Social Security Programs in the United States

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Preface

A little over 60 years ago, the Social Security Act was signed into law. This historically significant legislation changed how we as a Nation take care of our people. For the first time, there was direct Federal involvement in the welfare of individuals, particularly for alleviating poverty among the aged. Although the original law has been amended many times, it remains the cornerstone of our vast network of social programs.

The primary purpose of this publication is to give you a comprehensive picture of the programs under the Social Security Act and how they operate for the benefit of society as a whole and its individual members—be they workers, parents, children, persons with disabilities, or those who are poor. A picture of our Nation today is very different from the one taken in 1935. This publication provides an informative frame of reference for viewing our Social Security programs—a brief look back and a look at the present.

This edition was prepared by many individuals in the Office of Research, Evaluation and Statistics and other SSA offices. To those individuals, thank you for your work. An expression of appreciation is also extended to those in other agencies who reviewed and checked the accuracy of the materials related to their programs. For questions or comments you have concerning the contents of this publications please e:mail celine.d.houget@ssa.gov or telephone 202-282-7156.

Peter M. Wheeler
Associate Commissioner
for Research, Evaluation and Statistics
July 1997

Basically, all 10 programs inaugurated under the Social Security Act have a common aim in safeguarding the opportunity of American families to participate in the economic life of their times. This opportunity is furthered by the services to give children a chance for a fair start in life, to prevent sickness and the dependency resulting from sickness, and to help handicapped workers to regain a place in productive activity.

—Arthur J. Altmeyer,
Social Security Commissioner,
1937-53

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Abbreviations

AGI	Adjusted Gross Income
AIME	Average Indexed Monthly Earnings
AME	Average Monthly Earnings
CSRS	Civil Service Retirement System
DDS	Disability Determination Services
DI	Disability Insurance
DIC	Dependency and Indemnity Compensation
DUA	Disaster Unemployment Assistance
EBT	Electronic Benefit Transfer
EITC	Earned Income Tax Credit
FCS	Food and Consumer Services
FEMA	Federal Emergency Management Agency
FERS	Federal Employees Retirement System
FICA	Federal Insurance Contributions Act
FUTA	Federal Unemployment Tax Act
GDP	Gross Domestic Product
HCFA	Health Care Financing Administration
HI	Hospital Insurance
HMO	Health Maintenance Organization
HUD	Housing and Urban Development
IHA	Indian Housing Authority
IRS	Internal Revenue Service
OASDI	Old-Age, Survivors, and Disability Insurance
OBRA	Omnibus Budget Reconciliation Act
ORES	Office of Research, Evaluation and Statistics
PHA	Public Housing Agency
PPS	Prospective Payment System
PRO	Peer Review Organization
S+C	Shelter Plus Care
SECA	Self-Employed Contributions Act
SGA	Substantial Gainful Activity
SMI	Supplementary Medical Insurance
SRO	Single Room Occupancy
SSA	Social Security Administration
SSI	Supplemental Security Income
TTP	Total Tenant Payment
UI	Unemployment Insurance
USDA	United States Department of Agriculture
VA	Veterans Affairs
VEAP	Veterans' Educational Assistance Program
WIC	Special Program for Women, Infants, and Children

Historical Development

The U.S. social welfare structure has been shaped both by long standing traditions and by changing economic and social conditions. In its early history, the United States was an expanding country with a vast frontier and a predominantly agricultural economy. Up to 1870, more than half the Nation's adult workers were farmers. In the years that followed, however, industry developed rapidly and the economy tended increasingly to be characterized by industrialization, specialization, and urbanization. The result was a Nation of more employees who were dependent on a continuing flow of money income to provide for themselves and their families.

From the earliest colonial times, local villages and towns recognized an obligation to aid the needy when family effort and assistance provided by neighbors and friends were not sufficient. This aid was carried out through the poor relief system and almshouses or workhouses. Gradually, measures were adopted to provide aid on a more organized basis, usually through cash allowances to certain categories among the poor. Mothers' pension laws, which made it possible for children without paternal support to live at home with their mothers rather than in institutions or foster homes, were adopted in a number of States even before World War I. In the mid-twenties, a few States began to experiment with old-age assistance and aid to the blind.

Meanwhile, both the States and the Federal Government had begun to recognize that certain risks in an increasingly industrialized economy could best be met through a social insurance approach to public welfare. That is, the contributory financing of social insurance programs would ensure that protection was available as a matter of right as contrasted with a public assistance approach whereby only those persons in need would be eligible for benefits.

In the United States, as in most industrial countries, social insurance first began with workers' compensation. A Federal law covering civilian employees of the Government in hazardous jobs was adopted in 1908, and the first State compensation law to be held constitutional was enacted in 1911. By 1929, workers' compensation laws were in effect in all but four States. These laws made industry responsible for the costs of compensating workers

or their survivors when the worker was injured or killed in connection with his or her job.

Retirement programs for certain groups of State and local government employees—mainly teachers, police officers, and fire fighters—date back to the 19th century. The teachers' pension plan of New Jersey, which was established in 1896, is probably the oldest retirement plan for government employees. By the early 1900's, a number of municipalities and local governments had set up retirement plans for police officers and fire fighters. New York State and New York City set up retirement systems for their employees in 1920—the same year that the Civil Service Retirement System was set up for Federal employees.

Another area where the Federal Government accepted an early responsibility was in the provision of benefits and services for persons who served in the Armed Forces. These veterans' benefits at first consisted mainly of compensation for the war-disabled, widows' pensions, and land grants. Later, emphasis was placed on service pensions and domiciliary care. Following World War I, provisions were made for a full-scale system of hospital and medical care benefits.

The development of social welfare programs has been strongly pragmatic and incremental. Proposals for change are generally formulated in response to specific problems rather than to a broad national agenda. A second characteristic of U.S. social welfare policy development is its considerable degree of decentralization. Some programs are almost entirely Federal with respect to administration, financing, or both; others involve only the States (with or without participation of local government); still others involve all three levels of government. The important role played by the private sector is another aspect of decentralization in the development of American social welfare programs. The private sector shares a large role in the provision of health and medical care and income maintenance benefits in the form of employment related pensions, group life insurance, and sickness payments.

Development of U.S. programs has been pragmatic and incremental, formulated in response to specific problems, and characterized by a great degree of decentralization.

The 1935 Social Security Act

The severe Depression of the 1930's made Federal action a necessity, as neither the States and the local communities nor private charities had the financial resources to cope with the growing need among the American people. Beginning in 1932, the Federal Government first made loans, then grants, to States to pay for direct relief and work relief. After that, special Federal emergency relief and public works programs were started. In 1935, President Franklin D. Roosevelt proposed to Congress economic security legislation embodying the recommendations of a specially created Committee on Economic Security. There followed the passage of the Social Security Act, signed into law August 14, 1935.

This law established two social insurance programs on a national scale to help meet the risks of old age and unemployment: a Federal system of old-age benefits for retired workers who had been employed in industry and commerce, and a Federal-State system of unemployment insurance. The choice of old age and unemployment as the risks to be covered by social insurance was a natural development, since the Depression had wiped out much of the lifetime savings of the aged and reduced opportunities for gainful employment.

The Act also provided Federal grants-in-aid to the States for the means-tested programs of Old-Age Assistance, and Aid to the Blind. These programs supplemented the incomes of persons who were either ineligible for Social Security (Old-Age and Survivors Insurance) or whose benefits could not provide a basic living. The intent of Federal participation was to encourage States to adopt such programs.

The law established other Federal grants to enable States to extend and strengthen maternal and child health and welfare services, and these grants became the Aid to Families with Dependent Children program, which has been replaced in 1996 with a new block grant program for Temporary Assistance for Needy Families. (The Act also provided Federal grants to States for public health services and services of vocational rehabilitation. Provisions for these grants were later removed from the Social Security Act and incorporated into other legislation.)

Dependency status of the population aged 65 or older, 1937

Number (in thousands)	7,620
Percent	100
Self-dependent	35.1
Dependent	66.0
Public/private assistance	18.5
No income	47.5

OASDI Changes Since 1935

The Old-Age Insurance program was not actually in full operation before significant changes were adopted. In 1939,

Social Security Act

Title I	Grants to States for Old-Age Assistance
Title II	Federal Old-Age Benefits
Title III	Grants to States for Unemployment Compensation Administration
Title IV	Grants to States for Aid to Dependent Children
Title V	Grants to States for Maternal and Child Welfare
Title VI	Public Health Work
Title VII	Social Security Board
Title VIII	Taxes with Respect to Employment (for Old-Age Insurance)
Title IX	Tax on Employers of Eight or More (for administration of unemployment compensation)
Title X	Grants to States for Aid to the Blind
Title XI	General Provisions

Congress made the Old-Age Insurance system a family program when it added benefits for dependents of retired workers and surviving dependents of deceased workers. Benefits also became first payable in 1940, instead of 1942 as originally planned.

No major changes were made again in the program until the 1950's, when it was broadened to cover many jobs that previously had been excluded—in some cases because experience was needed to work out procedures for reporting the earnings and collecting the taxes of persons in certain occupational groups.

The scope of the basic national social insurance system was significantly broadened in 1956 through the addition of Disability Insurance. Benefits were provided for severely disabled workers aged 50 or older and for adult disabled children of deceased or retired workers. In 1958, the Social Security Act was further amended to provide benefits for dependents of disabled workers similar to those already provided for dependents of retired workers. In 1960, the age-50 requirement for disabled-worker benefits was removed. The 1967 amendments provided disability benefits for widows and widowers aged 50 or older.

The 1972 amendments provided for automatic cost-of-living increases in benefits tied to increases in the Consumer Price Index (CPI), and created the delayed retirement credit, which increased benefits for workers who retire after the normal retirement age (currently age 65).

The 1977 amendments changed the method of benefit computation to ensure stable replacement rates over time. Earnings included in the computation were to be indexed to account for changes in the economy from the time they were earned.

The 1983 amendments made coverage compulsory for Federal civilian employees and for employees of nonprofit organizations. State and local governments were prohibited from opting out of the system. The amendments also provided for gradual increases in the age of eligibility for full retirement benefits from 65 to 67, beginning with persons who attain age 62 in the year 2000. For certain higher income beneficiaries, benefits became subject to income tax.

The amendments in 1994 raised the threshold for coverage of domestic workers' earnings from $50 per calendar quarter to $1,000 per calendar year (with $100 amount increments after 1995, as average wages rise).

Other Program Changes

By the 1930's, private industrial pension plans were far more developed in the rail industry than in most other businesses or industries; but these plans had serious defects that were magnified by the Great Depression.

While the Social Security system was in the planning stage, railroad workers sought a separate railroad retirement system that would continue and broaden the existing railroad programs under a

uniform national plan. The proposed Social Security system was not scheduled to begin monthly benefit payments for several years and would not give credit for service performed prior to 1937, while conditions in the railroad industry called for immediate benefit payments based on prior service.

Legislation was enacted in 1934, 1935, and 1937 to establish a railroad retirement system separate from the Social Security program legislated in 1935. While the railroad retirement system has remained separate from the Social Security system, the two systems are closely coordinated with regard to earnings credits, benefit payments, and taxes. The railroad unemployment insurance was also established in the 1930's.

Other programs also made advances in the period since 1935. In 1948, the last of the States adopted a workers' compensation program. The laws relating to work-connected accidents gradually improved the provisions for medical benefits and rehabilitation extension services.

During the 1940's, four States adopted legislation providing weekly cash sickness benefits to workers who are temporarily disabled because of nonoccupational illness or injury. For Federal civilian employees, programs were enacted providing group life insurance in 1954 and health insurance benefits in 1959. Since then, an increasing number of State and local government jurisdictions initiated retirement programs for their employees. At present more than 75% of all State and local employees are covered both by the basic national OASDI program and by a supplementary State or local system.

As a result of World War II and the Korean conflict, special veterans' legislation was enacted, with primary emphasis on assisting ex-servicepersons to adjust from military to civilian life. Not only were the older compensation and pension benefits available to World War I veterans carried forward, but veterans were provided vocational rehabilitation, unemployment allowances, educational and training benefits, and job placement services.

One of the most important pieces of social legislation was the establishment of the Medicare program under the Social Security Amendments of 1965. The program provided for the medical needs of persons aged 65 or older, regardless of income.

The 1965 legislation also created Medicaid (Federal grants to States for Medical Assistance Programs). Medicaid provides medical assistance for persons with low incomes and resources. It replaced the former programs of medical vendor payments to public assistance recipients and medical assistance for medically needy persons aged 65 or older. Both Medicare and Medicaid have been subject to numerous legislative changes since 1965.

