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LATE-1972 AMENDMENTS TO THE SOCIAL SECURITY ACT

by C. L. Trowbridge

The September issue of *The Actuary* carried an article describing the changes in the Social Security System brought about by the mid-summer amendments attached to a bill extending the national debt ceiling. This article describes the additional changes brought about by the enactment of H.R. 1 in late October.

The new legislation, now referred to as the Social Security Amendments of 1972 (though in fact the second of two sets of amendments to the Social Security Act enacted in 1972), is a collection of benefit liberalizations, and some other changes involving OASI, DI, and parts A and B of Medicare.

The provisions with important financial effect on the OASDI program are as follows:

1. *Increase in widow's (and widower's) benefits.*

   The widow's benefit is now equal to 100% (instead of 82½%) of the husband's primary insurance amount, unless either husband or wife claims benefits prior to age 65.

2. *Age 62 computation point for men.*

   The period over which earnings are averaged, in the computation of the average monthly wage, was shortened by one year for men reaching age 62 in 1973; by two years for men reaching age 62 in 1974; and by three years for men reaching age 62 in 1975 or later. The computation period for men born after 1912 will be the same as for women.

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Gary N. See

The new Executive Director of the Society has already been given a biographical introduction to the members. On behalf of the Society we welcome him to the official family and look forward to meeting him in the flesh as he gets around to the Actuarial Clubs and Society meetings. *A.C.W.*

NO-FAULT IN PHILADELPHIA

by Robert W. Maull

At the September 1972 meeting, the Actuaries Club of Philadelphia had two guests from the non-life insurance field —Roy Miller, Secretary-Underwriting, Insurance Company of North America, and Robert Pollack, F.C.A.S., President, Colonial Penn Insurance Company. Without taking a position for or against, the guests led an enlightening discussion of the implications of no-fault automobile insurance.

Mr. Miller discussed the current legislative situation with respect to no-fault. Currently four states (Massachusetts, Florida, Delaware and Oregon) have no-fault insurance. New Jersey, Connecticut and Maryland will join the ranks in 1973 and, subject to voter approval in November of this year, Colorado will also have a no-fault insurance requirement. *(Proposal was defeated. Ed.)*

Mr. Miller pointed out that there is a potential conflict with health insurance. Under the present arrangement, the injured party sues the party at fault for medical expenses in excess of those covered by his own health insurance—in other words, he collects but once. Under no-fault, he will be compensated by his own automobile insurer for medical expenses and may also collect on any accident and health policy which he owns.

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INTERCOMPANY IMPAIRMENT STUDIES

by Joseph C. Sibigtroth

The intercompany Medico-Actuarial Studies have, over the years, provided valuable underwriting information. These studies have become increasingly expensive to produce. In the case of some impairments where there have been drastic changes in medical treatment, there have been questions as to whether the basic data may not be out-of-date by the time of publication.

For some time, medical directors and actuaries have been seeking a method, less expensive and more up-to-date, to provide impairment studies. In 1970, the Liaison Committees of the Association of Life Insurance Medical Directors and the Society of Actuaries recommended that a study be made of the possibility of establishing a joint industry center for medico-actuarial statistics to be affiliated with the Medical Information Bureau.

The Medical Information Bureau provides a computer-based inquiry-response service to inform life insurance underwriters of any recorded medical impairments on individual applicants. Automated name file organization concepts, sophisticated search strategies, and information retrieval techniques have been developed to provide an economical and accurate service. The basic data with which the Medical Information Bureau deals is the same as used in the intercompany impairment studies. Hitherto the data were prepared for the studies from the individual files of the contributing companies.

A feasibility study is now complete and the results are promising. In general, widespread industry support was found for inter-company medico-actuari-

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3. *Liberalization and automatic adjustment of the earnings test.*

The annual amount exempt under the earnings test was increased from $1,680 to $2,100. The amount of earnings an individual may earn in a month and receive full benefits was raised from $140 to $175. Benefits will be reduced by $1 for each $2 of earnings above $2,100. The annual exempt amount and the monthly test will be increased automatically in the future at the rate of increase in average covered earnings.

4. *Delayed retirement credit.*

A worker's old-age benefit was increased by 1/12 of 1% for each month after 1970 for which the worker between age 65 and 72 did not receive retirement benefits.

