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THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

COMMUNICATION

FROM

THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

TRANSMITTING

THE 1992 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, PURSUANT TO 42 U.S.C. 1395t(b)(2)

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1992 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

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THE BOARD OF TRUSTEES, FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Transmitting

THE 1992 ANNUAL REPORT OF THE BOARD, PURSUANT TO SECTION 1841(b) OF THE SOCIAL SECURITY ACT AS AMENDED

LETTER OF TRANSMITTAL

BOARD OF TRUSTEES OF THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND
Washington, D.C., April 2, 1992

HONORABLE THOMAS S. FOLEY
Speaker of the House of Representatives
Washington, D.C.

HONORABLE DAN QUAYLE
President of the Senate
Washington, D.C.

GENTLEMEN:

We have the honor of transmitting to you the 1992 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (the 27th such report), in compliance with the provisions of section 1841(b) of the Social Security Act.

Respectfully,

Nicholas F. Brady

NICHOLAS F. BRADY,
Secretary of the Treasury, and Managing Trustee of the Trust Fund

Lynn Martin

LYNN MARTIN,
Secretary of Labor, and Trustee

Louis W. Sullivan, M.D.

LOUIS W. SULLIVAN, M.D.,
Secretary of Health and Human Services, and Trustee

Stanford G. Ross

STANFORD G. ROSS,
Public Trustee

David M. Walker

DAVID M. WALKER,
Public Trustee

J. Michael Hudson

J. MICHAEL HUDSON,
Acting Administrator of the Health Care Financing Administration, and Secretary, Board of Trustees

Click on a Topic Below

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A. SUMMARY

1. Operations of the Supplementary Medical Insurance Program

The supplementary medical insurance (SMI) program pays for physician services, outpatient hospital services, and other medical expenses for both aged 65 and over and for the long-term disabled. In calendar year (CY) 1991, 33.1 million persons were covered under SMI. General revenue contributions during 1991 amounted to $37.6 billion, accounting for 73.4 percent of all SMI income. About 23.3 percent of all income resulted from the premiums paid by the enrollees. Interest payments to the SMI fund accounted for the remaining 3.3 percent. Of the $48.8 billion in SMI disbursements, $47.2 billion was for benefit payments while the remaining was spent for administrative expenses. SMI administrative expenses were 3.2 percent of total disbursements.

The SMI program essentially is yearly renewable term insurance financed from premium income paid by the enrollees and from income contributed from general revenue by the federal government. This means that the SMI program is financed on an accrual basis with a contingency margin, and, therefore, the SMI trust fund should always be somewhat greater than the claims that have been incurred by enrollees but not yet paid by the program. The trust fund holds all of the income not currently needed to pay benefits and related expenses. The assets of the fund may not be used for any other purpose; however, they may be invested in certain interest-bearing obligations of the federal government.

Financing for the SMI program is established annually on the basis of standard monthly premium rates (paid by or on behalf of all participants) and monthly actuarial rates determined separately for aged and disabled beneficiaries on which general revenue contributions are based. Prior to the 6-month transition period (July 1, 1983 through December 31, 1983), these rates were applicable in the 12-month periods ending June 30. Beginning January 1, 1984, the annual basis was changed to calendar years. Monthly actuarial rates are equal to one-half the monthly amounts necessary to finance the SMI program. These rates determine the amount to be contributed from general revenues on behalf of each enrollee. Pursuant to the formula in the law, the Government contribution effectively makes up the difference between twice the monthly actuarial rates and the standard monthly premium rate.

Overview

The financial status of the program depends on both the total net assets and liabilities. It is, therefore, necessary to examine the incurred experience of the program, since it is this experience that is used to determine the actuarial rates discussed above and which forms the basis of the concept of actuarial soundness as it relates to the SMI program.

The concept of actuarial soundness, as it applies to the SMI program, is closely related to the concept as it applies to many private group insurance plans. The SMI program is essentially yearly renewable term insurance financed from premium income paid by the enrollees, from income contributed from general revenue, and from interest payments on the trust fund assets.

In testing the actuarial soundness of the SMI program, it is appropriate to look only to the periods for which the enrollee premium rates and level of general revenue financing have been established. The primary tests of actuarial soundness, then, are that: (1) assets and income for years for which financing has been established be sufficient to meet the projected benefits and associated administrative expenses incurred for that period and (2) assets be sufficient to cover projected liabilities that will have been incurred by the end of that time but will not have been paid yet. Even if these tests of actuarial soundness are not met, the program can continue to operate if the trust fund remains at a level adequate to permit the payment of claims as presented. However, to protect against the possibility that cost increases under the program will be higher than assumed, assets should be sufficient to cover the impact of a reasonable degree of variation between actual and projected costs.

The primary tests for actuarial soundness and trust fund adequacy can be viewed by direct examination of absolute dollar levels. In providing an appropriate contingency or margin for variation, however, there must also be some relative measure. The relative measure or ratio used for this purpose is the ratio of the assets less liabilities to the following year's incurred expenditures.

2. Conclusion of the Board of Trustees

The financing established through December 1992 is sufficient to cover projected benefits and administrative costs incurred through that time period. This financing is sufficient to maintain a level of trust fund assets which is adequate to cover the impact of a reasonable degree of variation between actual costs and projected costs. On this basis, the SMI program can thus be said to be actuarially sound.

Although the SMI program is currently actuarially sound, the Trustees note with concern the past and projected rapid growth in the cost of the program. Growth rates have been so rapid that outlays of the program have increased 80 percent in aggregate and 66 percent per enrollee in the last 5 years. For the same time period, the program grew 36 percent faster than the economy despite recent efforts to control the cost of the program. As a result, the program is projected to increase from 0.88 percent of the Gross Domestic Product (GDP) in CY 1991 to 4.75 percent of GDP in CY 2065. This rapid growth is attributable primarily to the inability to control the rapid growth in (1) the volume of services billed per beneficiary and (2) the reported case mix intensity (the reporting of services which receive higher reimbursement). Given the past and projected cost of the program, the Trustees urge the Congress to take additional actions designed to control SMI costs either through specific program legislation or as a part of enacting more comprehensive health care reform.

