 rate is continued for that period. This assumption is not realistic since a continuation of the $5.60 rate would be inconsistent with the projected accrued expenditures for fiscal year 1973 shown in this report, and the Secretary is required by law to set the rate at a level that would produce accrued revenue in excess of accrued expenditures. Such a rate would produce at least a small surplus on a cash basis, increasing the trust fund by such an amount during fiscal year 1973.

TABLE 5.—ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS), FISCAL YEARS 1971-73, AND ACTUAL DATA FOR 1967-70

[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 [2]
Actual experience:						
1967	$647	$623	$664	[3] $134	$15	$486
1968	699	634	1,390	142	20	307
1969	903	984	1,645	195	23	378
1970	936	928	1,979	217	11	57
Estimate of future experience:						
1971	1,246	1,248	2,070	244	17	254
1972 [4]	1,339	1,339	2,300	273	33	392
1973	1,358	1,358	2,631	302	33	208

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

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

[4] Experience that would result if the standard premium rate was continued at $5.60 per month after June 1972.

Benefit expenditures for fiscal year 1971 are projected to increase by 4.6 percent over fiscal 1970, reaching $2,070 million. This increase is relatively small compared both to those in prior years and those projected for future years, due primarily to the inclusion in 1970 of a large transfer from the supplementary medical insurance trust fund to the hospital insurance trust fund to reimburse the latter for expenditures made on behalf of the former for inpatient radiology and pathology benefits covering fiscal year 1969 as well as 1970. Benefits are projected to increase to $2,300 million in fiscal 1972 and $2,631 million in 1973. Administrative expenses are also projected to increase, due primarily to personnel costs and to additional processing as a result of increased utilization of services under the program. Interest earned by the trust fund, after reaching a low of $11 million in fiscal year 1970 is projected to increase to $17 million in fiscal year 1971 and $33 million in fiscal year 1972 and fiscal year 1973, reflecting a similar increase in the trust fund.

The balance in the trust fund is projected to increase sharply from $57 million at the beginning of fiscal year 1971, reaching $254 million by the end of fiscal year 1971 and $392 million at the end of fiscal year 1972. Under the unrealistic assumption that the premium rate will not be raised for fiscal year 1973, the trust fund would decline sharply during fiscal 1973, reaching $248 million by the end of that fiscal year. The actual experience during fiscal 1973 will depend on the premium rate promulgated by the Secretary.

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; i.e., the solvency of the trust fund should be measured in terms of ability to pay the cost of the services performed, on the basis of which benefits must be paid.[1]

[1] The dependence of the actuarial status of the program on the accured experience is recognized in sec. 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." [Emphasis 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).

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 premiums voluntarily paid in advance and the Government matching contributions for such premiums, since they were paid for services to be performed in a subsequent year, are a liability of the program at the end of the year specified. (The effect of this entry on the actuarial deficit is the same as if such premiums had not been paid until due.) Offsetting these liabilities are premiums due and uncollected (negligible), Government matching contributions due but not yet transferred to the trust fund by the Treasury, and the cash on hand in the trust fund—which were available at the end of each year to pay the liabilities then outstanding. The net of the liabilities less the assets is the deficit accrued, and represents the additional funds that would have to be appropriated or otherwise financed to pay for services already performed if the program were superseded by another social insurance program.

TABLE 6.—SUMMARY OF PROJECTED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, AT END OF CALENDAR YEARS 1966–70[1]

[In millions of dollars]

	As of Dec. 31—				
	1966	1967	1968	1969	1970
A. Assets:					
Premiums due and uncollected	0	0	0	0	0
Government matching contributions due and unpaid	322	29	2	10	14
Balance in trust fund (cash on hand)	122	412	421	199	188
Total assets	444	441	423	209	202
B. Liabilities outstanding:					
Premiums collected in advance	3	1	3	3	11
Government matching contributions with respect to premiums paid in advance	3	1	3	3	11
Benefits incurred but unpaid	355	497	603	586	605
Administrative cost for processing benefits incurred but unpaid	38	58	65	90	90
Total liabilities	399	557	674	682	717
C. Net surplus (or deficit)	45	−116	−251	−473	−515