5. *Special minimum primary insurance amount.*

A special minimum primary insurance amount was provided, equal to $8.50 multiplied by the worker's years of coverage in excess of 10 years, but not more than $170. For those who will have 20 or more years of coverage, this special minimum exceeds the current regular minimum PIA ($84.50).

6. *Reduction in the waiting period for disability benefits.*

The waiting period was reduced from six to five months.

7. *Insured status for blind workers.*

A blind person no longer must meet the requirement of recent covered work to be eligible for disability insurance benefits, though he still must be fully insured.

For the Medicare program, the new provisions with important financial implications include:

8. *Extension of Medicare to the long-term disabled.*

Beginning in July 1973 Medicare coverage (both HI and SMI) will be extended to persons entitled to disability insurance benefits for not less than 24 consecutive months.

9. *Chronic kidney disease deemed to constitute disability for purposes of Medicare.*

Persons who require hemodialysis or renal transplantation will be deemed to be disabled, for purposes of coverage under both parts of Medicare, beginning with the third month after that in which a course of hemodialysis begins, and extending through the twelfth month after that in which a transplant takes place or hemodialysis terminates.

10. *Hospital insurance for the uninsured.*

Persons reaching age 65 but not eligible for hospital insurance can voluntarily enroll for hospital insurance, if they also enroll for supplementary medical insurance. The premium charged is an approximation to the full cost of hospital insurance benefits.

11. *Amount of supplementary medical insurance premium.*

As under previous law, the Secretary will promulgate each December the monthly enrollee premium (applicable to both the aged and the disabled) for the following fiscal year. However, the enrollee premium will be increased by no more than the percentage by which OASDI benefits have been increased since the premium was last increased. Federal general revenues will finance that part of the program costs not met through enrollee premiums.

This limitation on the increase in enrollee premium is not likely to have any effect on the premium set in December 1972 to become effective in July 1973, because of the 20% benefit increase in September 1972; but it may well hold down later increases in enrollee premiums.

12. *Change in supplementary medical insurance deductible.*

The supplementary medical insurance deductible is increased, for 1973 and later, from $50 to $60.

13. *Automatic enrollment for supplementary medical insurance.*

Coverage for supplementary medical insurance is now automatic for those becoming entitled to hospital insurance unless specifically declined, rather than effective only upon specific enrollment.

14. *Coverage of chiropractors' services under supplementary medical insurance.*

Coverage is now provided for the services of licensed chiropractors meeting uniform minimum standards, but only with respect to treatment by manual manipulation of the spine, and with respect to treatment of subluxation of the spine demonstrated by x-ray.

15. *Level-of-care requirements in extended care facilities.*

The Medicare definition of covered extended care services has been broadened to make it similar to the definition of skilled nursing facility services under Medicaid.

The 15 changes outlined above, while perhaps the most important from the point of view of immediate financial impact, are by no means a complete list of the Social Security changes brought about by the enactment of H.R. 1. More than 80 other amendments are included, a high proportion of them involving Medicare. Two in particular may play an important role in the future of the health delivery system. One provision is intended to encourage the development of "Health Maintenance Organizations," by making Medicare reimbursement fit more closely the prepayment concept under which these organizations operate. The second provides for the voluntary establishment by physicians of "Professional Standards Review Organizations" to assume responsibility for review of services covered under Medicare.

The additional benefits under OASDI and HI required an increase in the contribution rates paid by employer and employee. After the earlier 1972 Amendments the employee contribution rate for 1973-1977 was 4.6% for cash benefits, 0.9% for hospital insurance, or 5.5% in all. The taxable earnings base was $10,800 for 1973, $12,000 for 1974, and subject to the automatic provisions thereafter. These newer amendments do not change the earnings base in any way, but now the employee contribution rate for 1973-1977 is 4.85% for cash benefits, 1.0% for hospital insurance, and 5.85% overall.

As before, increases in rates of contribution for hospital insurance occur beginning in 1978; and there is a substantial increase in the cash benefits rate schedule after the year 2010.