B. THE BOARD OF TRUSTEES

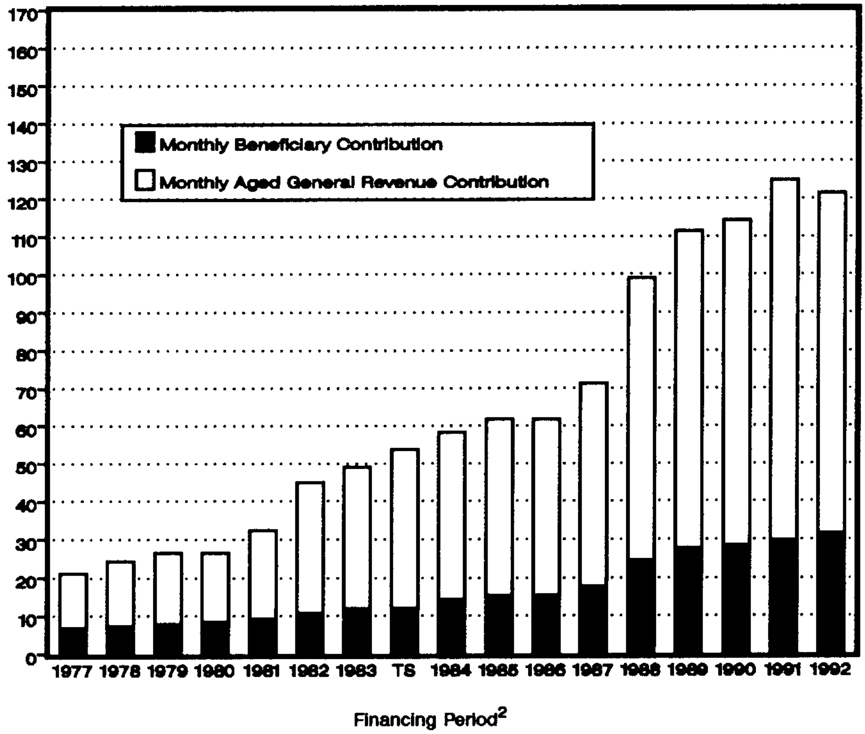
The Federal Supplementary Medical Insurance Trust Fund, established on July 30, 1965, is held by the Board of Trustees under the authority of section 1841(b) of the Social Security Act, as amended. The Board is composed of five members, three of whom serve in an ex officio capacity: the Secretary of the Board, the Secretary of Labor, and the Secretary of Health and Human Services. The President nominated and the Senate confirmed Stanford G. Ross and David M. Walker to be the other two members, who serve as representatives of the public. Mr. Ross and Mr. Walker are serving 4-year terms that began on October 2, 1990.

By law, the Secretary of the Treasury is designated as the Board Chairperson and the Managing Trustee, and the Administrator of the Health Care Financing Administration (HCFA) is designated as Secretary of the Trustees. The Board of Trustees reports to the Congress each year on the operation and status of the trust fund, in compliance with section 1841(b)(2) of the Social Security Act. This annual report, for 1992, is the 27th such report.

C. EXPECTED OPERATIONS AND STATUS OF THE TRUST FUND

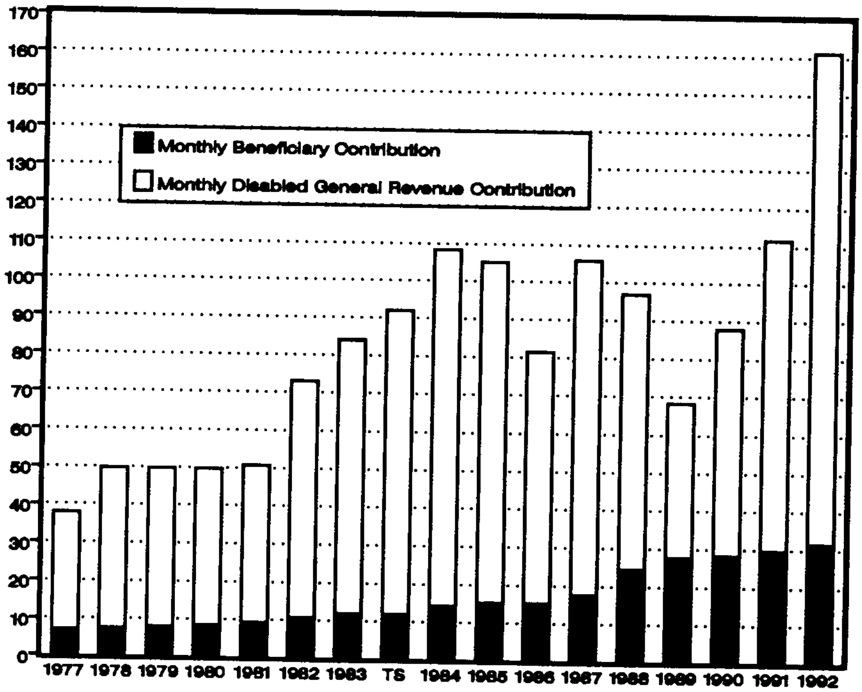
Financing for the SMI program is established annually on the basis of standard monthly premium rates (paid by or on behalf of the enrollees) and actuarial rates on which general revenue contributions are based. Beginning January 1, 1984, the annual basis has been the calendar year. For 1989, only, the financing was established also on the basis of the catastrophic coverage monthly premium rate. With the enactment of the Medicare Catastrophic Coverage Repeal Act of 1989 (Public Law 101-234), the financing for 1990 and beyond will no longer be established on the basis of catastrophic coverage premium rates. Figures 1 and 2 present these values for financing periods since 1977. These figures clearly indicate the extent to which general revenue financing is the major source of income for the program.

FIGURE 1
SUPPLEMENTARY MEDICAL INSURANCE AGED MONTHLY PER CAPITA INCOME[1]



[1]The amounts shown do not include the catastrophic coverage monthly premium rate for 1989.
[2]For periods 1983 and earlier, the financing period is July 1 through June 30. For the transitional semester(T.S.), the financing period is July 1, 1983 through December 31, 1983. For 1984 through 1992 the financing period is January 1 through December 31.

FIGURE 2
SUPPLEMENTARY MEDICAL INSURANCE DISABLED MONTHLY PER CAPITA INCOME[1]



[1]The amounts shown do no include the catastrophic coverage monthly premium rate for 1989.
[2]For periods 1983 and earlier, the financing period is July 1 through June 30. For the transitional semester(T.S.), the financing period is July 1, 1983 through December 31, 1983. For 1984 through 1992 the financing period is January 1 through December 31.

Although standard monthly premium rates have been set for periods through December 31, 1995 and actuarial rates have been set for periods through December 31, 1992, estimates in the report are presented for periods beyond those times. It has been assumed in this report that financing for those periods will be established in accordance with the provisions described in the section II.B. "Nature of the Trust Fund."

The estimates shown in Tables I.C.1, I.C.2, and I.C.3 are based on the economic assumptions labeled "alternative II." The economic and demographic assumptions underlying the alternative II estimates are described in detail in the 1992 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. The section II.D. "Actuarial Methodology and Principal Assumptions for Cost Estimates for the Supplementary Medical Insurance Program" presents an explanation of the effects of the alternative II assumptions on the estimates in this report.

The January 1, 1992 average update of the allowable fee for physician services is assumed to be 2.4 percent. Alternative II assumes the January 1, 1993 average update to be 1.1 percent. This average update is a weighted average of the updates of the allowed fees for various goods and services included in the "physician" category. Besides physician services, the "physician" category also includes some goods and services not considered to be physician such as laboratory tests performed in a physician's office, durable medical equipment (DME), ambulance services, and services performed in a free-standing ambulatory surgical center. The costs per enrollee for institutional and other services under the SMI program are projected to increase an average of 15.3 percent for CY 1992 and 15.6 percent for CY 1993. These increases represent price increases and increases due to other factors such as volume and intensity.