The public assistance provisions of the Social Security Act were also broadened. In 1972, the State-administered cash

Development of U.S. Social Security Programs

1935	Social Security Old-Age Insurance; Unemployment Insurance; and Public Assistance programs for needy aged, and blind (replaced by the SSI program in 1972); and Aid to Families with Dependent Children (replaced with block grants for Temporary Assistance for Needy Families in 1996)
1934	Railroad Retirement System
1937	Public Housing
1939	Social Security Old-Age and Survivors Insurance
1946	Natonal School Lunch Program
1950	Aid to the Permanently and Totally Disabled (replaced by the SSI program in 1972)
1956	Social Security Disability Insurance
1960	Medical Assistance for the Aged (replaced by Medicaid in 1965)
1964	Food Stamp Program
1965	Medicare and Medicaid Programs
1966	School Breakfast Program
1969	Black Lung Benefits Program
1972	Supplemental Security Income Program
1974	Special Supplemental Food Program for Women, Infants, and Children (WIC)
1975	Earned Income Tax Credit
1981	Low-Income Home Energy Assistance
1996	Temporary Assistance for Needy Families

assistance programs for the aged, blind, and disabled were replaced by the essentially federally administered Supplemental Security Income (SSI) program.

Other assistance programs not included in the Social Security Act were also broadened or new ones added. The Food Stamp program was enacted in 1964 to improve the nutrition of low-income families. Other nutrition programs include the Special Supplemental Food Program for Women, Infants, and Children (WIC) and school breakfasts and lunches. In addition, Federal-State programs provide home energy assistance, and public and subsidized housing.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) resulted in significant

changes to public assistance programs. The Aid to Families with Dependent Children program has been replaced by block grants to the States for Temporary Assistance for Needy Families. The legislation also has substantial implications for the SSI and Medicaid programs, which is explained in the individual program sections.

Although there is no system of family allowances in the United States, workers with dependent children are given deductions in the computation of their Federal income tax liability, and the working poor receive an additional reduction in their tax liability. Free public education is available to all children through secondary schools.

Social Insurance Programs

Old-Age, Survivors, and Disability Insurance

The OASDI program—which for most Americans means Social Security—is the largest income-maintenance program in the United States. Based on social insurance principles, the program provides monthly benefits designed to replace, in part, the loss of income due to retirement, disability, or death. Coverage is nearly universal: About 96% of the jobs in the United States are covered. Workers finance the program through a payroll tax that is levied under the Federal Insurance and Self-Employment Contribution Acts (FICA and SECA). The revenues are deposited in two trust funds (the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund), which pay benefits and the operating expenses of the program. Benefit payments totaled over $343.2 billion in fiscal year 1996.

In 1996, 43.7 million persons received monthly benefits

In December 1996, 43.7 million persons were receiving monthly benefits totaling $29.4 billion. These beneficiaries included 30.3 million retired workers and their spouses and children, 7.4 million survivors of deceased workers, and 6.1 million disabled workers and their spouses and children.

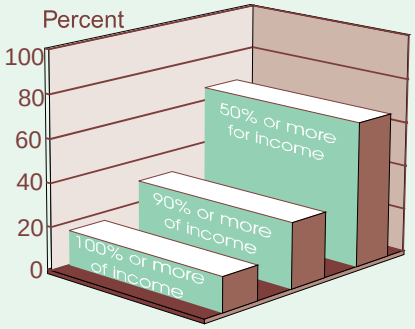
Social Security is an important source of retirement income for almost everyone; 3 in 5 beneficiaries aged 65 or older rely on it for at least half of their income. Social Security is also an important source of continuing income for young survivors of deceased workers: 98% of young children and their mothers or fathers are eligible for benefits should a working parent die. Four in five workers aged 21-64 and their families have protection in the event of a long-term disability.

Coverage

The Social Security Act of 1935 covered employees in nonagricultural industry and commerce only. Today, almost all jobs are covered.

Nearly all work performed by citizens and noncitizens is covered if it is performed within the United States (defined for Social Security purposes to include all 50 States, the District of Columbia, the

Portion of beneficiaries aged 65 or older who rely heavily on Social Security



Program Principles

Certain fundamental principles have shaped the development of the Social Security program. These basic principles are largely responsible for the program's widespread acceptance and support:

Work Related.—Economic security for workers and their families is based on their work history. Entitlement to benefits and the benefit level are related to earnings in covered work.

No Means Test—Benefits are an earned right and are paid regardless of income from savings, pensions, private insurance, or other forms of nonwork income.

Contributory—The concept of an earned right is reinforced by the fact that workers make contributions to help finance the benefits.

Universal Compulsory Coverage—Workers at all income levels and their families have protection if earnings stop or are reduced due to retirement, disability, or death. With nearly all employment covered by Social Security, this protection continues when workers change jobs.

Rights Clearly Defined in the Law.—How much a person gets and under what conditions are clearly defined in the law and are generally related to facts that can be objectively determined. The area of administrative discretion is severely limited.

Monthly OASDI benefits and average amount

Type of beneficiary	Number of beneficiaries December 1940	1960	1980	1996	Average amount, December 1996
All beneficiaries	222,488	14,844,589	35,618,840	43,736,836	$672.80
Retirement program	148,490	10,599,021	23,243,078	30,310,865	703.58
Retired workers	112,331	8,061,469	19,582,625	26,898,072	744.96
Wives and husbands	29,749	2,269,384	3,018,008	2,970,226	383.50
Children	6,410	268,168	642,445	442,567	337.07
Survivor program	73,998	3,558,117	7,600,836	7,353,284	637.95
Nondisabled widows and widowers	4,437	1,543,843	4,287,930	5,027,901	706.85
Disabled widows and widowers	...	...	126,659	181,911	470.95
Widowed mothers and fathers	20,499	401,358	562,798	242,135	514.91
Children	48,238	1,576,802	2,608,653	1,897,667	487.17
Parents	824	36,114	14,796	3,670	613.54
Disability program	...	687,451	4,682,172	6,072,034	561.36
Disabled workers	...	455,371	2,861,253	4,385,623	703.94
Wives and husbands	...	76,599	462,204	223,854	171.39
Children	...	155,481	1,358,715	1,462,557	193.51
Special age-72 beneficiaries	...	...	92,754	653	197.27

Commonwealth of Puerto Rico, the territories of Guam and American Samoa, the U.S. Virgin Islands, and the Northern Mariana Islands).

In addition, the program covers work performed outside the United States by American citizens or resident aliens who are employed by an American employer, employed by a foreign affiliate of an American employer electing coverage for its employees, or (under certain circumstances) the self-employed.

The majority of workers excluded from coverage are in three major categories: (1) Federal civilian employees hired before January 1, 1984, (2) agricultural workers and domestic workers whose earnings do not meet certain minimum requirements, and (3) persons with very low net earnings from self-employment (generally less than $400 per year). The remaining few groups excluded from coverage are very small. An example is certain nonresident, nonimmigrant aliens temporarily admitted into the United States to study, teach, or conduct research. Certain family employment is also excluded (such as employment of children under age 18 by their parents).

Major Exclusions

Federal civilian employees hired before 1/1/84

Agricultural workers and domestic workers whose earnings do not meet certain minimum requirements

Persons with very low net earnings from self-employment

Ministers and members of religious orders who have not taken a vow of poverty and Christian Science practitioners have their professional services covered automatically as self-employment unless within a limited period they elect not to be covered on the grounds of conscience or religious principle. Religious orders whose members have taken a vow of poverty may make an irrevocable election to cover their members as employees.

Employees of State and local governments are covered under voluntary agreements between the States and the Commissioner of Social Security. Each State decides whether it will negotiate an agreement and, subject to special conditions that apply to retirement system members, what groups of eligible employees will be covered. At present, more than 75% of State and local employees are covered.

Special rules of coverage apply to railroad workers and members of the uniformed services. Railroad workers have their own Federal insurance system that is closely coordinated with the Social Security program. If they have less than 10 years of railroad service, their railroad credits are transferred to the Social Security program. Under certain circumstances, members of the uniformed services may be given noncontributory wage credits in addition to the credits they receive for basic pay. The Social Security Trust Funds are reimbursed from Federal general revenues to finance noncontributory wage credits.

Eligibility for Benefits

To qualify for Social Security a person must be insured for benefits. Most types of benefits require fully insured status, which is obtained by acquiring a certain number of credits (also called

In 1997, workers earn one Social Security credit for each $670 of annual earnings, up to four credits ($2,680 = 4 credits) per year

quarters of coverage) from earnings in covered employment. The number of credits needed depends on the worker's age and type of benefit.

Workers can acquire up to four credits per year, depending on their annual covered earnings. In 1997, one credit is acquired for each $670 in covered earnings. This earnings figure is updated annually, based on increases in average wages.

Retirement and Survivors Insurance

Persons are *fully* insured for benefits if they have at least as many credits (acquired at any time after 1936) as the number of full calendar years elapsing after age 21 and before age 62, disability, or death, whichever occurs first. For workers who attained age 21 before 1951, the requirement is one credit for each year after 1950 and before the year of attainment of age 62, disability, or death. Persons reaching age 62 after 1990 need 40 credits to qualify for retirement benefits.

For workers who die before acquiring fully insured status, certain survivor benefits are payable if they were *currently* insured—that is, they acquired 6 credits in the 13-quarter period ending with the quarter in which they died.

Annual Earnings Test.—Beneficiaries may have some or all benefits withheld, depending on the amount of their annual earnings. Benefits payable to a spouse and/or child may also be reduced or withheld due to the earnings of the retired worker. This provision, known as the earnings test (or retirement test) is in line with the purpose of the program—to replace some of the earnings from work that are lost because of the worker's retirement, disability, or death.

1997 Earnings Test

Age 70
No limit

Age 65-69
$1 less for every $3 over $13,500

Under age 65
$1 less for every $2 over $8,640

The dollar amount beneficiaries can earn without having their benefits reduced depends on their age. Persons aged 70 or older receive full benefits regardless of their earnings. In 1997, benefits for persons under age 65 are reduced $1 for each $2 of annual earnings in excess of $8,640; benefits for persons aged 65-69 are reduced $1 for each $3 of earnings above $13,500.

The exempt amounts for persons aged 65-69 will increase gradually to $30,000 in 2002, while amounts for those under age 65 will be indexed to the growth in average wages. After the year 2002, amounts for persons aged 65-69 will also be indexed to increases in average wages.

A "foreign work test" applies to beneficiaries who work outside the United States in noncovered employment. Benefits are withheld for any month in which more than 45 hours of work is performed. Generally, any benefits to family members are also withheld. The test is based on the amount of time the beneficiary is employed rather than on the amount of money the beneficiary earns because

it is impractical to convert earnings in a foreign currency into specific dollar amounts.

Disability Insurance

To be eligible for disability benefits, workers must be fully insured and must meet a test of substantial recent covered work—that is, they must have credit for work in covered employment for at least 20 quarters of the 40 calendar quarters ending with the quarter the disability began. Young workers disabled before age 31 may qualify for benefits under a special insured status requirement. They must have credits in one-half the calendar quarters after age 21, up to the date of their disability, or, if disabled before age 24, one-half the quarters in the 3 years ending with the quarter of disability. Blind workers need only to be fully insured to qualify for benefits.

Disability Determination.—For purposes of entitlement, disability is defined as "the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months." A person's age, education, and work experience are considered along with the medical evidence in making a determination of disability. A less strict rule is provided for blind workers aged 55 or older. Such workers are considered disabled if, because of their blindness, they are unable to engage in SGA requiring skills and abilities comparable to those required in their past occupations.

Disability = the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

The impairment must be of a degree of severity that renders the individual unable to engage in any kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, or if a specific job vacancy exists for that person, or if that person would be hired upon application for the work. The amount of earnings that ordinarily demonstrates SGA is set forth in regulations. For nonblind beneficiaries, earnings averaging more than $500 a month are presumed to represent SGA, and earnings below $300 generally indicate the absence of SGA. The SGA level for statutorily blind beneficiaries is $1,000 a month.

Unlike the Retirement and Survivors Insurance program, which is an entirely Federal program, the law mandates Federal-State cooperation in carrying out the DI program. Each State's Disability Determination Services (DDS) develops the medical evidence and makes an initial determination of disability, after SSA determines that the applicant is insured for benefits. DDS costs are reimbursed to the States by the Federal Government.

The applicant may appeal an unfavorable decision through a four-step process taken in the following order: a reconsideration of

the initial decision; a hearing before an Administrative Law Judge; a review by the Appeals Council; and lastly, filing a civil suit in Federal District Court. A sample of DDS decisions is reviewed by SSA to assure consistency and conformity with national policies.