[1] All figures in this exhibit reflect an accounting change which, under the new procedure, charges the amounts payable in any year due to the carryover deductible provision to the year in which it is payable. For a discussion of this change, see app. IV. The net surplus indicated is increased by this change by approximately $1.30 per capita in all years except 1966, when the increase was $2.70 per capita.

The actuarial status of the program and the financial status of the trust fund at any time can thus 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 6). The accrued 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 increases in each asset or liability item during the period to the corresponding item on a "cash" basis for that 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. Otherwise, since the enrollee group is not the same from year to year, there would be some persons paying for other persons' costs.

(*2*) *Necessary limitations on accuracy of estimates of past and future experience* [1]

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 additional economic and social factors involved. There is special difficulty in projecting the rate at which physician fee increases will be recognized by the program as well as in projecting the increase in utilization of services. 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, and any errors in the former are necessarily incorporated into the latter. The estimates of the 1971–72 experience could vary as much as 15 percent from the actual experience, and estimates for subsequent years could vary further from the actual experience.[1]

Final conclusions as to the accrued experience of the program for 1969 and 1970 will not be possible until the deadlines for filing claims based on services performed then have passed, all claims have been adjudicated and documented by carriers and intermediaries, and payment records and bills covering all benefit payments have been prepared and forwarded to the Social Security Administration.

(*3*) *"Expected" estimates*

The financing of this program is essentially different from that for the cash benefit and hospital insurance programs in that the premium is 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. Due to the lags mentioned in obtaining data from the program experience, however, the forecasting period from a firm benchmark of data or experience to the year for which a premium is set is really 2½ to 3½ years. In addition, the cost of some items must be estimated entirely on indirect information, since no relevant data is available from the program for any period. The financing of the system is set at the level thought most likely to be actually required (i.e., a "maximum likelihood" estimate).

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

[1] See the Actuarial Appendix (app. IV) for a more detailed discussion of these problems.

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. If premiums cover benefit costs fully, interest earnings would provide a margin for reserves.

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. The premium rate, however, is determined for fiscal-year periods (except for the initial period July 1966–March 1968 and the period from April 1968 to June 1969). The prorated average monthly rate of these costs for the periods for which a particular premium rate was forecast, allocating interest on a cash basis, are as follows:

Period	Applicable premium rate	Benefit payments [1]	Administrative costs [1]	Total disbursements [1]	Total income [2]
July 1966 to December 1967 [3]	$3.00	$5.68	$.76	$6.44	$6.10
January 1968 to March 1968	3.00	7.36	.86	8.22	6.11
April 1968 to June 1969	4.00	7.65	.91	8.56	8.11
July 1969 to June 1970	4.00	8.34	1.00	9.34	8.05

[1] Assuming disbursements paid due to the carryover deductible are accrued in the year payable.
[2] Includes interest credited during period, i.e. on a cash basis.
[3] The premium rate forecast was not implemented on the date originally scheduled by law, due to action by the Congress to delay the change until legislation then under consideration was enacted.

The estimates of the accrued liability in each period reflect a basic accounting change. Previously, the additional amounts paid in any year due to the carryover deductible provision were charged to the previous year. This procedure was originally adopted so that the accrued costs shown for 1966 and 1967 would reflect more accurately the actual trend in levels of the costs of services performed in 1966–67. The application of the full deductible to the last 6 months of 1966 resulted in artificially low accrued claims that year; and, through the carryover deductible, artificially higher accrued costs in 1967. Under present normal conditions, the carryover from the prior year is approximately equal to the carryover from the current year to the next so that this procedure would not alter the accrued costs by a significant amount.