Table I.C.1 shows the estimated operations of the trust fund for alternative II on a fiscal-year basis through FY 1994. Table I.C.2 shows the corresponding development on a calendar-year basis. The level of the trust fund increased in FY 1991 and CY 1991 mainly due to the passage of Public Law 101-508 after the financing for CY 1991 had been established. Public Law 101-508 reduced expenditures beginning in CY 1991. For CY 1992, the actuarial rates were promulgated with specific margins to reduce aged assets and to increase disabled assets. Based on these actuarial rates and the above economic assumptions, the fund is estimated to decrease to a level of $13.6 billion by the end of CY 1992 and then decrease to $13.4 billion by the end of CY 1993.

TABLE I.C.1.—OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) DURING FISCAL YEARS 1967-1994

[In millions]

	Income				Disbursements			
Fiscal year[1]	Premium from enrollees	Government contributions[2]	Interest and other income[3]	Total income	Benefit payments	Administrative expenses	Total disbursements	Balance at end of year[4]
Historical Data:								
1967	$647	$623	$15	$1,285	$664	$135[5]	$799	$486
1968	698	634	21	1,353	1,390	142	1,532	307
1969	903	984	24	1,911	1,645	195	1,840	378
1970	936	928	12	1,876	1,979	217	2,196	57
1971	1,253	1,245	18	2,516	2,035	248	2,283	290
1972	1,340	1,365	29	2,734	2,255	289	2,544	481
1973	1,427	1,430	45	2,902	2,391	246	2,637	746
1974	1,704	2,029	76	3,809	2,874	409	3,283	1,272
1975	1,887	2,330	105	4,322	3,765	405	4,170	1,424
1976	1,951	2,939	104	4,994	4,672	528	5,200	1,219
T.Q.	539	878	4	1,421	1,269	132	1,401	1,239
1977	2,193	5,053	137	7,383	5,867	475	6,342	2,279
1978	2,431	6,386	228	9,045	6,852	504	7,356	3,968
1979	2,635	6,841	363	9,839	8,259	555	8,814	4,994
1980	2,928	6,932	415	10,275	10,144	593	10,737	4,532
1981	3,320	8,747	372	12,439	12,345	883	13,228	3,743
1982	3,831	13,323	473	17,627	14,806	754	15,560	5,810
1983	4,227	14,238	682	19,147	17,487	824	18,311	6,646
1984	4,907	16,811	807	22,525	19,473	899	20,372	8,799
1985	5,524	17,898	1,155	24,577	21,808	922	22,730	10,646
1986	5,699	18,076	1,228	25,003	25,169	1,049	26,218	9,432
1987	6,480	20,299	1,018	27,797	29,937	900	30,837	6,392
1988	8,756	25,418	828	35,002	33,682	1,265	34,947	6,447
1989	11,548[6]	30,712	1,022[6]	43,282[6]	36,867	1,450[6]	38,317[6]	11,412[6]
1990	11,494[6]	33,210	1,434[6]	46,138[6]	41,498	1,524[6]	43,022[6]	14,527[6]
1991	11,807	34,730	1,629	48,166	45,514	1,505	47,019	15,675
Estimates:								
1992	12,616	38,684	1,489	52,789	52,850	1,623	54,473	13,991
1993	14,523	45,964	916	61,403	59,958	1,694	61,652	13,742
1994	16,679	52,110	869	69,658	67,868	1,774	69,642	13,758

[1]For 1967 through 1976, fiscal years cover the interval from July 1 through June 30; the three-month interval from July 1, 1976, through September 30, 1976, is labeled "T.Q.", the transition quarter; FY 1977-94 cover the interval from October 1 through September 30.

[2]The payments shown as being from the general fund of the Treasury include certain interest-adjustment items.

[3]Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and other miscellaneous income.
[4]The financial status of the program depends on both the total net assets and the liabilities of the program (See Table I.D.2).
[5]Administrative expenses shown include those paid in FY 1966 and 1967.
[6]Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

TABLE I.C.2.—OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) DURING CALENDAR YEARS 1966-1994

[In millions]

	Income				Disbursements			
Calendar year	Premium from enrollees	Government contributions[1]	Interest and other income[2]	Total income	Benefit payments	Administrative expenses	Total disbursements	Balance at end of year[3]
Historical Data:								
1966	$322	$0	$2	$324	$128	$75	$203	$122
1967	640	933	24	1,597	1,197	110	1,307	412
1968	832	858	21	1,711	1,518	184	1,702	421
1969	914	907	18	1,839	1,865	196	2,061	199
1970	1,096	1,093	12	2,201	1,975	237	2,212	188
1971	1,302	1,313	24	2,639	2,117	260	2,377	450
1972	1,382	1,389	37	2,808	2,325	289	2,614	643
1973	1,550	1,705	57	3,312	2,526	318	2,844	1,111
1974	1,804	2,225	95	4,124	3,318	410	3,728	1,506
1975	1,918	2,648	107	4,673	4,273	462	4,735	1,444
1976	2,060	3,810	107	5,977	5,080	542	5,622	1,799
1977	2,247	5,386	172	7,805	6,038	467	6,505	3,099
1978	2,470	6,287	299	9,056	7,252	503	7,755	4,400
1979	2,719	6,645	404	9,768	8,708	557	9,265	4,902
1980	3,011	7,455	408	10,874	10,635	610	11,245	4,530
1981	3,722[4]	11,291[4]	361	15,374	13,113	915	14,028	5,877
1982	3,697[4]	12,284[4]	599	16,580	15,455	772	16,227	6,230
1983	4,236	14,861	727	19,824	18,106	878	18,984	7,070
1984	5,167	17,054	959	23,180	19,661	891	20,552	9,698
1985	5,613	18,250	1,243	25,106	22,947	933	23,880	10,924
1986	5,722	17,802	1,141	24,665	26,239	1,060	27,299	8,291
1987	7,409[5]	23,560[5]	875	31,844	30,820	920	31,740	8,394
1988	8,761[5]	26,203[5]	861	35,825	33,970	1,260	35,230	8,990
1989	12,263[6]	30,852	1,234[6]	44,349[6]	38,294	1,489[6]	39,783[6]	13,556[6]
1990	11,320	33,035	1,558	45,913	42,468	1,519	43,987	15,482
1991	11,934	37,602	1,688	51,224	47,229	1,541	48,770	17,935

TABLE I.C.2.—OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) DURING CALENDAR YEARS 1966-1994

[In millions]

	Income				Disbursements			
Calendar year	Premium from enrollees	Government contributions[1]	Interest and other income[2]	Total income	Benefit payments	Administrative expenses	Total disbursements	Balance at end of year[3]
Estimates:								
1992	12,864	37,889	1,129	51,882	54,603	1,640	56,243	13,574
1993	15,076	47,482	871	63,429	61,873	1,712	63,585	13,418
1994	17,213	53,652	869	71,734	70,033	1,794	71,827	13,325