Applicants may be referred to the State vocational rehabilitation agency. If they are offered services and refuse them without good reason, benefits may be withheld. SSA pays for the cost of the rehabilitation services if such services result in a beneficiary's return to work at the SGA level for at least 9 continuous months.

Other Disabled Beneficiaries.—Monthly benefits at a permanently reduced rate are payable to disabled widow(er)s beginning at age 50, based on the same definition of disability that applies to workers. The disability must have occurred within 7 years after the spouse's death or within 7 years after the last month of previous entitlement to benefits based on the worker's earnings record.

Benefits are also payable to an adult child of a retired, disabled, or deceased worker if the child became disabled before age 22. The child must meet the same definition of disability that applies to workers.

Work Incentives.—Beneficiaries are allowed a trial work period to test their ability to work without affecting their eligibility for benefits. The trial work period can last up to 9 months (not necessarily consecutive) during which an individual's entitlement to benefits and benefit payment are unaffected by earnings, so long as the individual's impairment meets program standards. Months in which earnings are below a threshold amount, which is currently $200, do not count as months of trial work. At the end of the trial work period, a decision is made as to the individual's ability to engage in SGA. If the beneficiary is found to be working at SGA, disability benefits are paid for an additional 3 months (period of readjustment) and then cease; otherwise, benefits continue.

Work Incentives

- Trial work period
- Extended period of eligibility
- Work excluded as not SGA
- Elimination of second waiting period for both cash and Medicare benefits
- Medicare buy-in
- Impairment-related expenses

The law also includes other work incentive provisions: (1) A 36-month extended period of eligibility after a successful trial work period. This special benefit protection allows benefit payments during any month in the 36-month period in which earnings fall below $500. (2) The continuation of Medicare coverage for at least 39 months beyond the trial work period and, after that, the opportunity to purchase Medicare coverage when benefits terminate because of work. (3) Deductions from earnings for impairment-related work expenses in determining SGA. Deductible costs include such things as attendant care, medical devices, equipment, and prostheses.

Additionally, family benefits payable in disabled-worker cases are subject to a lower cap than the one that prevails for other types of benefits, because of concern that some disabled workers might be discouraged from returning to work because their benefits could exceed their predisability net earnings.

Type of Benefits

Monthly retirement benefits are payable at age 62 but are permanently reduced if claimed before the normal retirement age (currently, age 65). Benefits may also be payable to the spouse and children of retired-worker beneficiaries. A spouse receives benefits at age 62 or at any age if he/she is caring for a child under age 16 or disabled. A divorced spouse aged 62 or older who had been married to the worker for at least 10 years is also entitled to benefits. If the spouse has been divorced for at least 2 years, the worker who is eligible for benefits need not be receiving benefits for the former spouse to receive benefits. Benefits are payable to unmarried children under age 18, or aged 18-19 if they attend elementary or secondary school full time. A child can be the worker's natural child, adopted child, stepchild, and—under certain circumstances—a grandchild or stepgrandchild. A person aged 18 or older may also receive benefits under a disability that began before age 22.

Monthly benefits are payable to disabled workers after a waiting period of 5 full calendar months. This rule applies because Disability Insurance is not intended to cover short-term disabilities. Benefits terminate if the beneficiary medically improves and returns to work (at a substantial gainful activity level) despite the impairment. At age 65, beneficiaries are transferred to the retirement program. Benefits for family members of a disabled worker are payable under the same conditions as for those of retired workers.

Monthly benefits are payable to survivors of a deceased worker. A widow(er) married to the worker for at least 9 months (3 in the case of accidental death) may receive an unreduced benefit if claimed at age 65 (if the spouse never received a retirement benefit reduced for age). It is permanently reduced if claimed at age 60-64, and for disabled survivors at age 50-59. Benefits are payable to a widow(er) or surviving divorced spouse at any age who is caring for a child under age 16 or disabled. A surviving divorced spouse aged 60 or older is entitled to benefits if he or she had been married to the worker for at least 10 years. A deceased worker's dependent parent aged 62 or older may also be entitled to benefits.

Surviving children of deceased workers may receive benefits if they are under age 18, or are full-time elementary or secondary school students aged 18-19, or were disabled before age 22.

A lump sum of $255 is payable upon an insured worker's death, generally to the surviving spouse. If there is no surviving spouse or entitled child, no lump sum is payable.

Benefit Amounts

The OASDI benefit amount is based on covered earnings averaged over a period of time equal to the number of years the worker reasonably could have been expected to work in covered

Benefits payable and insured status requirements under Social Security

Type of benefit	Requirement for entitlement
Retired worker	Fully insured: • Age 65 or older (100% of PIA) • Age 62-64 (PIA reduced 5/9 of 1% (or 1/180) for each month of entitlement before age 65)
Disabled worker	Fully insured and has 20 quarters of coverage in the 40 calendar quarters ending with the disability onset: • Under age 65 • Under age 31, a special insured status requirement applies
Spouse or child (of a worker receiving retirement or disability benefits)	Spouse married to the worker for at least 1 year, or is the parent of the worker's child, and meets one of the following age requirements: • Any age, if caring for an entitled child who is under 16 or disabled (50% of the worker's PIA) • Age 65 (50% of the worker's PIA) • Age 62 or older (50% of the worker's PIA, permanently reduced for each month of the spouse's entitlement before age 65) Divorced spouse, married to the worker for at least 10 years, and meets one of the following age requirements: • Age 65 or older (50% of the worker's PIA) • Age 62-65 (50% of the worker's PIA, permanently reduced for each month of the spouse's entitlement before age 65) Child: • Under age 18 and unmarried (50% of the worker's PIA) • Attending elementary or secondary school full time at age 18 and through the end of the school term in which age 19 is attained (50% of the worker's PIA) • Disabled child, age 18 or older, who was disabled before age 22 (50% of the worker's PIA)
Survivors (of a deceased worker)	Widow/widower: • Married to the worker at least 9 months (3 months in the case of accidental death), or is the parent of the worker's child, and meets one of the following age requirements: – Any age, caring for an entitled child who is under age 18, or disabled (75% of the worker's PIA) – Age 65 (100% of worker's PIA) – Age 60-64 (permanently reduced benefit) – Age 50-59 and disabled (permanently reduced benefit) • Surviving divorced spouse, married to the worker at least 10 years, aged 60 or older (permanently reduced benefit if entitled before age 65) • Surviving divorced spouse, regardless of length of marriage, of any age caring for an entitled child of the deceased worker (75% of the worker's PIA) Child: • Under age 18 and unmarried (75% of the worker's PIA) • Attending elementary or secondary school full time at age 18 and through end of school term in which age 19 is attained (75% of the worker's PIA)

Benefits payable and insured status requirements under Social Security—*Continued*

Type of benefit	Requirement for entitlement
	• Disabled child, aged 18 or older, who was disabled before age 22 (75% of worker's PIA)
	Dependent parent aged 62 or older: • One surviving parent (82½% of the worker's PIA) • Two surviving parents (75% of the worker's PIA payable to each parent)
	Lump-sum death payment: • A one-time amount of $255 is payable, upon the death of an insured worker, to a spouse with whom the worker was living at the time of death or to a spouse or child who is eligible for monthly survivor benefits for the month of the worker's death

Note: Auxiliary and survivor benefits are subject to a family maximum amount.

employment. Specifically, the number of years in the averaging period equals the number of full calendar years after 1950 (or, if later, after age 21) and up to the year in which the worker attains age 62, becomes disabled, or dies. In survivor claims, earnings in the year of the worker's death may be included. In general, 5 years are excluded. Fewer than 5 years are disregarded in the case of a worker disabled before age 47. The minimum length of the averaging period is 2 years.

For persons who were first eligible (attained age 62, became disabled, or died) after 1978, the actual earnings are indexed—updated to reflect increases in average wage levels in the economy. For persons first eligible before 1979, the actual amount of covered earnings is used in the computations. After a worker's average indexed monthly earnings (AIME) or average monthly earnings (AME) have been determined, a benefit formula is applied to determine the worker's primary insurance amount (PIA), on which all Social Security benefits related to the worker's earnings are based. The benefit formula is weighted to replace a higher portion of lower paid workers' earnings than of higher paid workers' earnings (although higher paid workers will always receive higher benefits).

For persons first eligible for benefits in 1997, the formula is:

90% of the first $455 of AIME, plus
32% of next $2,286 of AIME, plus
15% of AIME over $2,741.

The dollar amounts defining the AIME brackets are adjusted annually based on changes in average wage levels in the economy. As a result, initial benefit amounts will generally keep pace with future increases in wages. A special minimum PIA is payable to persons who have had covered employment or self-employment for many years at low earnings. It applies only if the

resulting payment is higher than the benefit computed by the regular formula.

Persons who retire at age 65 (in 1997), with average earnings, have 45% of their prior year's earnings replaced by Social Security benefits. For those with maximum earnings the replacement rate is 25%; for minimum earners, 61%. The PIA is $1,326 for workers whose earnings were at or above the maximum amount that counted for contribution and benefit purposes each year and who retire at age 65 in 1997.

Earnings replaced by Social Security benefits

Pre-retirement earnings replaced (Workers retiring at age 65 in 1997)		Disabled workers earnings replaced (Workers age 45 in 1997)	
Maximum earnings	$62,700	Maximum earnings	$62,700
Worker	25.4%	Worker	27.7%
Worker/spouse	38.1%	Worker/spouse	41.5%
Average earnings	$24,706	Average earnings	$24,706
Worker	45.3%	Worker	44.8%
Worker/spouse	67.9%	Worker/spouse	67.2%
Low earnings	$11,118	Low earnings	$11,118
Worker	61.0%	Worker	60.4%
Worker/spouse	91.4%	Worker/spouse	85.0%

After the initial benefit amount has been determined for the year of first eligibility, the amount is increased automatically each December (payable in the January checks) to reflect any increase in the Consumer Price Index. The 1997 cost-of-living adjustment is 2.9%. The benefit may be recomputed if, after retirement, the worker has additional earnings that produce a higher PIA.

The monthly benefit for a worker retiring at age 65 is equal to the PIA rounded to the next lower multiple of $1. For workers retiring before age 65, the benefit is actuarially reduced to take account of the longer period over which they will receive benefits. Currently, a worker who retires at age 62 receives 80% of the full benefit amount (20% reduction). The benefit is reduced 5/9 of 1% for each month of entitlement before age 65. The maximum reduction is 20% for those entitled to benefits for all 36 months between ages 62-65. A spouse who begins to receive benefits at age 62 receives 75% of the amount that would have been payable at age 65; a widow(er) at age 60 will be paid 71-1/2% of the deceased spouse's PIA, as will a disabled widow(er) aged 50-59.

The normal retirement age (the age of eligibility for unreduced benefits) will be increased gradually from 65 to 67 beginning with workers who reach age 62 in the year 2000. The normal retirement age will be increased by 2 months per year in two stages—2000-2005 and 2017-2022—until it reaches age 67 for workers attaining age 62 in 2022 and later. During 2006-2016, the normal retirement age will remain at 66 for workers attaining age 62 in that period. Benefits will continue to be payable at age 62 for retired workers

and their spouses and at age 60 for widow(er)s, but the maximum benefit reduction for workers and spouses will be greater. Workers retiring before the normal retirement age will have benefits reduced by 5/9 of 1% for the first 36 months of receipt of benefits immediately preceding age 65, plus 5/12 of 1% for months in excess of 36 months (maximum reduction 30%).

Age for full Social Security benefits

Retirees, spouses, and divorced spouses		Widow(er)s and divorced widow(er)s	
Full benefit at age	Date of birth*	Full benefit at age	Date of birth*
65	Prior to 1938	65	Prior to 1940
65 and 2 months	1938	65 and 2 months	1940
65 and 4 months	1939	65 and 4 months	1941
65 and 6 months	1940	65 and 6 months	1942
65 and 8 months	1941	65 and 8 months	1943
65 and 10 months	1942	65 and 10 months	1944
66	1943–1954	66	1945–1956
66 and 2 months	1955	66 and 2 months	1957
66 and 4 months	1956	66 and 4 months	1958
66 and 6 months	1957	66 and 6 months	1959
66 and 8 months	1958	66 and 8 months	1960
66 and 10 months	1959	66 and 10 months	1961
67	1960 or later	67	1962 or later

*Month and date are January 2 unless otherwise shown.

Similarly, spouses of retired workers electing benefits before the normal retirement age in effect at the time will have their benefits reduced 25/36 of 1% for each of the first 36 months and 5/12 of 1% for up to 24 earlier months (maximum reduction 35%).