There does not appear to be any convincing reason to follow this chargeback procedure any longer, and the natural procedure of charging claims to the date at which they are first actually payable has been put into effect. The net effect of this change is to decrease the net accrued deficit for the entire experience through the end of any calendar year (i.e., table 6, line C, and table 7, last column) by approximately $1.30 per capita in all years after 1966. Also, the net deficit in the premium rate for 1966–67 is reduced by $0.11 per month, and that for all other periods is unaffected.

(*4*) *Analysis of past experience*

The premium rate for the period from July 1966 through December 1967 was about 7 percent lower than the combined benefits and admin-

istrative expenses accrued during this period. The somewhat 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 midpoint 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 9½ percent in 1967 and 12 percent in 1968, as against the initial estimate of 8 percent. A special action of Congress continued the $3 rate until the 1967 amendments went into effect on April 1, 1968. Consequently, a much larger deficit occurred in this period than would have occurred if the current schedule with which premium rates are promulgated had been in effect.

A premium rate of $4 was promulgated for the 15-month period April 1968 through June 1969. This rate proved to be inadequate by approximately 5.5 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 $0.30 per capita per month to disbursements.

(*b*) Physician fees, utilization of physician services, and the cost of utilization of institutional services covered by the program continued to rise more than estimated. The rise in physican fees was due partially to continuing general 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 somewhat faster than benefit costs, and to exceed those estimated. Excluding initial startup expenses, administrative expenses were approximately 9½ percent of benefits paid in 1966–67; the current ratio is approximately 12 percent. The additional cost primarily reflects the additional cost of improved operation of the reasonable charge screens and compilation of statistical information.

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. The estimate of the fiscal year 1969 base which was used to estimate the premium rate for fiscal year 1970 was too low, however, in part because of the influenza epidemic that occurred in the middle of fiscal year 1969, the implications of which were not understood in November 1968 when this estimate was made.

The per capita cost for the period April 1, 1968, through June 30, 1969, is now estimated to have been $8.56. Similarly, the per capita cost for fiscal year 1970 is now estimated to have been about $9.33 per month compared to the recommended premium rate, matching contribution, and interest earning of $8.85.

The continuance of a $4 premium rate was accompanied by a variety of steps, taken by the Social Security Administration designed to lower the cost of the program. Increases in allowed charges were restricted, starting with January 1969, as follows:

(*a*) The customary charge for any service could be increased only in individually identified situations where equity clearly required such an adjustment. For example, generally, when physi-

cians raised their fees only those who had not raised their fees for 3 years would be considered administratively to have raised their customary charges which were reimbursable under the program.

(*b*) Until July 1970, the prevailing charges recognized by carriers participating in administration could be increased only with the approval of the Social Security Administration. No increases in prevailing charges were approved. New standards of carrier performance were promulgated, including detailed specifications for applying the customary and prevailing charge screens. Under these new standards, the definition of prevailing charges was changed by (i) promulgating uniform standards as to the definition of prevailing fees at a level generally lower than that set by carriers, so that reimbursements would cover in full a lower proportion of charges, 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 altered so as to preclude upward adjustments unless there is adequate evidence that the new higher fees have been in effect for a substantial period of time; that is, increases in fees would be recognized only after the delay required to accumulate direct evidence in statistical data from actual charges by a physician, and to abulate and analyze such data.

Also, physician charges for purchased laboratory services were set at the reasonable 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 lessened the increase in cost that might otherwise have been expected. Estimates of the effect of these changes in policy adopted with respect to recognition of increases in physician fees are shown in table A in appendix IV, under the heading "Effect of Screens." During fiscal year 1970, 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. Also, during that fiscal year, there was an increase in the rate of denial of claims for services that were judged by the carriers not to be medically necessary.

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 monetary effect of reductions of billed charges to the level allowable under the program is estimated, on the basis of data submitted by the carriers, to have been at a rate of about $155 million a year (these effects 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 6.5 percent of claims submitted were being denied as noncovered.