[1]The payments shown as being from the general fund of the Treasury include certain interest adjustment items.
[2]Other income includes recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund and other miscellaneous income.
[3]The financial status of the program depends on both the total net assets and the liabilities of the program (See Table I.D.2).
[4]Section 708 of Title VII of the Social Security Act modified the provisions for the delivery of Social Security benefit checks when the regularly designated delivery day falls on a Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January, 1982 occurred on December 31, 1981. Consequently, the SMI premiums withheld from the checks ($264 million) and the general revenue contributions ($883 million) were added to the SMI trust fund on December 31, 1981. These amounts are excluded from the premium income and general revenue income for CY 1982.
[5]Delivery of benefit checks normally due January, 1988 occurred on December 31, 1987. Consequently, the SMI premiums withheld from the checks ($692 million) and the general revenue contributions ($2,178 million) were added to the SMI trust fund on December 31, 1987. These amounts are excluded from the premium income and general revenue income for CY 1988 (Refer to footnote 4).
[6]Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

Table I.C.3 shows the calendar-year average increase in aggregate and per capita benefit payments on a cash basis under alternative II through CY 1994. To reflect the size of the program relative to the economy as a whole, Table I.C.3 also shows SMI benefit expenditures on a cash basis as a percent of GDP. During CY 1991, the program grew 11.2 percent on an aggregate basis, grew 9.2 percent on a per capita basis, and increased from 0.77 to 0.83 percent of GDP. For CY 1992, there was no legislation enacted in the preceding year to limit program growth as occurred for CY 1990 and 1991. As a result, during CY 1992, the program is expected to grow 15.6 percent on an aggregate basis, to grow 13.5 percent on a per capita basis, and to increase from 0.83 to 0.92 percent of GDP.

TABLE I.C.3—GROWTH IN TOTAL CASH BENEFITS UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM THROUGH DECEMBER 31, 1994

Calendar year	Aggregate benefits [millions]	Percent change	Per capita benefits	Percent change	SMI benefits as a percent of GDP
Historical Data:					
1967	$1,197	—	$66.97	—	0.15
1968	1,518	26.8	82.27	22.8	0.17
1969	1,865	22.9	97.86	19.0	0.19
1970	1,975	5.9	101.30	3.5	0.20
1971	2,117	7.2	106.68	5.3	0.19
1972	2,325	9.8	114.91	7.7	0.19
1973	2,526	8.6	122.02	6.2	0.19
1974	3,318	31.4	144.47	18.4	0.23
1975	4,273	28.8	179.96	24.6	0.27
1976	5,080	18.9	207.39	15.2	0.29
1977	6,038	18.9	239.27	15.4	0.31
1978	7,252	20.1	279.58	16.8	0.32
1979	8,708	20.1	326.86	16.9	0.35
1980	10,635	22.1	389.87	19.3	0.39
1981	13,113	23.3	471.15	20.8	0.43
1982	15,455	17.9	545.55	15.8	0.49
1983	18,106	17.2	627.79	15.1	0.53
1984	19,661	8.6	670.77	6.8	0.52
1985	22,947	16.7	768.25	14.5	0.57
1986	26,239	14.3	861.37	12.1	0.61
1987	30,820	17.5	992.69	15.2	0.68
1988	33,970	10.2	1,078.41	8.6	0.69
1989	38,294	12.7	1,197.55	11.0	0.73
1990	42,468	10.9	1,307.27	9.2	0.77
1991	47,229	11.2	1,427.38	9.2	0.83
Estimates:					
1992	54,603	15.6	1,619.79	13.5	0.92
1993	61,873	13.3	1,802.51	11.3	0.99
1994	70,033	13.2	2,006.68	11.3	1.05

Table I.C.4 shows the estimated incurred disbursements of the SMI program under alternative II, expressed as a percentage of GDP, for selected years over the 75-year period 1992-2066. These estimated incurred disbursements are for benefit payments and administrative expenses combined unlike the values in Table I.C.3 which only express benefit payments on a cash basis as a percentage of GDP. The 75-year period fully allows for the presentation of future contingencies that reasonably may be expected to occur, such as the impact of a large increase in enrollees which occurs after the turn of the century. This large increase in enrollees occurs because the relatively large number of persons born during the period between the end of World War II and the early 1960's (known as the "baby boom") will reach retirement age and begin to receive benefits. Increases in the costs per enrollee during the initial 25-year period are assumed to gradually decline in the last 15 years to the same rate as GDP per capita and then continue at the same rate as GDP per capita in the last 50 years. Given the historical experience of SMI costs per enrollee increasing faster than GDP per capita, the assumption of the increases in costs per enrollee declining to the same rate as GDP per capita may be considered optimistic because changes in the last 50 years of the estimation period reflect only the impact of the changing demographic composition of the population. Based on these assumptions, incurred SMI disbursements as a percentage of GDP increase rapidly from 0.88 percent in CY 1991 to 4.59 percent in CY 2036, decrease slightly to 4.44 percent by CY 2051, and then increases to 4.77 percent by CY 2066.

TABLE I.C.4—SUPPLEMENTARY MEDICAL INSURANCE INCURRED DISBURSEMENTS AS A PERCENT OF THE GROSS DOMESTIC PRODUCT[1]

Calendar year	SMI Disbursements as a percent of GDP
1991	0.88
1992	0.97
1993	1.03
1994	1.10
1995	1.17
2000	1.61
2005	2.19
2010	2.74
2015	3.20
2020	3.58
2025	4.03
2030	4.40
2035	4.57
2040	4.56
2045	4.49

TABLE I.C.4—SUPPLEMENTARY MEDICAL INSURANCE INCURRED DISBURSEMENTS AS A PERCENT OF THE GROSS DOMESTIC PRODUCT[1]

Calendar year	SMI Disbursements as a percent of GDP
2050	4.44
2055	4.48
2060	4.62
2065	4.75

[1]Disbursements are the sum of benefit payments and administrative expenses.

Since future health care usage and cost experience may vary considerably from the intermediate set of assumptions (alternative II) on which the cost estimates were based, estimates have also been prepared on the basis of two additional alternative sets of assumptions: alternative I and alternative III. The estimated operations of the SMI trust fund during CY 1991-2001 are summarized in Table I.C.5 for all three alternatives. The assumptions underlying alternative II are presented in substantial detail in the section II.D. "Actuarial Methodology and Principal Assumptions for Cost Estimates for the Supplementary Medical Insurance Program." The assumptions used in preparing estimates under alternative I and III are also summarized in this section.