Workers who retire after age 65 have their benefits increased based on the delayed retirement credit. The credit is 5.0% of the PIA per year for workers attaining age 65 in 1996-97. It will increase gradually until it reaches 8% per year for workers attaining age 66 in 2009 or later.

Benefits for eligible family members are based on a percentage of the worker's PIA. A spouse or child may receive a benefit of up to 50% of the worker's PIA. A surviving widow's or widower's benefit is equal to as much as 100% of the amount of the deceased worker's PIA. The benefit of a surviving child is 75% of the worker's PIA.

The law sets a limit on the total monthly benefit amount to workers and their eligible family members. This limitation assures that the families are not considerably better off financially after the retirement, disability, or death of the worker than they were while the worker was employed.

Persons eligible for benefits based on their own earnings and as an eligible family member or survivor (generally as a wife or

widow) will receive the full amount of the worker benefit, plus an amount equal to any excess of the other benefit over their own—in effect, the larger of the two.

Benefits for disabled workers are computed in much the same way as are benefits for retired workers. Benefits to the family members of disabled workers are paid on the same basis as those to the family of retired workers. The limitation on family benefits is, however, somewhat more stringent for disabled-worker families than for retired-worker or survivor families.

Taxation of Benefits

Up to 85% of Social Security benefits may be subject to Federal income tax depending on the taxpayer's amount of income (under a special definition) and filing status. The applicable definition of income is:

> Adjusted gross income (before Social Security or Railroad Retirement benefits are considered), plus tax-exempt interest income—with further modification of adjusted gross income in some cases involving certain tax provisions of limited applicability among the beneficiary population—plus one-half of Social Security and Tier I Railroad Retirement benefits.

For married taxpayers filing jointly whose income under this definition is between $32,000 and $44,000, the amount of benefits included in gross income is the lesser of one-half of Social Security and Tier I Railroad Retirement benefits or one-half of income over $32,000. If their income exceeds $44,000, the amount of benefits included in gross income is the lesser of (1) 85% of Social Security and Tier I railroad retirement benefits or (2) the sum of $6,000 plus 85% of income over $44,000.

For married taxpayers filing separate returns, no exempt amounts are applicable. The amount of benefits included in the gross income is the lesser of 85% of Social Security or Tier I Railroad Retirement benefits, or 85% of income (as defined above). For individuals in all other filing categories, the amount of benefits to be included in gross income is determined in a manner analogous to that for married taxpayers filing jointly. The difference lies in the lower amounts of gross income exempted.

Financing

The OASDI program requires workers and their employers and self-employed persons to pay taxes on earnings in covered jobs up to the annual taxable maximum ($65,400 in 1997). This amount is automatically adjusted as wages rise. These taxes are deposited in two separate trust funds—the OASI Trust Fund and the DI Trust Fund.

The money received by the trust funds can be used only to pay

the benefits and operating expenses of the program. Money not needed currently for these purposes is invested in interest-bearing securities guaranteed by the U.S. Government.

In addition to the Social Security taxes, trust fund income includes amounts transferred from the general fund of the U.S. Treasury, income from the taxation of benefits, and interest on invested assets of the funds. Transfers from the general fund include payments for gratuitous military service wage credits and for limited benefits to certain very old persons who qualify under special insured status requirements. Interest income on trust fund assets is derived from securities guaranteed by the U.S. Government.

Based on 75-year actuarial forecasts, a schedule of current and future tax rates designed to produce sufficient revenues, together with other revenues, to finance the program over the long range is set forth in the law. This schedule also specifies what portion of total revenues collected is to be allocated to each of the Social Security programs.

Tax Rate

Maximum taxable amount of earnings
$62,700

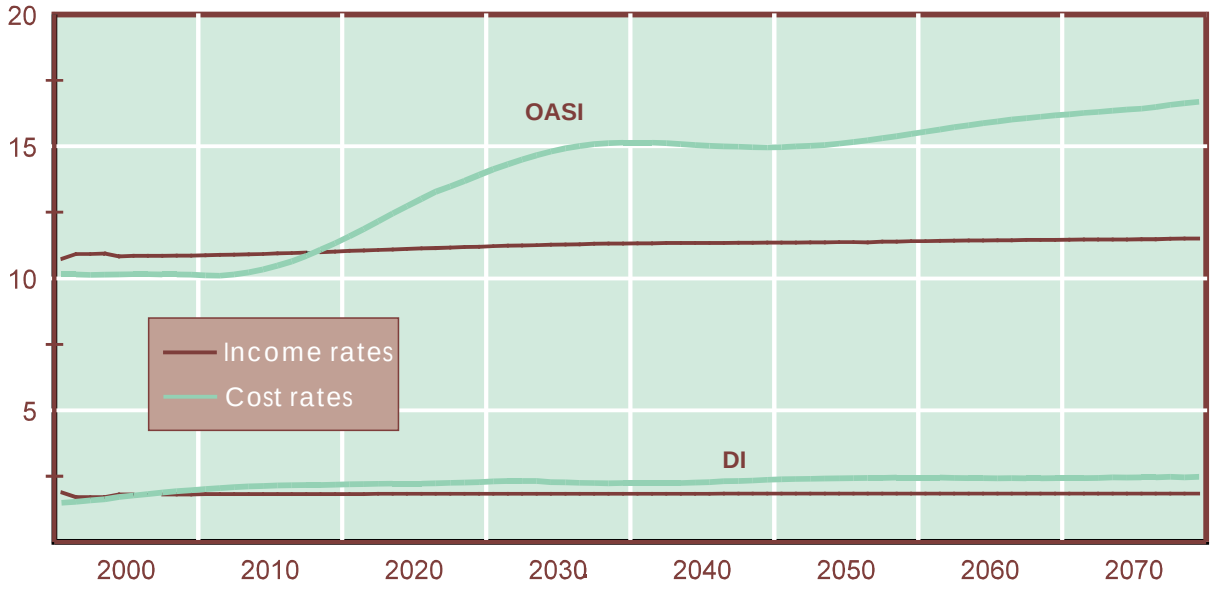
Tax rate for—
Employers and employees each
6.20%

Self-employed persons
12.40%

The OASDI tax rate is 6.20% each for employees and employers. Self-employed persons pay at the combined employee-employer rate, or 12.40%. (Note: Medicare (HI) taxes are paid on total earnings. The tax rate, for both employee and employer is 1.45%.)

For self-employed persons, two deduction provisions reduce their OASDI and income tax liability. The intent of these provisions is to treat the self-employed in much the same manner as employees and employers are treated for purposes of Social Security and income taxes. The first provision allows persons to deduct

Income rates and cost rates



Source: OASDI Trustees' Report.

Administrative expenses for OASDI were $3.0 billion in CY '96, or about 0.9% of benefit payments in the year

from their net earnings from self-employment an amount equal to one-half their Social Security taxes. The effect of this deduction is intended to be analogous to the treatment of the OASDI tax paid by the employer, which is disregarded as remuneration to the employee for OASDI and income tax purposes. The second provision allows a Federal income tax deduction, equal to one-half of the amount of the self-employment taxes paid, which is designed to reflect the income tax deductibility of the employer's share of the OASDI tax.

A Board of Trustees is responsible for managing the OASDI Trust Funds and for reporting annually to Congress on the financial and actuarial status of the trust funds. This Board is comprised of six members—four of whom serve automatically by virtue of their positions in the Federal Government: The Secretary of the Treasury, who is the Managing Trustee, the Secretary of Labor, the Secretary of Health and Human Services, and the Commissioner of Social Security. The other two members are appointed by the President and confirmed by the Senate to serve as public representatives.

Administration

The Commissioner of Social Security is responsible for administering the OASDI program (except for the collection of FICA taxes, which is performed by the Internal Revenue Service of the Department of the Treasury), the preparation and mailing of benefit checks (or the payment of benefits through direct deposit), and the management and investment of the trust funds, which is supervised by the Secretary of the Treasury as Managing Trustee. The Commissioner is appointed by the President and confirmed by the Senate for a 6-year term.

A bipartisan Advisory Board, which is composed of seven members who serve 6-year terms, examines issues regarding the Social Security system and advises the Commissioner on policies related to the OASDI (and SSI) programs.

The Social Security number (SSN) is the method used for posting and maintaining the earnings and employment records of persons covered under the Social Security program.

Employers withhold FICA taxes from their employees' paychecks and forward these amounts, along with an equal amount of employer tax, to the IRS on a regular schedule. By the end of February, employers file wage reports (Form W-2) with the Social Security Administration showing the wages paid to each employee during the preceding year. In turn, SSA shares this information with the IRS. Self-employed persons report their earnings for Social Security purposes and pay SECA taxes in connection with their Federal income tax return. Information from self-employment income reports is sent by IRS to SSA.

Reported earnings are posted to the worker's earnings record at SSA headquarters in Baltimore, Maryland. When a worker or his

or her family member applies for Social Security benefits, the worker's earnings record is used to determine the claimant's eligibility for benefits and the amount of any cash benefits payable.

Payment is certified by SSA to the Department of the Treasury, which, in turn, mails out benefit checks or deposits the proper amounts directly into the beneficiary's bank account.

SSA's administrative offices and computer operations are located in its central office in Baltimore, Maryland. The Office of Disability and International Operations are also at that location. Program service centers in New York City, Philadelphia, Birmingham, Chicago, Kansas City (Missouri), and Richmond (California) certify benefit payments to the Department of the Treasury's Regional Disbursing Centers, maintain beneficiary records, review selected categories of claims, collect debts, and provide a wide range of other services to beneficiaries.

In addition, SSA has a nationwide network of about 1,300 field offices. The field operations are directed by Regional Commissioners and their staffs. Personnel in the field installations are the main points of public contact with SSA. They issue Social Security numbers, help claimants file applications for benefits, adjudicate Retirement and Survivors Insurance claims and help determine the amounts of benefits payable, and forward disability claims to a State DDS for a determination of disability. In calendar year 1995, administrative expenses of SSA amounted to $3.1 billion, or 0.9% of total benefits payable.

SSA also provides personal and automated services through its toll-free telephone number (1-800-772-1213). The 800-number network received about 62.3 million calls in calendar year 1995.

The Office of Hearings and Appeals administers the nationwide hearings and appeals program for SSA. The Appeals Council, located in Falls Church, Virginia, reviews hearing decisions.

Social Security and Foreign Systems

Through international "totalization" agreements, the U.S. Social Security program is coordinated with the programs of other countries. These agreements benefit both workers and employers. First, they eliminate dual coverage and taxation when persons from one country work in another country and are required to pay social security taxes to both countries for the same work. Second, they prevent the loss of benefit protection for workers who have divided their careers between two or more countries.

The agreements allow SSA to totalize U.S. and foreign coverage credits only if the worker has at least six quarters of U.S. coverage. Similarly, a person may need a minimum amount of coverage under the foreign system in order to have U.S. coverage counted toward meeting the foreign benefit eligibility requirements. The United States currently has Social Security agreements in effect with 17 countries (Austria, Belgium, Canada, Finland,

France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the United Kingdom).

Beneficiaries and average benefit amounts under U.S. totalization agreements, December 1995

Austria	314	$182.07
Belgium	260	$155.84
Canada	25,721	$110.13
Finland	28	$167.25
France	1,748	$136.40
Germany	7,694	$199.93
Greece	120	$107.92
Ireland	264	$138.92
Italy	5,098	$119.26
Netherlands	653	$120.52
Norway	1,750	$136.92
Portugal	964	$113.45
Spain	909	$113.72
Sweden	523	$135.58
Switzerland	1,509	$132.77
United Kingdom	7,251	$162.60

Country	Agreement
Italy	1979
Germany	1979
Switzerland	1980
Belgium	1984
Norway	1984
Canada	1984
United Kingdom	1985
Sweden	1987
Spain	1988
France	1988
Portugal	1989
Netherlands	1990
Austria	1991
Finland	1982
Ireland	1993
Luxembourg	1993
Greece	1994

Benefits are generally payable to U.S. citizens regardless of where they reside. Benefits cannot be paid to an alien who is outside the United States for more than 6 months unless that person meets one of several exceptions in the law. For example, an exception is provided if (1) the worker on whose earnings the benefit is based had acquired at least 40 credits or had resided in the United States for at least 10 years, or (2) nonpayment of benefits would be contrary to a treaty obligation of the United States, or (3) the alien is a citizen of a country that has a social insurance or pension system of general applicability that provides for the payment of benefits to qualified U.S. citizens who are outside that country. Even if they qualify under these exceptions, aliens who are first eligible after 1984 for benefits as family members or survivors generally must also have resided in the United States for 5 years and been related to the worker during that time. Benefits are not payable to an alien living in a country in which the mailing of U.S. Government checks is prohibited.