A premium rate of $5.30 was promulgated for fiscal 1971. This premium rate contained a somewhat larger margin for contingencies than usual due to the poor financial condition of the program at that time. As a result, the financial position of the program has improved and is expected to improve further through June 1971. The trust fund had reached such a low level in June 1970 that adverse experience, such as a flu epidemic like that which occurred in 1968–69, might have resulted, unless additional funds were advanced by the Treasury, in a situation in which the program was unable to pay for the services already provided to enrollees and for which premiums had been paid. As a result of the higher premium rate for fiscal year 1971, however, the trust fund increased rapidly, reaching $188 million by the end of 1970, and is expected to increase to $254 million by June 1971.

The measures taken to reduce the cost of the program continue to have a significant impact on benefit payments for physicians' services. A survey conducted in October 1970 indicated that 40 percent of the bill of the physician services covered by the program were being reduced with the aggregate reduction being 10.5 percent of physician benefits. It is estimated that total reductions during 1970 were 10 percent of the amounts that would have been paid had no reductions been made; this represented a 4-percent increase over the reductions made during 1969.

Two fundamental facts about the reductions made in the fees recognized by the program should be noted.

In general physicians will accept assignments if (i) the reimbursements received on previously assigned bills are reasonably close to the amount the doctor expects to receive, or if (ii) the doctor expects to encounter difficulty in collections or to produce a difficulty to the patient he does not wish to occur.

Thus if there is too large a discrepancy between fees being charged by physicians and those recognized by the program, assignments will tend to be accepted only for low income patients. The effect will be to provide less comprehensive insurance than originally intended for those able to pay, and force those unable to pay for their services to find physicians who are either willing to perform services for less than the going rate or are willing to donate some portion of the value of the services provided. On both accounts the intent of the program would not be accomplished. For this reason, the level of prevailing fees can-

[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 changes being reduced.

not fall far behind the going rate without causing difficulties to beneficiaries.

(2) The reductions in fees recognized by the program result from—

(i) Basing customary and prevailing fees on actual experience in a past period, i.e. sufficiently after the end of a period on which the experience is to be based to allow for tabulations, analysis, and reprograming.

The effect of the policy followed is that on the average prevailing fees for any period are based on the fees charged by physicians one and one-half years before. To the extent that fees are rising rapidly, the fee level recognized by the program increase less rapidly, however, the increase in recognized fees will be higher than that which has actually taken place. Something of this nature is expected to take place over the next two years; for example, in 1971–72 the level of fees recognized by the program will increase more rapidly than physicians' fees are expected to increase in those years, due to the fees allowed to those physicians whose fees are being reduced catching up. There will still be a net reduction from the level of payments that would have been made had there been no fee screen.

(ii) The interpretation of what is a prevailing fee.

The definition currently used is that a prevailing fee is that which is charged most often by a physician who is substantially above the median for customary charges for that fee, i.e., the 75th percentile of customary fees.

Because many services are provided at the same fee level, general use of the 75th percentile of fees as a limit will result in payment in full for more than 75 percent of services, perhaps 80 percent. The lag between the date for which the data were compiled and that for which they are used reduces somewhat the percent payable in full, since, on the average, fees are rising about 6 percent a year. Over half (by amount) of all bills are paid on an assignment basis, however, so that a majority of services are reimbursed in full.

In all cases, the fee screens are based on a recent body of data. To the extent that physicians raise fees, the recognized fees must rise also. For example, if every physician exactly doubled his fee in some year, the recognized fees under the program would also double, but with a lag of several years. Thus the authority under the program only enables the administration to delay recognition of fee increases. There is no authority to postpone indefinitely recognition of fee increases or to eliminate or reduce them.