TABLE I.C.5.—ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) DURING CALENDAR YEARS 1991-2001

[In billions]

Calendar year	Premiums from enrollees	Other income[1]	Total income	Total disburse-ments	Balance in fund at end year
Alternative I:					
1991	11.9	41.1	53.0	48.8	17.9
1992	12.9	39.0	51.9	56.2	13.6
1993	15.1	47.5	62.6	62.8	13.4
1994	17.2	52.4	69.6	69.8	13.2
1995	19.6	59.2	78.8	77.6	14.5
1996	20.5	67.2	87.7	86.3	15.8
1997	21.3	75.9	97.1	95.6	17.3
1998	22.1	85.3	107.4	105.8	19.0
1999	23.0	95.8	118.8	117.0	20.8
2000	23.9	107.7	131.7	129.6	22.9
2001	24.9	121.4	146.3	144.0	25.2

TABLE I.C.5.—ESTIMATED OPERATIONS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) DURING CALENDAR YEARS 1991-2001

[In billions]

Calendar year	Premiums from enrollees	Other income[1]	Total income	Total disburse-ments	Balance in fund at end year
Alternative II:					
1991	11.9	41.1	53.0	48.8	17.9
1992	12.9	39.0	51.9	56.2	13.6
1993	15.1	48.4	63.4	63.6	13.4
1994	17.2	54.5	71.7	71.8	13.3
1995	19.6	63.1	82.7	81.4	14.6
1996	20.6	73.3	93.9	92.4	16.1
1997	21.6	84.7	106.3	104.6	17.8
1998	22.7	97.6	120.3	118.4	19.7
1999	23.9	112.5	136.3	134.2	21.8
2000	25.0	129.8	154.9	152.4	24.3
2001	26.3	149.9	176.2	173.3	27.1
Alternative III:					
1991	11.9	41.1	53.0	48.8	17.9
1992	12.9	39.0	51.9	56.2	13.6
1993	15.1	51.2	66.3	66.4	13.5
1994	17.2	60.1	77.3	77.4	13.4
1995	19.6	70.3	89.9	88.5	14.9
1996	21.1	82.8	104.0	102.4	16.5
1997	22.6	98.7	121.4	119.5	18.4
1998	23.9	116.5	140.4	138.3	20.6
1999	25.3	137.4	162.7	160.1	23.1
2000	26.8	162.2	189.0	186.0	26.1
2001	28.4	191.6	220.1	216.6	29.6

[1]Other income contains government contributions and interest.

NOTE: Totals do not necessarily equal the sum of rounded components.

The three alternative sets of assumptions were selected in order to indicate the general range in which the cost of the program reasonably might be expected to fall. The alternative I assumptions are somewhat more optimistic than the alternative II assumptions, resulting in a lower average expenditure growth over the estimation period. The alternative III assumptions are somewhat more pessimistic than alternative II assumptions, resulting in a higher average expenditure growth over the estimation period. Alternatives I and III provide for a fairly wide range of possible experience. Actual experience is expected to fall within the range, but no assurance can be given that this will be the case, particularly in light of the wide variations in experience that have occurred since the beginning of the program.

SMI expenditures are estimated to grow faster than the GDP under all three alternatives, with the most rapid growth occurring under alternative III assumptions and the least rapid under alternative I assumptions. Table I.C.5 indicates that by CY 2001 total disbursements for alternative I and for alternative III will be 17 percent lower and 25 percent higher, respectively, than for alternative II. Similarly, for CY 2001 total income for alternative I and for alternative III will be 17 percent lower and 25 percent higher, respectively, than for alternative II. However, the trust fund balances for alternative I and III do not display this divergence. The CY 2001 trust fund balance under alternative I is 7 percent lower than the trust fund balance for alternative II, and the trust fund balance for alternative III is 9 percent higher than under alternative II. The reason the trust fund balances show much smaller variations under the three alternatives is that the financing has only been fully established through CY 1992. It is assumed that financing for years beyond 1992 will be established to adequately finance the expenditures, irrespective of the underlying economic assumptions.

D. ACTUARIAL STATUS OF THE TRUST FUND

1. Actuarial Soundness of the Supplementary Medical Insurance Program

The concept of actuarial soundness, as it applies to the SMI program, is closely related to the concept as it applies to many private group insurance plans. The SMI program essentially is yearly renewable term insurance financed from premium income paid by the enrollees and from income contributed from general revenue by the federal government. Consequently, the income to the program during a 12-month period for which financing is being established should be sufficient to maintain assets at a level to pay for services (including associated administrative costs) expected to be rendered during that period, even though payment for some of these services will not be made until after the close of the period. The portion of income required to cover those benefits not paid until after the close of the year is added to the trust fund. Thus, the assets in the trust fund at any time should be no less than the costs of the benefits and the administrative expenses incurred but not yet paid.

The law requires the Secretary of Health and Human Services (HHS) to establish income on the basis of incurred costs (including associated administrative costs) for the 12-month period for which financing is being established. Financing on an incurred basis means that income should be sufficient to cover the cost of services rendered during the period. However, since the income per enrollee (premium rate plus Government contribution) is established prospectively, it is subject to projection error. Additionally, legislation enacted after the financing has been established but effective for the period for which financing has been set may affect program costs. As a result, the income to the program may not be equal to incurred costs; therefore, trust fund assets should be maintained at a level which is adequate to cover the impact of a reasonable degree of variation between actual and projected costs, as well as the value of incurred but unpaid expenses.

In testing the actuarial soundness of the SMI program, it is appropriate to look only to the periods for which the enrollee premium rates and level of general revenue financing have been established. The primary tests of actuarial soundness, then, are that: (1) assets and income for years for which financing has been established be sufficient to meet the projected benefits and associated administrative expenses incurred for that period and (2) assets be sufficient to cover projected liabilities that will have been incurred by the end of that time but will not have been paid yet. Even if these tests of actuarial soundness are not met, the program can continue to operate if the trust fund remains at a level adequate to permit the payment of claims as presented. However, to protect against the possibility that costs under the program will be higher than assumed, assets should be sufficient to include contingency levels to cover the impact of a reasonable degree of variation between actual and projected costs.

Contingency levels to accommodate costs that may be higher than expected are measured by the excess of assets over liabilities. An appropriate target level for this excess depends on numerous factors. The most important of these factors are: (1) the difference from prior years in the actual performance of the program and the estimates made at the time financing was established and (2) the expected relationship between incurred and cash expenditures. Ongoing analysis is made of the former as trends in the differences vary over time.

2. Incurred Experience of the Supplementary Medical Insurance Program

The tests of actuarial soundness of the SMI program noted above rely on the incurred experience of the program. 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. Outstanding liabilities result from the lag between the time that services are performed and the time that payments for them are made.

The experience of the program is substantially more difficult to determine on an incurred basis than on a cash basis. Payment for some services is reported only on a cash basis, and the incurred experience must be inferred from the cash payment information. For recent time periods, the tabulations of bills are incomplete due to normal processing delays. Finally, since bills are tabulated only for a sample of beneficiaries, the data is subject to biases and random fluctuations inherent in the sampling process.

Table I.D.1 shows the estimated transactions of the trust fund on an incurred basis. For the reasons stated above, the incurred experience must be viewed as an estimate even for historical years. Various checks, such as cash outlay data, assure that the estimates are reasonably close, however.