Unemployment Insurance

Unemployment insurance was initiated on a national basis in the United States as Title III and Title IX of the Social Security Act of 1935. It is a Federal-State coordinated program. Each State administers its own program within national guidelines promulgated under Federal law.

The program is designed to provide partial income replacement to regularly employed members of the labor force who become involuntarily unemployed. To be eligible for benefits a worker must register at a public employment office, must have a prescribed amount of employment and earnings during a specified base period, and be available for work and able to work. In most States, the base period is the first four quarters of the last five completed calendar quarters preceding the claim for unemployment benefits.

The amount of the weekly benefit amount a worker may receive while unemployed varies according to the benefit formula used by each State and the amount of the worker's past earnings. All States establish a ceiling on the maximum amount a worker may receive.

The number of weeks for which unemployment benefits can be paid ranges from 1 to 39 weeks. The most common duration is 26 weeks for the regular permanent program. Workers who have exhausted their unemployment benefits in the regular program may be eligible for additional payments for up to 13 weeks under a permanent program for extended benefits during periods of very high unemployment. Federal unemployment benefits have been established for several groups, including Federal military and civilian personnel.

The Department of Labor is responsible for ascertaining that the State unemployment insurance programs conform with Federal requirements. Unemployment benefits and funding for administration of the program generally are financed from taxes paid by employers on workers' earnings up to a set maximum.

Background

In 1932, the State of Wisconsin established the first unemployment insurance law in the United States, which served as a forerunner for the unemployment insurance provisions of the Social Security Act of 1935. The existence of the Wisconsin law, concerns over the constitutionality of an exclusively Federal system, and uncertainties about untried aspects of administration were among the factors that led to the Federal-State character of the system (unlike the old-age insurance benefit provisions of the Social Security legislation, which are administered by the Federal Government alone).

The Social Security Act provided two inducements to the States to enact unemployment insurance laws. A uniform national tax was imposed on the payrolls of industrial and commercial employers who employed 8 or more workers in 20 or more weeks

in a calendar year. Employers who paid a tax to a State with an approved unemployment insurance law could credit up to 90% of their State tax against the national tax. Thus, employers in States without an unemployment insurance law would have little advantage in competing with similar businesses in States with such a law, because they would still be subject to the Federal payroll tax. Moreover, their employees would not be eligible for benefits. As a further inducement, the Social Security Act authorized grants to States to meet the costs of administering their systems.

By July 1937, all 48 States, the then territories of Alaska and Hawaii, and the District of Columbia had passed unemployment insurance laws. Puerto Rico later established its own unemployment insurance program, which was incorporated into the Federal-State system in 1961. Similarly, a program for workers in the Virgin Islands was added in 1978.

Federal law requires State unemployment insurance programs to meet certain requirements if employers are to receive their offset against the Federal tax and if the State is to receive Federal grants for administration. These requirements are intended to assure that State systems are fairly administered and financially secure.

One of these requirements is that all contributions collected under State laws be deposited in the unemployment trust fund in the Department of the Treasury. The fund is invested as a whole, but each State has a separate account to which its deposits and its share of interest on investments are credited. A State may withdraw money from its account at any time, but only to pay benefits.

Thus, unlike the workers' compensation and temporary disability insurance benefits in the majority of States, unemployment insurance benefits are paid exclusively through a public fund. Private plans cannot be substituted for the State plan.

Aside from Federal standards, each State has major discretion regarding the content and development of its unemployment insurance law. The State itself decides the amount and duration of benefits (except for certain Federal requirements concerning Federal-State Extended Benefits); the contribution rates (within limits); and, in general, eligibility requirements and disqualification provisions. The States also directly administer their programs—collecting contributions, maintaining wage records (where applicable), taking claims, determining eligibility, and paying benefits to unemployed workers.

Coverage

At the end of 1995, approximately 113 million workers were in jobs covered by unemployment insurance. Originally, coverage was limited to employment covered by the Federal Unemployment Tax Act (FUTA), primarily industrial and commercial workers in private industry. However, several Federal laws (such as the Employment Security Amendments of 1970 and the Unemployment Compensation Amendments of 1976) substantially increased both the

number and types of workers protected under the State programs.

Private employers in industry and commerce are subject to the law if they employ one or more individuals on 1 day in each of 20 weeks during the current or preceding year, or if they paid total wages of $1,500 or more during any calendar quarter in the current or preceding year.

Agricultural workers are covered on farms with a quarterly payroll of at least $20,000 or employing 10 or more persons in 20 weeks of the year. A domestic employee in a private household is subject to FUTA if its employer paid wages of $1,000 or more in a calendar quarter. Self-employed individuals and workers employed by their own families are excluded from coverage.

Before 1976, State and local government and most nonprofit organizations were exempt from FUTA. However, most employment in these groups now must be covered by State law as a condition for securing Federal approval. Local governments and nonprofit employers have the option of making contributions as under FUTA, or of reimbursing the State for benefit expenditures actually made.

Elected officials, legislators, members of the judiciary, and the State National Guard are still excluded, as are employees of nonprofit organizations that employ fewer than four workers in 20 weeks in the current or preceding calendar year. However, many States have extended coverage beyond the minimum required by Federal legislation.

Federal civilian employees and ex-servicemembers have been brought under the unemployment insurance system through special Federal legislation. Their benefits are financed through Federal funds, but administered by the States and paid in accordance with State laws. Railroad workers are covered by a separate unemployment insurance law enacted by Congress. (This law is described in the section on programs for railroad workers.)

Eligibility for Benefits

Unemployment benefits are available as a matter of right (that is, without a means test) to unemployed workers who have demonstrated their attachment to the labor force by a specified amount of recent work and/or earnings in covered employment. All workers whose employers contribute to or make payments in lieu of contributions to State unemployment funds are eligible if they become involuntarily unemployed and are able to work, available for work, and actively seeking work.

Workers must also meet the eligibility and qualifying requirements of the State law. Workers who meet these eligibility conditions may still be denied benefits if they are found to be responsible for their own unemployment.

The benefit may be reduced if the worker is receiving certain types of income—pension, back pay, or workers' compensation for temporary partial disability. Unemployment benefits are subject to Federal income taxes.

Work Requirements

A worker's monetary benefit rights are based on his or her employment in covered work over a prior reference period, called the "base period," and these benefit rights remain fixed for a "benefit year." In most States, the base period is the first four quarters of the last five completed calendar quarters preceding the claim for benefits.

Six States specify a flat minimum amount of base period earnings, ranging from $1,000 to $2,964, to qualify. One-fourth of the States express their earnings requirements in terms of a multiple of the benefit for which the individual will qualify (such as 30 times the weekly benefit amount). Most of these jurisdictions, however, have an additional requirement that wages be earned in more than one calendar quarter or that a specified amount of wages be earned in the calendar quarter other than that in which the claimant had the most wages.

Almost half the States simply require base period wages totaling a specified multiple—commonly 1-1/2 of the claimant's high-quarter wages. Seven States require a minimum number of weeks of covered employment (minimum number of hours in one State), generally reinforced by a requirement of an average or minimum amount of wages per week.

If the unemployed worker meets the State requirements, his or her eligibility extends throughout a "benefit year," a 52-week period usually beginning on the day or the week for which the worker first filed a claim for benefits. No State permits a claimant who received benefits in one benefit year to qualify for benefits in a second benefit year unless he or she had intervening employment.

Other Requirements

All States require that for claimants to receive benefits, they must be able to work and must be available for work—that is, they must be in the labor force and their unemployment must be due to lack of work. One evidence of ability to work is the filing of claims and registration for work at a State public employment office. Most State agencies also require that the unemployed worker make an independent job-seeking effort.

Eleven States have added a proviso that no individual who has filed a claim and has registered for work shall be considered ineligible during an uninterrupted period of unemployment because of illness or disability, so long as no work, which is considered suitable but for the illness or disability, is offered and refused after becoming

ill or disabled. In Massachusetts the period during which benefits will be paid is limited to 3 weeks and in Alaska 6 consecutive weeks.

Most States have special disqualification provisions that specifically restrict the benefit rights of students who are considered not available for work while attending school. Federal law also restricts benefit eligibility of some groups of workers under specified conditions: school personnel between academic years, professional athletes between sports seasons, and aliens not present in the United States under color of law.

The major reasons for disqualification for benefits are voluntary separation from work without good cause; discharge for misconduct connected with the work; refusal, without good cause, to apply for or accept suitable work; and unemployment due to a labor dispute. In all jurisdictions, disqualification serves at least to delay receipt of benefits. The disqualification may be for a specific uniform period, for a variable period, or for the entire period of unemployment following the disqualifying act. Some States not only postpone the payment of benefits but also reduce the amount due to the claimant. However, benefit rights cannot be eliminated completely for the whole benefit year because of a disqualifying act other than discharge for misconduct, fraud, or because of disqualifying income (that is, workers' compensation, holiday pay, vacation pay, back pay, and dismissal payments). Also, no State may deny unemployment insurance benefits when a claimant undergoes training in an approved program.

The Federal Unemployment Tax Act also provides that no State can deny benefits if a claimant refuses to accept a new job under substandard labor conditions, or where required to join a company union or to resign from or refrain from joining any bona fide labor organization. However, in all States unemployment due to labor disputes results in postponing benefits, generally for an indefinite period depending on how long the unemployment lasts because of the dispute. State laws vary as to how this disqualification applies to workers not directly involved.

Under Federal law, States are required under certain conditions to reduce the weekly benefit by the amount of any governmental or other retirement or disability pension, including Social Security benefits and Railroad Retirement annuities. States may reduce benefits on a less than dollar-for-dollar basis to take into account prior contributions by the worker to the pension plan.

In nearly half the States, workers' compensation either disqualifies the worker for unemployment insurance for the week concerned, or reduces the unemployment insurance benefit by the amount of the workers' compensation. Wages in lieu of notice or dismissal payments also disqualify a worker for benefits or reduce his or her weekly benefit in half the States.

Types and Amounts of Benefits

During 1995, the average weekly number of persons paid unemployment benefits under the regular programs (including State programs and programs for Federal employees and ex-servicemembers) was 2.6 million. Benefit payments totaled $21.9 billion, of which $21.3 billion was expended under State programs and $640 million to Federal employees and ex-servicemembers. The average weekly benefit was $187 and the average duration was 14.7 weeks.

Under all State laws, the amount payable for a week of total unemployment varies with the worker's past wages within minimum and maximum limits. In most of the States, the formula is designed to compensate for a fraction of the usual weekly wage (normally about 50%), subject to specified dollar maximums. The benefits provisions under State unemployment insurance laws are shown in Appendix III.

Three-fourths of the laws specify a formula that computes weekly benefits as a fraction of wages in one or more quarters of the base period—most commonly, the quarter during which wages were highest, because this quarter most nearly reflects full-time work. In most of these States, the same fraction is used at all benefit levels. The other laws provide for a weighted schedule that gives a greater proportion of high-quarter wages to lower-paid workers. Six States compute the weekly benefit amount as a percentage of annual wages, and five States base it directly on average weekly wages during a specified recent period.

Each State establishes a maximum weekly benefit, either a fixed dollar amount or a flexible ceiling. Under the latter arrangement, adopted in 35 jurisdictions, the maximum is adjusted automatically in accordance with the weekly wages of covered employees and is expressed as a percentage of the Statewide average—varying from 49.5% to 70%. Such provisions remove the need for amending the maximum as wage levels change.

The maximum weekly benefit for all States varies from $133 to $362 (excluding allowances for dependents provided by 13 jurisdictions). Because statutory increases in the maximum tend to lag behind increases in wage levels, the maximum in States with fixed amounts often reduces the benefit amounts of workers to below the 50% level. Minimum benefits—ranging from $5 to $87 a week—are provided in every State.

All States pay the full weekly benefit amount when a claimant has had some work during the week, but has earned less than a specified (relatively small) sum. In the majority of States, this amount is defined as a wage that is earned in a week of less than full-time work and that is less than the claimant's regular weekly benefit amount. All States also provide for the payment of reduced weekly benefits—partial payments—when earnings exceed that specified amount.

Twelve States and the District of Columbia provide additional

allowances for certain dependents. They all include children under specified ages (16, 18, or 19 and, generally, older if incapacitated); nine States provide for a nonworking spouse; and three States cover other dependent relatives. The amount paid per dependent varies considerably by State but generally is $20 or less per week and, in the majority of States, it is the same for each dependent.

All but 11 States require a waiting period of one week of total unemployment before benefits can begin. Three States pay waiting-period benefits retroactively if unemployment reaches a certain duration or if the employee returns to work within a specified time.