(5) Estimates of the past accrued experience

The estimates for the past accrued experience of the supplementary medical insurance program for calendar years 1966–70 appear in table 7.[1] As can be seen by examination of this table, the program netted an estimated surplus of $45 million on an accrual basis during the calendar year 1966, an abnormal period due to the application of the full $50 deductible in a 6-month period, partially offset by nonrecurring startup expenses. Due to the inadequacy of the $3 premium, however, the benefit payments and administrative expenses incurred exceeded accrued income during calendar year 1967 by an estimated $161 million,

[1]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 Dec. 31, 1969, and has now expired.

leaving an estimated deficit of $116 million on an accrual basis for the initial 1½-year period. The estimated accrued deficit increased during 1968 by $135 million to reach $251 million by December 31, 1968, increased by $222 million during 1969 to reach an estimated $473 million as of December 31, 1969, and increased by $42 million in 1970 to $515 million on December 31, 1970.

TABLE 7.—ESTIMATED INCOME AND DISBURSEMENTS PAYABLE (ACCRUAL BASIS) UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM, CALENDAR YEARS 1966–70 [1]

[In millions]

Calendar year	Premiums from participants	Government contributions	Benefit payments	Administrative expenses	Interest on fund	Net of operations in year	Accumulated surplus at end of year
1966	$319	$319	$483	[2] $112	$2	$45	$45
1967	642	642	1,338	130	23	−161	−116
1968	830	830	1,625	190	20	−135	−251
1969	915	915	1,848	222	18	−222	−473
1970	1,088	1,088	1,993	237	12	−42	−515
Total	3,794	3,794	7,287	891	75	−515	−515

[1] All figures in this exhibit reflect an accounting change which under the new procedure charges the amounts payable in any year due to the carry-over deductible provision to the year in which it is payable. For a discussion of this change, see appendix IV. The net surplus indicated is increased by this change by approximately $1.30 per capita in all years except 1966, when the increase was $2.70 per capita.

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

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 reduced the net accrued deficit that would otherwise have been accrued for that period.

(6) Past experience on a cash basis

The income and disbursements of the trust fund on a "cash" basis for calendar years 1966–70 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 $116 million on that date, due to the large liabilities outstanding on account of incurred but unpaid claims (as shown in table 6). 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 a rate known to be considered inadequate by the actuaries, disbursements exceeded income by a large margin, resulting in a reduction of 50 percent in the trust fund, from $421 million as of December 31, 1968, to $199 million as of December 31, 1969, and to $57 million on June 30, 1970. 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 1966–70

[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	1,196	110	23	412
1968	832	859	1,519	183	20	421
1969	915	907	1,865	197	18	199
1970	1,096	1,092	1,974	237	12	188
Total, 1966–70	3,805	3,791	6,682	801	75	188

[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 incurred under the program. Due to the 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 has proved adequate through fiscal year 1970, albeit by a narrow margin.

The premium rate of $5.30 that is set for the period July 1970 through June 1971 is estimated to be more than adequate to meet the benefit costs and applicable administrative expenses during that period. In fact, indications are that experience in this period has been more favorable than expected, due in part to favorable health experience and in part to measures placing tighter limits on program payments. Accordingly, the estimated net deficit will be reduced during the period. The rate promulgated for fiscal year 1972 is adequate, according to the expected estimates as to expenditures anticipated, and is expected to reduce the deficit further.

Conclusion

The future course of the supplementary medical insurance program over the period immediately ahead will depend largely on the adequacy of the $5.30 premium rate in effect for the remainder of the current fiscal year, and the $5.60 premium rate promulgated for fiscal 1972. Current indications are that these rates will prove to be adequate, and that the actuarial status of the program will improve.

The projected improvement is not a certainty. Any of several possible unfavorable developments or later discovered projection difficulties could result in the inadequacy of these premium rates, as has in fact happened in the past. On the other hand, favorable developments could act to reduce the accumulated deficit at a rate faster than now seems likely.