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Up to this point this article has emphasized the changes in those parts of the Social Security Act usually considered the Social Security System. Although the welfare reform legislation, originally an important part of H.R. 1, failed with respect to the so-called Family Protection Plan, it was successful as to the so-called adult categories. A new Supplementary Security Income Program for the Aged, Blind, and Disabled (SSI) provides for a 100% federally financed floor under the previously state administered Old-Age Assistance, Aid to the Blind, and Aid to the Disabled programs. State supplementation can take place if the state so provides, but in any case the Social Security Administration, a federal agency, assumes administrative responsibility for SSI. These changes in the Social Security Act may be as important as the changes toward which most actuarial interest has been directed. □

Impairment Studies

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al investigations, provided they are conducted at a reasonable cost. Most medical directors, actuaries, and underwriters felt that more recent statistical experience is needed as the data available from the 1951 Impairment Study is several decades old. In addition, a continuing centralized system of collecting and studying industry experience on the mortality associated with build, blood pressure, and medical impairments would show current impairment mortality. The proposed study would capitalize on the available off-shift computer resources at MIB, thus reducing the total cost of the study.

The MIB will be responsible only for the central bureau work in connection with mortality studies. The responsibility for the design of studies and analysis of results will rest with the Liaison Committees. It is expected that the Mortality Committee of the Society will also be involved in the design and analysis work.

The proposed methodology is as follows: each contributing company will post current status (i.e., in force, dead, lapse, etc.) to its entire medico-actuarial statistical file for the issue years to be studied. Each company will then convert this file of individual policy records to a standard format by a relatively straightforward computer program. The central bureau will receive unsorted, unsummarized contributions from each contributing company, and from these will select records containing medical impairments of interest, to which study numbers will be assigned. The selected records will be sorted by study number, and summarized, and the mortality experience taken out in the usual manner.

The experience will be printed, for each individual company and for all companies combined, in a traditional format. While only the intercompany results will be published, individual contributing companies will receive their own experience in intercompany format for their own internal uses. Thus, contributing companies would be able to evaluate their own experience and compare it with intercompany results.

More flexible analysis will be possible, because all the data will be available for preliminary investigation before studies are decided upon. Also, the study can be conducted on a schedule convenient to the industry. Finally, the cost and confusion of periodically transferring processing data from the last compiling company to the next is eliminated.

The cost to most companies of supporting the proposed study will be, both in time and money, much less than for the 1951 Impairment Study and the 1959 Build and Blood Pressure Study. This last study took about four years to complete with computer costs alone running into hundreds of thousands of dollars. Any proposed study under the new arrangement will be funded by MIB member companies through an increase in the MIB basic charge. The extra home office costs of the contributing companies would be significantly reduced since all they have to do is convert their medico-actuarial statistical file of individual policy records to a standard format for submission to the MIB.

This plan of having a central processing bureau for the preparation of intercompany studies on a timely basis appears to be an excellent means of providing up to date medico-actuarial statistics at reasonable cost. □

Letters

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ture capacity and willingness to pay. If actuaries don't speak out against this financial skullduggery, who will? Who else can even understand it?

The Railroad Retirement System is already going down the drain. The Civil Service Retirement System is in a pathetic state. Can we afford to let Social Security be "improved" to the point where the only solution is "General Revenue financing"?

Kenneth P. Veit

* * * *

Sir:

E. H. Wells, in his October 1972 review of "An American Philosophy of Social Security," gives a clear and excellent picture of the contents of the book.

However, I question the judgment (his or the book's?) that, in 1935 in starting up U.S. Social Security, "Fortunately all the right decisions were made." I also question that U. S. Social Security favours "lower paid employees" more than higher paid employees.

The taxes typically collected by earnings-related "social insurance" schemes such as U. S. Social Security (and the Canada Pension Plan, and the Quebec Pension Plan) actually *worsen* the poverty of the "working poor." Was that a "right decision"?

As for the retired, never mind the theories and the percentages. Look at the facts. Look at the dollars paid out. For two people of the same age, and currently retired, the *number of dollars* given as a subsidy, as a gift, or as a windfall, is larger in the monthly benefit that goes to the retired person who had the higher income, and is smaller in the monthly benefit that goes to the average person who had a lower income before he retired. This is equally true of the U. S. Social Security, the Canada Pension Plan, and the Quebec Pension Plan.

Each scheme is most generous in giving out subsidies and gifts and windfalls to those who already have most by way of employment pensions, home ownership, other investments, and so on. They are not "social". They are not "insurance". Calling them "social insurance" is surely false labelling. What they actually are is "upside-down welfare." Was that a "right decision"?

James L. Clare

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