All but two jurisdictions set a statutory maximum of 26 weeks of benefits in a benefit year. However, only nine jurisdictions provide the same maximum for all claimants. The remaining 44 jurisdictions vary the duration of benefits through formulas that relate potential duration to the amount of former earnings or employment—generally by limiting total benefits to a certain fraction of base period earnings or to a specified multiple of the weekly benefit amount, whichever is less.

Extended Benefits

In the 1970's, a permanent Federal-State program of extended benefits was established for workers who exhaust their entitlement to regular State benefits during periods of high unemployment. The program is financed equally from Federal and State funds. Extended Benefits are triggered when unemployment among insured workers in an individual State averages 5% or more over a 13-week period, and is at least 20% higher than the rate for the same period in the 2 preceding years. If the insured unemployment rate reaches 6% a State may, at its discretion, disregard the 20% requirement.

Once triggered, extended benefit provisions remain in effect for at least 13 weeks. When a State's benefit period ends, extended benefits to individual workers also end, even if they have received less than their potential entitlement and are still unemployed. Further, once a State's benefit period ends, another Statewide period cannot begin for at least 13 weeks.

Most eligibility conditions for extended benefits are determined by State law (and they are payable at the same rate as the regular State weekly amount). However, under Federal law a claimant applying for extended benefits must have had 20 weeks in full-time employment (or the equivalent in insured wages) and must meet special work requirements. A worker who has exhausted regular benefits is eligible for a 50% increase in duration, to a maximum of 13 weeks of extended benefits. There is, however, an overall maximum of 39 weeks of regular and

UI summary data, calendar year 1996 (third quarter)

[Benefits paid in millions]

State	Regular[1]	Average weekly benefit	Average compensable duration (in weeks)
United States	$4,736,798	$183.02	14.92
Alabama	51,002	141.40	10.41
Alaska	18,919	168.87	15.01
Arizona	46,806	147.60	14.31
Arkansas	38,969	169.32	12.14
California	652,690	152.81	16.97
Colorado	41,488	206.67	12.45
Connecticut	98,849	213.81	16.60
Delaware	23,866	230.06	15.58
District of Columbia	25,151	233.58	19.08
Florida	191,370	175.09	14.27
Georgia	71,448	164.69	9.59
Hawaii	47,624	206.58	16.47
Idaho	14,790	176.13	12.19
Illinois	260,999	204.26	17.20
Indiana	49,066	177.48	11.19
Iowa	32,819	196.45	12.08
Kansas	32,114	201.66	13.42
Kentucky	46,651	170.49	12.31
Louisiana	35,163	127.85	14.32
Maine	19,044	170.20	14.07
Maryland	78,946	193.00	15.77
Massachusetts	167,770	246.13	16.35
Michigan	192,969	133.54	11.45
Minnesota	59,372	218.51	14.64
Mississippi	32,312	140.61	13.64
Missouri	63,007	150.54	13.35
Montana	9,605	159.52	14.20
Nebraska	10,373	156.34	11.54
Nevada	31,910	192.91	13.85
New Hampshire	8,611	158.81	9.61
New Jersey	309,518	247.86	17.31
New Mexico	18,018	160.53	16.20
New York	445,592	203.73	19.65
North Carolina	89,526	194.13	9.22
North Dakota	4,519	167.21	12.57
Ohio	137,334	197.23	13.66
Oklahoma	24,620	173.92	12.78
Oregon	84,489	191.02	15.45
Pennsylvania	340,281	205.43	16.81
Puerto Rico	55,940	93.87	18.61
Rhode Island	40,421	220.59	15.61
South Carolina	48,328	166.19	10.94
South Dakota	2,563	144.42	10.94
Tennessee	72,653	155.34	11.88
Texas	247,676	187.77	15.69
Utah	13,892	196.22	10.74
Vermont	9,664	162.38	14.50
Virginia	41,346	173.29	10.22
Virgin Islands	1,237	160.74	15.62
Washington	174,178	211.67	18.57
West Virginia	28,395	174.70	14.86
Wisconsin	87,869	192.59	12.10
Wyoming	5,038	180.69	14.39

[1] Includes extended benefits of $527 million in Alaska and $8,817 million in Puerto Rico.

Source: U.S. Department of Labor, Unemployment Insurance Service, Division of Actuarial Services, *UI Data Summary, December 1996.*

extended benefits. Because of the way extended benefits were triggered, only nine jurisdictions qualified for them during the economic downturn of 1991.

The Unemployment Compensation Amendments of 1992 (P.L. 102-318), modified the permanent Extended Benefits program to provide more effective protection on an ongoing basis. Effective March 7, 1993, States had the option of amending their laws to use alternative total unemployment rate triggers, in addition to the current insured unemployment rate triggers. Under this option, extended benefits would be paid when the State's seasonally adjusted total unemployment rate for the most recent 3 months is at least 6.5%, and that rate is at least 110% of the State average total unemployment rate in the corresponding 3-month period in either of the 2 preceding years.

States triggering the extended benefits program using other triggers would provide the regular 26 weeks of unemployment benefits, in addition to 13 weeks of extended benefits (the same number provided previously). States that have opted for the total unemployment rate trigger will also amend their State laws to add an additional 7 weeks of extended benefits (for a total of 20 weeks) when the total unemployment rate is at least 8% and is 110% of the State's total unemployment rate for the same 3 months in either of the 2 preceding years.

Financing

The Unemployment Trust Fund in the Federal unified budget contains a separate account for each of the States, the District of Columbia, the Virgin Islands, and Puerto Rico. These 53 jurisdictions deposit their respective unemployment taxes in their accounts and withdraw funds to cover the costs of regular State benefits and half of the extended benefits program. Three additional Federal accounts are for administration, extended benefits, and loans to States; they are funded by the Federal unemployment tax.

Effective January 1985, all employers covered by the Federal Unemployment Tax Act are charged 6.2% of the first $7,000 annually for each worker's covered wages. However, employers do not actually pay the full amount because they credit toward their Federal tax the payroll tax contributions that they paid into a State unemployment insurance program. Their credit may also include any savings on the State tax achieved under an approved experience rating plan, as described below.

The credit available to employers in a State may be reduced if the State has fallen behind on repayment of loans to the Federal Government. Many States have taken out such loans when their reserves were depleted during periods of high unemployment. These loans to States had been interest free, but beginning April 1982, interest has been payable except on certain short-term

"cash flow" loans. As of January 1, 1996, no State had a loan outstanding.

Effective January 1985, the total credit may not exceed 5.4% of taxable wages. The remaining 0.8%, including a 0.2% temporary surcharge, is collected by the Federal Government. The permanent 0.6% portion is used for the expenses of administering the unemployment insurance program for the 50% share of the costs of extended benefits, and for loans to States. Any excess is distributed among the States in proportion to their taxable payrolls. The "temporary" 0.2% FUTA surcharge was added in 1977 and was extended through 1998 by a number of public laws.

All States finance unemployment benefits through employer contributions. There is no Federal tax on employees, and only three States collect employee contributions. In January 1996, 41 jurisdictions had set their tax bases higher than the $7,000 Federal base.

Most States have a standard tax rate of 5.4% of taxable payroll. However, the actual tax paid depends on the employer's record of employment stability, measured generally by benefit costs attributable to former employees. All jurisdictions use this system, called experience rating. Employers with favorable benefit cost experience are assigned lower rates than those with less favorable experience. Experience rating systems vary widely among the States. In 50 jurisdictions, the amount of benefits paid to former workers is the basic factor in measuring an employer's experience. The other jurisdictions rely on the number of separations from an employer's service, or the amount of decline in covered payrolls.

Contribution rates may also be modified according to the current balance of each State's Unemployment Trust Fund. When the balance falls below a specified level, rates are raised. In some States, it is possible for an employer with a good experience rating to be assigned a tax rate as low as 0%; the maximum in three States is 10%.

Benefits are commonly charged against all employers who paid the claimant wages during the base period, either proportionately or in inverse order of employment. However, a few States charge benefits exclusively to the separating employer. In some, benefits paid after a disqualification are not charged to any employer's account.

In 1995, the estimated national average employer contribution rate actually paid was 2.3% of taxable payroll, or 0.8% of total wages in covered work. The average contribution rate varied widely by State, however. The percent of State taxable payroll ranged from 0.6 to 4.9; the percent of total wages from 0.2 to 2.1.

Disaster Unemployment Assistance (DUA) is paid out of funds provided by the Federal Emergency Management Agency (FEMA). Benefits for former Federal civilian employees, including postal workers (and, after October 1, 1983, former members of the Armed Forces) are paid out of the Federal Employees Compensation

Account (FECA) in the Unemployment Trust Fund, subject to reimbursement by the former employing agency.

Administration

States have the direct responsibility for establishing and operating their own unemployment insurance programs, while Federal unemployment insurance tax collections are used to finance expenses deemed necessary for proper and efficient administration. State unemployment insurance tax collections are used solely for the payment of benefits, and may not be used for any program administration cost, nor for training, job search, or job relocation payments. However, several States collect a supplementary tax for the administration of their unemployment insurance laws because funds appropriated each year by Congress out of the proceeds of the earmarked Federal unemployment tax for "proper and efficient administration" have not proven adequate.

Federal regulations do not specify the form of the organization administering unemployment insurance or its place in the State government. Twenty-eight States have placed their employment security agencies in the Department of Labor or under some other State agency, while the others rely on independent departments, boards, or commissions. Advisory councils have been established in all but four jurisdictions; 46 of them are mandated by law. These councils assist in formulating policy and addressing any problems related to the administration of the Employment Security Act. In most States, they include equal representation of labor and management, as well as representatives of the public interest.

State agencies operate through local full-time unemployment insurance and employment offices that process claims for unemployment insurance and also provide a range of job development and placement services. State employment offices were established by Congress in 1933 under the Wagner-Peyser Act, and thus actually antedate the unemployment insurance provisions of the Social Security Act. Federal law provides that the personnel administering the program must be appointed on a merit basis, with the exception of those in policymaking positions.

Federal law also requires that States must provide workers whose claims are denied an opportunity for a fair hearing before an impartial tribunal. Generally, there are two levels of administrative appeal: first to a referee or tribunal, and then to a board of review. Decisions of the board of review may be appealed to the State courts in all jurisdictions.

Generally, claims must be filed within 7 days after the week for which the claim is made, unless there is good cause for late filing. They must continue to be filed throughout the period of unemployment, usually biweekly and by mail. Benefits are paid on a biweekly basis in most States.

All the States have adopted interstate agreements for the payment of benefits to workers who move across State lines. They also have made special wage-combining agreements for workers who earned wages in two or more States.

The Federal functions of the unemployment insurance program are chiefly the responsibility of the Employment and Training Administration's Unemployment Insurance Service in the U.S. Department of Labor. It verifies each year that State programs conform with Federal requirements, provides technical assistance to the State agencies, and serves as a clearinghouse for statistical data. The Internal Revenue Service in the Department of the Treasury collects FUTA taxes, and the Treasury also maintains the Unemployment Insurance Trust Fund.

Workers' Compensation

Workers' compensation was the first social insurance to develop widely in the United States. In 1908, the first workers' compensation program covering certain Federal civilian employees in hazardous work was enacted. Similar laws were passed in 1911 in some States for workers in private industry, but not until 1949 had all States established programs to furnish income-maintenance protection to workers disabled by work-related illness or injury. For the next several decades, State laws expanded coverage, raised benefits, and liberalized eligibility requirements and increased the scope of protection in other ways.

Today, such laws are in effect in all the States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. In addition, three separate programs cover longshore, harbor, and other maritime workers; Federal employees; and coal miners.

Workers' compensation laws very widely among the States with regard to the number of weeks for which benefits may be paid and the amount of benefits payable. Payments for total disability are generally based on the worker's wages at the time of injury—usually 66-2/3% of weekly wages, up to a statutory maximum.

Workers' compensation programs are almost exclusively financed by employers on the principle that the cost of work accidents is part of production expenses. Costs are influenced by the hazards of the industry and the method used to insure for liability. A few State laws contain provisions for nominal employee contributions for hospital and medical benefits.

Coverage

State and Federal workers' compensation laws cover the Nation's wage and salary labor force. Common coverage exemptions are domestic service, agricultural employment, and casual

labor, although some programs cover agricultural and domestic workers. Many programs exempt employees of nonprofit, charitable, or religious institutions; some limit coverage to workers in hazardous occupations.

The coverage of State and local public employees differs widely among State programs. States may provide full coverage, specifying no exclusions. Some have broad coverage, excluding only such groups as elected or appointed officials. Other programs limit coverage to public employees of specified political subdivisions or to employees engaged in hazardous occupations. In some States, coverage of government employees is optional with the State, city, or other political subdivision.