TABLE I.D.1.—ESTIMATED INCOME AND DISBURSEMENTS INCURRED UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM FOR FINANCING PERIODS THROUGH DECEMBER 31, 1992

[In millions]

Financing period	Premiums from enrollees	Government contri-butions	Interest and other income	Benefit pay-ments	Adminis-trative expenses	Net operations in year
Historical Data:						
12-Month period ending June 30,						
1967	$647	$647	$15	$1,109	$123[1]	$77
1968	698	698	21	1,443	155	-181
1969	903	903	24	1,765	198	-133
1970	936	936	12	1,929	213	-258
1971	1,253	1,253	18	2,090	259	175
1972	1,340	1,340	29	2,289	259	161
1973	1,427	1,426	45	2,500	302	96
1974	1,704	2,031	76	3,170	353	288
1975	1,887	2,396	105	3,953	438	-3

TABLE I.D.1.—ESTIMATED INCOME AND DISBURSEMENTS INCURRED UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM FOR FINANCING PERIODS THROUGH DECEMBER 31, 1992

[In millions]

Financing period	Premiums from enrollees	Government contributions	Interest and other income	Benefit payments	Administrative expenses	Net operations in year
1976	1,951	2,972	109	4,847	485	-300
1977	2,156	4,697	157	5,894	515	601
1978	2,358	5,991	254	6,988	511	1,104
1979	2,601	6,570	365	8,202	649	685
1980	2,823	6,627	421	9,975	645	-749
1981	3,178	8,219	371	12,068	692	-992
1982	3,737	12,488	495	14,041	728	1,951
1983	4,202	13,951	686	17,057	708	1,074
T.S.[2]	2,120	7,836	374	9,718	483	129
Calendar year						
1984	5,167	17,052	962	20,306	869	2,006
1985	5,613	18,243	1,248	22,881	986	1,237
1986	5,722	17,802	1,141	26,686	1,000	-3,021
1987	6,717	21,377	880	30,827	1,036	-2,869
1988	9,453	28,342	903	34,619	1,343	2,736
1989	12,263[3]	30,826	1,257[3]	38,406	1,546[3]	4,394[3]
1990	11,320	33,035	1,558	42,361	1,518	2,034
1991	11,934	37,558	1,732	48,142	1,572	1,510
Estimates:						
1992	12,864	37,875	1,143	55,596	1,640	-5,354

[1]Includes administrative expenses incurred prior to the beginning of the program.
[2]The transition semester (T.S.) is the 6-month period July 1, 1983 to December 31, 1983.
[3]Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

3. Accumulated Excess of Assets Over Liabilities

The liability outstanding at any time for the cost of services performed for which no payment has been made is referred to as "benefits incurred but unpaid." Estimates of the amount of benefits incurred but unpaid as of the end of each financing period, and of the administrative expenses related to processing these benefits, appear in Table I.D.2. For some years of the program, assets have not been as large as liabilities. Nonetheless, the fund has remained positive, allowing claims to be paid.

TABLE I.D.2.—SUMMARY OF ESTIMATED ASSETS AND LIABILITIES OF THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM AS OF THE END OF THE FINANCING PERIOD, FOR PERIODS THROUGH DECEMBER 31, 1992

[Dollar amounts in millions]

	Balance in trust fund	Government contributions due but unpaid	Total assets	Benefits incurred but unpaid	Administrative costs incurred but unpaid	Total liabilities	Excess of assets over liabilities	Ratio[1]
Historical Data:								
As of June 30,								
1967	$486	$24	$510	$445	-$12	433	$77	0.05
1968	307	88	395	498	1	499	-104	-0.05
1969	378	7	385	618	4	622	-237	-0.11
1970	57	15	72	568	0	568	-496	-0.21
1971	290	22	312	623	11	634	-322	-0.13
1972	481	-3	478	657	-19	638	-160	-0.06
1973	746	-7	739	766	37	803	-64	-0.02
1974	1,272	-5	1,267	1,062	-19	1,043	224	0.05
1975	1,424	67	1,491	1,250	14	1,264	227	0.04
1976	1,219	106	1,325	1,425	-29	1,396	-71	-0.01
1977	2,170	91	2,261	1,730	3	1,733	528	0.07
1978	3,786	48	3,834	2,161	40	2,201	1,633	0.18
1979	4,880	2	4,882	2,443	123	2,566	2,316	0.22
1980	4,657	0	4,657	2,902	188	3,090	1,567	0.12
1981	3,801	0	3,801	3,212	13	3,225	576	0.04
1982	5,534	1	5,535	3,017	-9	3,008	2,527	0.14
1983	6,780	2	6,782	3,229	-48	3,181	3,601	0.18
As of December 31,								
1983	7,070	1	7,071	3,049	-69	3,340	3,731	0.18
1984	9,698	2	9,700	4,054	-91	3,963	5,737	0.24
1985	10,924	0	10,924	3,988	-38	3,950	6,974	0.25
1986	8,291	0	8,291	4,435	-98	4,337	3,954	0.12
1987	8,394[2]	0	8,394[2]	4,442	17	7,329[2]	1,065	0.03
1988	8,990	3	8,993	5,092	100	5,192	3,801	0.10
1989[3]	13,556	0	13,556	5,204	157	5,361	8,195	0.19
1990	15,482	0	15,482	5,097	156	5,253	10,229	0.21
1991	17,935	0	17,935	6,010	187	6,197	11,738	0.21
Estimates:								
1992	13,574	0	13,574	7,003	187	7,190	6,384	0.10

[1]Ratio of the excess of assets over liabilities to the following year's total incurred expenditures.

[2]Section 708 of Title VII of the Social Security Act modified the provisions for the delivery of Social Security benefit checks when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January, 1988 occurred on December 31, 1987. Consequently, the SMI premiums withheld from the checks ($692 million) and the general revenue matching contributions ($2,178 million) were added to the SMI trust fund on December 31, 1987 and were included in the liabilities.

[3]The 1989 transactions of Medicare Catastrophic Coverage Account are included in the assets and liabilities of the trust fund.

Program financing has been established through December 31, 1992. The financing for CY 1992 was designed with specific margins to reduce the excess of assets over liabilities as a percent of incurred expenditures for the following year. However, this was accomplished by including specific margins to decrease the excess of assets over liabilities for the aged and to increase it for the disabled. As a result, for CY 1992, incurred disbursements are expected to exceed incurred income by $5,354 million, as shown in Table I.D.1, and the excess of assets over liabilities is expected to decrease from $11,738 million at the end of December 1991 to $6,384 million at the end of December 1992 for alternative II, as shown in Table I.D.2. This excess as a percent of incurred expenditures for the following year is expected to decrease from 21 percent as of December 31, 1991 to 10 percent as of December 31, 1992.

4. Sensitivity Testing

Some of the assumptions underlying the estimates presented in this report are highly uncertain, and variations in these assumptions would have a substantial impact on estimated expenditures. Since the financing rates are set prospectively, the actuarial soundness depends on the variations in these assumptions. In order to test the actuarial soundness of the program under varying assumptions, a low cost projection and a high cost projection were prepared by varying these key assumptions through the period for which the financing has been set. The low and high cost alternative sets of assumptions are intended to reflect growth rates for the various components of program costs which are more favorable and adverse, respectively, than those of the intermediate estimates (alternative II) and which are not unreasonable themselves in light of the nature and historical experience of the program. As such, they provide a range of financial outcomes within which the actual experience of the program might reasonably be expected to fall. The values for the low and high assumptions were determined from a study on the average historical variation in the respective increase factors.

This sensitivity analysis differs from the alternative I and III analysis discussed in the section I.C. "Expected Operations and Status of the Trust Fund." This analysis examines the variation in the projection factors through the period for which the financing has been established (1992 for this report). The alternative I and III analysis begins the variation in program growth with the first year after the year for which financing has been established (1993 for this report).