Two other major groups outside the coverage of workers' compensation laws are railroad employees engaged in interstate commerce and seamen in the merchant marine. These workers are covered by Federal statutory provisions for employer liability that give the employee the right to charge an employer with negligence. The employer is barred from pleading the common law defenses of assumed risk of the employment, negligence of fellow workers, and contributory negligence.

The programs are compulsory for most covered jobs in private industry except in New Jersey, South Carolina, and Texas. In these States, the programs are elective—that is, employers may accept or reject coverage under the law; but if they reject such coverage, they lose the customary common law defenses against suits by employees.

The programs use varying methods to assure that compensation will be paid when it is due. No program relies on general taxing power to finance workers' compensation. Employers in most programs may carry insurance against work accidents or give proof of financial ability to carry their own risks. Federal employees are protected through a federally financed and operated system.

Eligibility for Benefits

Although at first virtually limited to injuries or diseases traceable to industrial "accidents," the scope of the programs has broadened to cover occupational diseases as well. However, protection against occupational disease is still restricted because of time limitations, prevalent in many States, on the filing of claims. That is, benefits for diseases with long latency periods are not payable in many cases because most State laws pay benefits only if the disability or death occurs within a relatively short period after the last exposure to the occupational disease (such as 1-3 years) or if the claim is filed within a similar time after manifestation of the disease or after disability begins. Some programs restrict the scope of benefits in cases of dust-related diseases such as silicosis and asbestosis.

These eligibility restrictions reflect the problems associated with determining the cause of disease. Work-related ailments such as heart disease, respiratory disorders, and other common ailments may be brought on by a variety of traumatic agents in the individual's environment. The role of the workplace in causing such disease is often very difficult to establish for any individual.

Types and Amounts of Benefits

The benefits provided under workers' compensation include periodic cash payments and medical services to the worker during a period of disablement, and death and funeral benefits to the worker's survivors. Lump-sum settlements are permitted under most programs. However, a lump-sum settlement may, in some cases, provide inadequate protection to disabled workers, especially where lump-sum agreements prevent payment of future benefits (particularly for medical care) when the same disabling condition recurs. In many States, special benefits are included (for example, maintenance allowances during rehabilitation and other rehabilitation services for injured workers). To provide an additional incentive for employers to obey child labor laws, extra benefits may be provided for minors injured while illegally employed.

The cash benefits for temporary total disability, permanent total disability, permanent partial disability, and death of a worker are usually calculated as a percentage of weekly earnings at the time of accident or death—most commonly 66-2/3%. In some States, the percentage varies with the worker's marital status and the number of dependent children, especially in case of death.

All programs, however, place dollar maximums on the weekly amounts payable to a disabled worker or to survivors with the result that some beneficiaries (generally higher-paid workers) receive less than the amount indicated by these percentages. Five out of six programs have adopted flexible provisions for setting the maximum weekly benefit amounts, basing them on automatic adjustments in relation to the average weekly wage in the jurisdiction. Without these automatic adjustments, annual legislation would be required to increase the maximum weekly benefit amount; consequently, an even greater number of injured workers would fail to receive a benefit equal to the State's percentage.

Other provisions in workers' compensation programs limit the number of weeks for which compensation may be paid or the aggregate amount that may be paid in a given case, and establish waiting-period requirements. These provisions also operate to reduce the specified percentage.

Compensation is payable after a waiting period ranging from 3 to 7 days, with 3 days the most common, except in the Virgin Islands, which pays after the first full day of disability. However, for workers whose disabilities continue from 4 days to 6 weeks, the payment of benefits is retroactive to the date of injury.

Temporary and Permanent Total Disability

A large majority of compensation cases involve temporary total injury—that is, the employee is unable to work at all while he or she is recovering from the injury, but the employee is expected to recover fully. When it has been determined that the worker is permanently and totally disabled for any type of gainful employment, permanent total disability benefits are payable. Both temporary and permanent total disability are usually compensated at the same rate.

Most programs provide for temporary disability benefits for the duration of the disability if the possibility exists for further improvement with medical treatment. But 16 programs specify payment of benefits only up to a maximum number of weeks, a maximum monetary total, or both. (See Appendix IV: Minimum and maximum benefits for temporary total disability provided by workers' compensation statutes, January 1, 1996.)

If the total injury appears to be permanent, the majority of programs provide for the payment of weekly benefits for life or the entire period of disability. A few programs reduce the weekly benefit amount after a specified period, or they provide discretionary payments after a specified time. Among the 9 programs where permanent total disability benefits are limited in duration, amount, or both, the periods range from 312 weeks to 500 weeks. Some programs provide additional payments for an attendant if one is required.

In 9 States, injured persons who are compensated for temporary and/or permanent total disability receive additional benefits for dependents. In two of these programs, such payments are made in case of temporary disability only, and in two others these allowances are only for permanent disability. The effect of these allowances in general is to increase the maximum weekly payments that a disabled worker receives. Under a few programs, however, the additional allowances are limited by the same weekly maximum benefit amount or aggregate maximum that is payable whether or not there are dependents.

Permanent Partial Disability

If the permanent disability of a worker is only partial and may or may not lessen work ability, permanent partial disability benefits are payable—in part as compensation for the injury and ensuing suffering and handicap, and in part as compensation for a potential reduction in earning capacity. The typical law recognizes two types of permanent partial disabilities: Specific or "schedule" injuries (such as the loss of an arm, leg, eye, or other part of the body) and general or "nonschedule" injuries (such as a disability caused by injury to the head, back, or nervous system).

Compensation for schedule injuries is generally made at the same rate as for total disability, but in a number of States it is subject to different (generally lower) dollar maximums. Compensation is determined in terms of a fixed number of weeks without regard to loss of earning power. For nonschedule injuries, the compensation is usually the percentage of the total disability payment that corresponds to the percentage of wage loss or reduction in earning capacity—that is, the difference between wages before and after impairment. Under many programs, there are limitations on the maximum amounts and/or periods of payment.

Under a majority of programs, the compensation payable for permanent partial disability is in addition to that payable during the healing period or while the worker is temporarily disabled. Additional amounts usually are allowed for disfigurement. Under some programs, no benefits are payable for permanent partial disability resulting from occupational disease; under other programs, such benefits are lower than for disability due to accidental injury.

Death Benefits

Generally, compensation related to earnings and graduated by the number of dependents is payable to the survivors of workers who die from work injury. Thirty-five programs, including those covering Federal employees and longshore and harbor workers, provide weekly or monthly death payments to the spouse for life or until remarriage (regardless of the spouse's age at the time of the death of the worker). All programs provide payments to children until age 18 or later if they are incapacitated or are students.

All the programs provide for payment of burial expenses subject to a specified maximum amount that ranges from $800 to $6,000.

Medical Benefits

All compensation programs require that medical aid be furnished to injured workers without delay, whether or not the injury entails work interruption. This care includes first-aid treatment, physician services, surgical and hospital services, nursing care, medical drugs and supplies, appliances, and prosthetic devices. Medical aid is furnished without a limit on time or amount, except in six jurisdictions.

Under most programs, the employee has the right to designate the physician, although in some cases the physician must be chosen from a list prepared by the State agency or by the employer. Under others, the employer has the right to select the physician. In several States where the worker may choose the physician, the administering agency has the authority to require a change of physician, and, in some States where the worker may not make

the original choice, the employee may choose his or her own physician after a specified period.

In practice, the employer's right to designate the physician may be transferred to the insurance company that carries the risk for medical care and compensation. Some employers provide the medical services directly, even though they are insured for cash compensation costs. Others are self-insured for medical services and cash benefits. First aid and, less commonly, hospital facilities may be provided by the employer at the place of employment.

Because medical care is generally provided by physicians in private practice on a fee-for-service basis, the programs commonly contain provisions restricting the responsibility of the employer (or insurer) to such charges as generally prevail in the community for treating persons who are of the same general economic status as the employee and who pay for their own treatment. State programs may also provide for use of medical fee schedules and managed medical care plans.

Offset Provisions

Disabled workers may be eligible for benefits under both workers' compensation and the Social Security Disability Insurance (DI) program. The total amount of benefits that can be received is limited by the 1965 Amendments to the Social Security Act. Under these provisions, the DI benefit (and in family benefits based on the worker's earnings record) may be reduced for any month to fully or partially offset a worker's compensation benefit received for the same month. This reduction is made only if the total benefits payable to the worker (and dependents) under the Social Security Act, plus those paid to the worker as workers' compensation, exceed the higher of 80% of his or her "average current earnings" before onset of disability or the family's total Social Security benefit before reduction. The DI benefit will not be reduced if the workers' compensation law provides for the reduction of that benefit when he or she is entitled to DI benefits, if such provision was in effect as of February 1981. Federal Black Lung benefits are not reduced due to receipt of DI benefits, but are reduced to the extent that workers' compensation benefits, attributable to the same disease, are being paid. Workers' compensation benefits may be reduced because of receipt of Social Security benefits other than for disability, unemployment insurance, or disability benefits under private plans.

Financing

Workers' compensation programs are almost exclusively financed by employers based on the principle that the cost of work-related accidents is a business expense.

The employer's cost of protecting workers varies with the risk involved and is influenced primarily by such factors as the

employer's industrial classification and the hazards of that industry, sometimes modified by the employer's experience rating. The premium rate an employer pays in a given State, compared with the premium rate for the same industrial classification in another State, also reflects the level of benefits provided in a given jurisdiction. Costs are also influenced by the method used to insure for compensation liability—through a commercial carrier, through an exclusive or competitive State fund, or through self-insured—and the proportion of the employer premium assigned to acquisition costs and costs for services and general administration.

In three-fourths of the States, State costs of administering the workers' compensation laws and supervising the operations of the insurance medium—private carriers, the self-insured, or State funds—may be provided through assessments on insurance carriers and self-insurers (including premium receipts in States with exclusive State funds). In the remaining States, administrative costs are derived from either general revenues or a combination of general revenues and assessments.

Administration

State workers' compensation laws generally are administered by commissions or boards created by law. Court administration exists in three States with limited administrative activities performed by an administrative unit. The Federal provisions are administered by the Office of Workers' Compensation Programs of the Department of Labor, except for part of the Black Lung program that is administered by the Social Security Administration (SSA).

Generally, State administrative agencies supervise, adjudicate, and enforce payment of obligations and compliance with the laws. This is often carried out by boards or commissions. However, in States that maintain exclusive State funds, tasks of administration are merged with those of providing the insurance protection—that is, setting rates, collecting premiums, and paying benefits.

The programs may require reports by employers of all work-related accidents or injuries; or they may require such reports only if medical care beyond first aid is required, if time is lost after the day of the accident, or if compensation is to be paid. Time limits for employee notice to employers of injury are set, as well as time limits for filing claims for compensation. The deadline is commonly not longer than 1 year or 2 years after the injury, onset of disability, or death. These are extended under certain conditions, particularly with regard to occupational diseases.

Under most programs, the employer or the carrier, when notified of the injury, is required to begin the payment of compensation to the worker or his or her dependents. The injured worker does not have to enter into an agreement and need not sign any papers before compensation starts. The law specifies the amount a worker should get. If the worker fails to receive that amount, the administrative agency can step in, investigate the matter, and correct any

error. In many cases, however, these provisions have not been actively enforced.

Under some programs, uncontested cases are settled by agreement among the employing firm, its insurance carrier, and the worker before payments start. Further, the agreement must be approved by the administrative agency under a few of the laws. In contested cases, most workers' compensation laws are adjudicated through hearings before an administrative body that usually has exclusive jurisdiction over the determination of facts; appeals to the courts usually are limited to questions of law.

Rehabilitation

Workers' compensation programs provide for physical rehabilitation when needed. In addition, most workers' compensation laws contain special provisions for retraining, education, and job placement and guidance to help injured workers find suitable work.

In most of the programs, payments for food, lodging, and travel are provided to facilitate the vocational rehabilitation of the worker. These payments are provided through the extension of the period for which regular compensation is payable, or are in addition to the payment of indemnity benefits, sometimes with time limitations.

In addition to any special rehabilitation benefits and services provided under the workers' compensation laws, an injured worker may be eligible for the services provided by the Federal-State program of vocational rehabilitation. This program is operated by the State divisions of vocational rehabilitation and applies to disabled persons whether or not the disability is work connected. The services rendered include medical examination, medical and vocational diagnosis, counsel and guidance in selecting a suitable job, and training for and placement in that job.

To help place injured workers in jobs and to relieve the fear of employers that their workers' compensation costs will be unduly burdened if they hire workers with disabilities, all but three States have some form of subsequent-injury or second-injury fund. When a subsequent injury occurs to a worker who has sustained a previous permanent injury, the employee is compensated for the disability resulting from the combined injuries. The current employer pays only for the last injury and the remainder of the award is paid from the second-injury fund.