Table I.D.3 indicates that, under the low cost assumptions, trust fund assets would exceed liabilities by the end of December 1992 (the period through which financing has been established), reaching a level of 19.0 percent of the following year's incurred expenditures. If these low costs were actually to materialize, then subsequent financing rates would be adjusted downward in order to lower the excess of assets over liabilities to an appropriate level to maintain the actuarial soundness of the trust fund. Under the high cost assumptions, trust fund assets would still exceed liabilities by the end of December 1992, dropping to a level of 2.0 percent of the following year's incurred expenditures. Therefore, even if these high growth rates were to occur, assets would still be sufficient to cover outstanding liabilities. Figure 3 shows this ratio for historical years and for projected years under the intermediate assumptions (alternative II), as well as high (pessimistic) and low (optimistic) cost sensitivity scenarios.

Table I.D.3.—ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND UNDER THREE SETS OF ALTERNATIVE ASSUMPTIONS FOR FINANCING PERIODS THROUGH DECEMBER 31, 1992

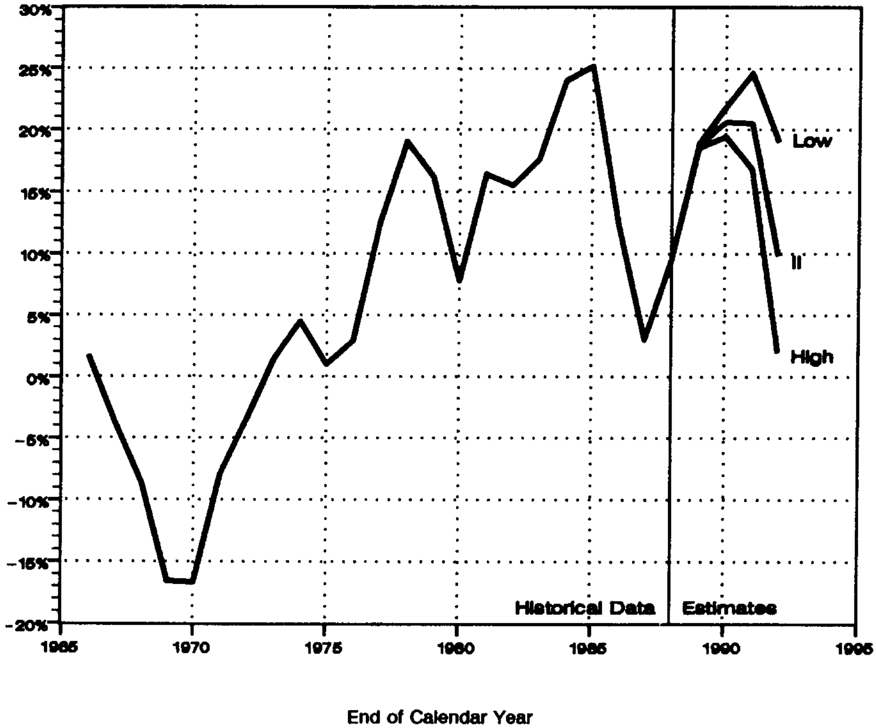
	Alternative II projection			Low cost projection			High cost projection		
	12-Month period ending June 30,			12-Month period ending June 30,			12-Month period ending June 30,		
	1991	1992	1993	1991	1992	1993	1991	1992	1993
Projection factors (in percent):									
Physician fees[1]									
Aged	-1.6	-0.3	1.7	-1.9	-1.1	0.7	-1.3	0.5	2.7
Disabled	-1.6	-0.3	1.7	-1.9	-1.1	0.7	-1.3	0.5	2.7
Utilization of physician services[2]									
Aged	5.6	14.6	7.6	5.1	13.1	3.8	6.1	16.1	11.4
Disabled	6.8	11.3	5.9	5.0	8.6	2.5	8.6	14.0	9.3
Outpatient hospital services per enrollee									
Aged	15.5	14.3	14.3	10.8	9.9	11.6	20.2	18.8	17.0
Disabled	15.1	10.8	11.4	10.2	4.6	4.7	20.0	17.0	18.0
	As of December 31,			As of December 31,			As of December 31,		
	1990	1991	1992	1990	1991	1992	1990	1991	1992
Actuarial status (in millions):									
Assets	$15,482	$17,935	$13,574	$15,482	$17,935	$16,530	$15,482	$17,935	$10,480
Liabilities	5,253	6,197	7,190	4,944	4,622	5,347	5,562	7,802	9,080
Assets less liabilities	$10,229	$11,738	$6,384	$10,538	$13,313	$11,183	$9,920	$10,133	$1,400
Ratio of assets less liabilities to expenditures (in percent)[3]	20.6	20.5	9.9	21.8	24.6	19.0	19.4	16.8	2.0

[1]As recognized for payment under the program.

[2]Increase in the number of services recieved per enrollee and greater relative use of more expensive services.

[3]Ratio of assets less liabilites at the end of the year to the total incurred expenditures during the following year, expressed as a percent.

FIGURE 3
ACTUARIAL STATUS OF THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND THROUGH CALENDAR YEAR 1992



Note: The actuarial status of the SMI trust fund is measured by the ratio of the end of year surplus or deficit to the following year incurred expenditures.

E. CONCLUSION

The financing for the SMI program has been established through December 1992 by the setting of the standard monthly premium rate (paid by or on behalf of each enrollee) of $31.80 for CY 1992 and of actuarial rates that determine the amount to be contributed from general revenue on behalf of each enrollee. General revenue contributions are expected to account for 73.0 percent of all SMI income during CY 1992.

Overview

Under alternative II assumptions used in this report, disbursements are estimated to exceed income during CY 1992 by $4,361 million. Income is composed of premiums paid by the enrollees, general revenue contributions, and interest earned by the trust fund. As a result, the assets in the trust fund on a cash basis are estimated to decrease from $17.9 billion at the end of CY 1991 to $13.6 billion at the end of CY 1992.

The main reason for the decrease in assets during CY 1992 is that the financing for CY 1992 was established specifically to reduce assets. As a result, the excess of assets over liabilities is expected to decrease from $11,738 million at the end of December 1991 to $6,384 million by the end of December 1992 representing 9.9 percent of the following year's projected incurred expenditures. Under more pessimistic assumptions as to cost increases, assets based on financing already established will still be sufficient to cover outstanding liabilities. Hence, the financing established through December 1992 is sufficient to cover projected benefit and administrative costs incurred through that time period, and to maintain a level of trust fund assets adequate to cover the impact of a reasonable degree of variation between actual and projected costs.

Even though the projections under alternative II in this report show that the financing is adequate through 1992, the lack of experience under the newly implemented physician fee schedule contributes to greater uncertainty of the projections. If volume and intensity of services increase by more than expected, then SMI assets could be reduced more than projected, possibly to an unacceptably low level.

Although the SMI program is currently actuarially sound, the Trustees note with concern the past and projected rapid growth in the cost of the program. Growth rates have been so rapid that outlays of the program have increased 80 percent in aggregate and 66 percent per enrollee in the last 5 years. For the same time period, the program grew 36 percent faster than the economy despite recent efforts to control the cost of the program. As a result, the program is projected to increase from 0.88 percent of the GDP in CY 1991 to 4.75 percent of GDP in CY 2065. This rapid growth is attributable primarily to the inability to control the rapid growth in (1) the volume of services billed per beneficiary and (2) the reported case mix intensity (the reporting of services which receive higher reimbursement). Given the past and projected cost of the program, the Trustees urge the Congress to take additional actions designed to control SMI costs either through specific program legislation or as a part of enacting more comprehensive health care reform.

II. TECHNICAL

A. SOCIAL SECURITY AMENDMENTS SINCE THE 1991 REPORT

Since the 1991 Annual Report was transmitted to Congress on May 17, 1991, there have been no legislative changes enacted which would have a significant effect on the financial status of the SMI program.

B. NATURE OF THE TRUST FUND

The Federal SMI Trust Fund was established on July 30, 1965, as a separate account in the United States Treasury. All the financial operations of the SMI program are handled through this fund.

The major sources of revenue of the trust fund are: (1) contributions of the Federal Government that are authorized to be appropriated and transferred from the general fund of the Treasury and (2) premiums paid by eligible persons who are voluntarily enrolled in the program. The premiums paid by eligible persons in 1989 include both those specified by the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) and those needed to finance the non-catastrophic benefits. With the enactment of the Medicare Catastrophic Coverage Repeal Act of 1989 (Public Law 101-234), there are no catastrophic premiums after 1989. Therefore, the discussion in the remainder of this section will deal only with non-catastrophic coverage. Eligible persons aged 65 and over have been able to enroll in the program since its inception in July 1966. Since July 1973, disabled persons under age 65, who have met certain eligibility requirements, have also been able to enroll in the program.

The premiums paid by enrollees are based on the standard monthly premium rate, which is the same for enrollees aged 65 and over and for disabled enrollees under age 65. Premiums paid for FY 1967 through 1973 were matched by an equal amount of Government contributions. Beginning July 1973, the amount of Government contributions corresponding to premiums paid by each of the two groups of enrollees is determined by applying a ratio (known as the matching ratio), prescribed in the law for each group, to the amount of premiums received from that group of enrollees. The ratio is equal to: (1) twice the amount of the monthly actuarial rate applicable to the particular group of enrollees, minus the amount of the standard monthly premium rate, divided by (2) the amount of the standard monthly premium rate.

Standard monthly premium rates and actuarial rates are promulgated each year by the Secretary of HHS. The standard monthly premium rates in effect from July 1966 through June 1983, the rate for July 1983 through December 1983, and the rates for CY 1984 through 1992 are shown in Table II.B.1. Actuarial rates and the corresponding matching ratios in effect from July 1973 through June 1983, the rates and ratios applicable for July 1983 through December 1983, and the rates and ratios for CY 1984 through 1992 are also shown. For a detailed discussion of the determination of the actuarial and premium rates, see Appendix A.

TABLE II.B.1.—STANDARD MONTHLY PREMIUM RATES, ACTUARIAL RATES, AND MATCHING RATIOS

	Standard monthly premium rate	Monthly actuarial rate		Matching ratio	
		Enrollees aged 65 and over	Disabled enrollees under age 65	Enrollees aged 65 and over	Disabled enrollees under age 65
July 1966 - March 1968	$3.00	–	–	–	–
April 1968 - June 1970	4.00	–	–	–	–
12-month period ending June 30 of –					
1971	5.30	–	–	–	–
1972	5.60	–	–	–	–
1973	5.80	–	–	–	–
1974[1]	6.30	$6.30	$14.50	1.0000	3.6032
1975	6.70	6.70	18.00	1.0000	4.3731
1976	6.70	7.50	18.50	1.2388	4.5224
1977	7.20	10.70	19.00	1.9722	4.2778
1978	7.70	12.30	25.00	2.1948	5.4935
1979	8.20	13.40	25.00	2.2683	5.0976
1980	8.70	13.40	25.00	2.0805	4.7471
1981	9.60	16.30	25.50	2.3958	4.3125
1982	11.00	22.60	36.60	3.1091	5.6545
1983	12.20	24.60	42.10	3.0328	5.9016
July 1983 - December 1983	12.20	27.00	46.10	3.4262	6.5574
Calendar year					
1984	14.60	29.20	54.30	3.0000	6.4384
1985	15.50	31.00	52.70	3.0000	5.8000
1986	15.50	31.00	40.80	3.0000	4.2645

TABLE II.B.1.—STANDARD MONTHLY PREMIUM RATES, ACTUARIAL RATES, AND MATCHING RATIOS

	Standard monthly premium rate	Monthly actuarial rate		Matching ratio	
		Enrollees aged 65 and over	Disabled enrollees under age 65	Enrollees aged 65 and over	Disabled enrollees under age 65
1987	17.90	35.80	53.00	3.0000	4.9218
1988	24.80	49.60	48.60	3.0000	2.9194
1989	31.90[2]	55.80	34.30	3.0000[3]	1.4588[3]
1990	28.60	57.20	44.10	3.0000	2.0839
1991	29.90	62.60	56.00	3.1873	2.7458
1992	31.80	60.80	80.80	2.8239	4.0818

[1]In accordance with limitations on the costs of health care imposed under Phase III of the Economic Stabilization program, the standard premium rate for July and August 1973 was set at $5.80 and $6.10, respectively. Effective September 1973, the rate increased to $6.30.

[2]This is the premium paid by most groups. This rate includes the $4.00 catastrophic coverage monthly premium which was paid by most enrollees.

[3]The matching rates for CY 1989 apply to the non-catastrophic portion of the standard monthly premium rate.

Another source from which revenue of the trust fund is derived is interest received on investments held by the fund. The investment procedures of the fund are described later in this section. Section 201(i) of the Social Security Act authorizes the Managing Trustee to accept and deposit in the trust fund unconditional money gifts or bequests made for the benefit of the fund or for any activity financed through the 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 HHS and by the Department of the Treasury in carrying out the SMI provisions of Title XVIII of the Social Security Act are charged to the trust fund. The Secretary of HHS certifies benefit payments to the Managing Trustee, who makes the payments from the trust fund in accordance therewith.

The Social Security Amendments of 1967 and 1972 authorize the Secretary of HHS to develop and conduct a broad range of experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under the hospital insurance (HI) and SMI programs. A sizeable portion of such costs of such experiments and demonstration projects are paid out of the HI and SMI trust funds, with the remainder funded through general revenues.

Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the SMI program. Both the capital costs of construction financed directly from the trust fund and the rental and lease, or purchase contract costs of acquiring facilities are included in trust fund expenditures. In 1972-75, construction of several large facilities was authorized under purchase contract authority, wherein initial capital costs were borne by the private sector. Under this method of facilities acquisition, trust fund expenditures for use and ultimate Government ownership of a facility are made over periods of from 10 to 30 years. Whatever the manner of acquisition, the net worth of facilities and other fixed capital assets is not carried in the statement of the assets of the trust fund presented in this report. This is because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and, therefore, is not viewed as being a consideration in assessing the actuarial status of the funds.

That portion of the 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 (including special public-debt obligations described below), 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.

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 bear interest at a rate based on the average market yield (computed 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.