The method of financing the subsequent-injury fund differs among the various programs. Generally, financing is by assessment of insurance carriers, self-insurers, or employers. In some States, an assessment is made against certain types of compensation payments.

Black Lung Benefits

The Black Lung Benefits Program was established as part of the Federal Coal Mine Health and Safety Act of 1969. It provides

monthly cash benefits to coal miners who are totally disabled by pneumoconiosis (black lung) contracted as a result of employment in and around the Nation's coal mines. Benefits are payable to a worker's dependents or to the survivors of a worker who has died as a result of this disease. A coal miner is considered to be totally disabled if unable to engage in comparable and gainful work by reason of pneumoconiosis that has lasted or can be expected to last for 12 months or to result in death.

The Social Security Administration (SSA) generally exercises jurisdiction over all black lung claims filed by miners from enactment of the law through June 1973 and, therefore, pays monthly benefits to a declining number of people. The Department of Labor (DOL) has primary responsibility for all claims filed after June 1973. Although the DOL makes the disability determinations, the SSA field offices accept black lung applications for the DOL on a reimbursable basis.

Black Lung (Part B) Program Data, 1996

- The total number of beneficiaries: 131,100. The beneficiaries included 21,500 miners, 85,600 widows, and 24,100 dependents.
- Total annual payments: $654.6 million.
- Average monthly benefits for miners were $663.80, and $448.50 for widows.
- 96% of miners and widows were over 64 years old.
- 72% of all beneficiaries resided in five States: Pennsylvania, West Virginia, Kentucky, Virginia, and Ohio.

Temporary Disability Insurance

Temporary disability insurance, sometimes referred to as cash sickness benefits, provides workers with partial compensation for loss of wages caused by temporary nonoccupational disability. Only five States, Puerto Rico, and the railroad industry have temporary disability insurance laws.

It was during the severe depression of the thirties that the United States began its national social insurance programs of unemployment insurance and old-age insurance. Consequently, providing protection against costs of sickness that are more or less recurring regardless of economic conditions did not seem to have the same urgency as providing protection against cyclical unemployment and old-age dependency. The Federal law provided no basis for a system of compensation for wage loss due to short-term sickness or disability that was comparable to the Federal-State system of unemployment insurance.

The first State temporary disability insurance or cash sickness insurance law was enacted by Rhode Island in 1942, followed by legislation in California in 1946, New Jersey in 1948, and New York

in 1949. Then came a hiatus of two decades before Puerto Rico and Hawaii passed laws in 1968 and 1969, respectively.

The Railroad Unemployment Insurance Act of 1938 established a system of benefits for persons employed in the railroad industry. The Act was amended in 1946 to include sickness benefits. (This federally operated program is described in the section on programs for railroad workers.)

Coverage

The temporary disability insurance laws, like the unemployment insurance programs, cover most commercial and industrial wage and salary workers in private employment. Principal occupational groups excluded are domestic workers, family workers, government employees, and the self-employed (except California law permits elective coverage for self-employed persons). State and local government employees are included in Hawaii, and the other State laws permit some or all public employees to elect coverage. Only California, Hawaii, New Jersey, and Puerto Rico cover agricultural workers.

In Rhode Island and the railroad industry, all benefits are provided from publicly operated disability insurance funds. In California, New Jersey, and Puerto Rico, employers may "contact out" of the public plan by providing an approved private plan, usually one insured by a commercial company or financed on a self-insured basis. The laws in Hawaii and New York require employers to provide sickness protection of a specified value for their employees by establishing a privately insured or self-insured plan, or in the case of New York, by insuring with a State fund that itself has many characteristics of a private carrier. In jurisdictions that allow private plans, union or union-management plans may provide the sickness benefits required by law.

Eligibility for Benefits

To qualify for benefits, a claimant must have a specified amount of past employment or earnings and be disabled. The laws generally define disability as the inability to perform regular or customary work because of a physical or mental condition.

In most jurisdictions with private plans, workers become immediately insured upon their employment or, in some cases, some probationary period of employment is required, usually from 1 to 3 months. Upon cessation of employment after a specified period, workers generally lose their private plan coverage and must look to the State fund for such protection.

All the laws restrict payment of benefits when the claimant is also receiving workers' compensation. However, the statutes usually contain some exceptions to this rule—for example, if the workers' compensation is for partial disability or for previously incurred work disabilities. California and the railroad program will pay the difference if the temporary disability payment is larger than the

workers' compensation benefit (and, in the case of the railroad program, if the temporary disability benefit is larger than benefits from certain other social insurance programs as well).

The laws differ with respect to the treatment of sick leave payments. Rhode Island pays temporary disability benefits in full even though the claimant draws wage-continuation payments. New York deducts from the benefits any payment from the employer or from a fund contributed to by the employer, except for benefits paid pursuant to a collective bargaining agreement. In California, New Jersey, and Puerto Rico, benefits plus paid sick leave for any week during disability may not exceed the individual's weekly earnings before his or her disablement. Railroad workers are not eligible for temporary disability benefits while they receive sick leave pay.

All the laws provide that a claimant cannot receive disability benefits for any week for which he or she receives unemployment benefits. The New Jersey law deducts from disability payments the amount of any pension received if the pension was contributed to by the claimant's most recent employer. Puerto Rico disallows benefits if a pension is being received without the claimant's having had insured work for at least 15 weeks immediately preceding the disability claim.

Types and Amounts of Benefits

In all seven temporary disability insurance systems, as with unemployment insurance in the United States, weekly benefit amounts are related to the claimant's previous earnings in covered employment. In general, the benefit amount for a week is intended to replace at least one-half of the weekly wage loss for a limited time. All the laws, however, specify minimum and maximum amounts payable for a week. In three States (Hawaii, New Jersey, and Rhode Island), the maximum amount is recomputed annually so that it will equal a specified percentage of the State's average weekly wage in covered employments. Rhode Island also pays benefits to dependents.

The maximum duration of benefits varies between 26 and 52 weeks. The length of time that benefits are payable depends on the total amount of base period earnings and the length of employment.

A noncompensable waiting period of a week or 7 consecutive days of disability (4 days for railroad workers) is generally required before the payment of benefits for subsequent weeks. The waiting period, however, applies only to the first sickness in a benefit year in Rhode Island, and is waived in California and Puerto Rico from the date of confinement in a hospital. In New Jersey, the waiting period is compensable after benefits have been paid for 3 consecutive weeks. In each of the temporary disability insurance programs, a worker may be paid benefits on a prorated basis for partial weeks of sickness after the waiting period has been satisfied.

The statutory provisions described above govern the benefits payable to employees covered by the State-operated plans. In

those States where private plans are permitted to participate, the public plans represent standards against which the private plan can be measured (in accordance with provisions in the State law). Thus, although identical statutory provisions apply to all covered workers under the public system in Rhode Island, a different situation prevails in the other States where private plans may deviate sharply from statutory specifications.

In California, before a private insurance plan can be substituted for the State plan, it must afford benefit rights greater than those under the State-operated plan. In Hawaii, New Jersey, and Puerto Rico, private plan benefits must be at least as favorable as those under the government plans. Hawaii permits deviation from statutory benefits if the aggregate benefits provided under the private plan are actuarially equal or better. In New York, adherence to precise statutory benefits is not required; the benefit package provided by alternate private plans must be "actuarial equivalent" to the statutory formula and must meet certain minimum standards. Some features of an alternate private plan can be inferior to the standards of State law if other features are more favorable. Moreover, the New York law also provides that medical, hospital, and surgical care benefits may be substituted for cash sickness benefits for up to 40% of the statutory benefits.

Private plans may also deviate from the statute with respect to conditions under which benefits will be paid, as long as benefits are not denied in any case in which they would have been paid under the statute. In fact, financial considerations tend to operate as a restrictive force on the liberalization of private plans in relation to State-operated plans or statutory formulas. To exceed the statutory formula would mean higher costs for the average employer, since the law forbids requiring employees to pay higher premiums for private plan coverage than for State plan coverage.

In areas where private plan participation is permitted, special arrangements are needed to ensure continuity of coverage for a worker who changes employers or experiences periods of unemployment. In New York, the law requires that a worker be covered by a private plan for 4 weeks after termination of employment unless he or she is reemployed, in which case he or she will be covered by the new employer without a waiting period. Puerto Rico requires that benefits under a private plan be payable for periods of disability that begin during unemployment or employment in uninsured work. In the other three States that allow private plans—California, Hawaii, and New Jersey—the employer's responsibility for coverage lasts only 2 weeks after separation.

After such coverage lapses, the worker may be eligible for continued disability benefits through the State fund. Special

benefit and eligibility provisions are also in effect for disabled unemployed workers in Hawaii, New Jersey, and New York.

In Rhode Island and in the railroad industry, there is no reason to make a distinction between employed and unemployed workers because all benefits are paid from a single fund and workers are assured of continuous protection during short periods of unemployment and job turnover.

Financing

Under each of the laws, except for that governing the railroad program, employees may be required to contribute to the cost of the temporary disability insurance. In five of the jurisdictions (all but California and Rhode Island), employers are also required to contribute. In general, the government does not contribute.

Under programs in California, New Jersey, and Puerto Rico, workers covered by approved private plans are relieved from contributing to the government-operated fund; but when they are asked to contribute to the private plan, they may not pay more than they otherwise would be required to pay for the State fund. When benefit costs exceed this amount, employers must pay the balance. In Hawaii and New York, higher contributions than specified in the law may be required of employees if the level of benefits provided bears a reasonable relationship to costs.

The administrative costs of the government-operated plans, like the benefit outlays, are met from the payroll taxes collected under the law. California, New Jersey, New York, and Puerto Rico levy assessments on private plans to cover the added administrative costs to the States of supervising these plans. In Hawaii, the administrative costs are paid from general revenues. In New Jersey, employers covered by the State-operated plan pay an extra assessment for the costs of maintaining separate accounts for experience-rating purposes.

Those disability laws that permit private insurance require these plans to pay part of the cost of paying benefits to insured workers who become disabled while unemployed—generally by means of a levy proportional to the insurable payroll covered by private plans. This arrangement is considered necessary so that the cost of benefits to unemployed workers will not be borne exclusively by the public funds.

Administration

Five of the seven temporary disability insurance programs are administered by the same agency that administers unemployment insurance. Under these five programs, unemployment insurance administrative machinery is used to collect contributions, to maintain wage records, to determine eligibility, and to pay benefits to workers under the State-operated funds. The New York law is administered by the State Workers' Compensation Board, and the

Hawaii law is administered separately in the Department of Labor and Industrial Relations.

By way of contrast, claims in New York and Hawaii are filed with and paid by either the employer, the insurance carrier, or the union health and welfare fund that is operating the private plan. The State agency limits its functions with respect to employed workers to exercising general supervision over private plans, setting standards of performance, and adjudicating disputed claims arising between claimants and carriers. A similar situation applies to claimants under private plans in California, New Jersey, and Puerto Rico.

All the laws require the claimant to be under the care of a physician (or, in California and Hawaii, the claimant may be under the care of an authorized religious practitioner of the claimant's faith). The first claim must be supported by a physician's certification. It must include a diagnosis, the date of treatment, an opinion as to whether the illness or injury prevents the claimant from carrying on his or her customary work, and an estimate of the date when the claimant will be able to work again.

An individual whose claim for benefits is denied, in whole or in part, has the right to appeal the determination through the State courts. Decisions by private carriers are also subject to appeal to the State administrative agency and then to the courts. If a carrier should fail to pay promptly in accordance with a decision on appeal, the benefits may be paid by the State agency and assessed against the employer.

Health Insurance and Health Services

Medicare

Since early in this century, health care issues have continued to escalate in importance for our Nation. Beginning in 1915, various efforts to establish government health insurance programs have been initiated every few years. From the 1930's on, there was a broad agreement on the need for some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs. The main health care issue at that time was whether health insurance should be privately or publicly financed.

Private health insurance coverage expanded rapidly during World War II, when fringe benefits were increased to compensate for the government limits on direct wage increases. This trend continued after the war. Private health insurance (mostly group insurance financed through the employment relationship) was especially needed and wanted by middle income people. Yet not everyone could obtain or afford private health insurance. Government involvement was sought.

Various national health insurance plans, financed by payroll taxes, were proposed in Congress starting in the 1940's, but none was ever brought to a vote. After various considerations and approaches, and following lengthy national debate, Congress passed legislation in 1965 that established the Medicare program as Title XVIII of the Social Security Act.

The 1965 amendments to the Social Security Act established two separate but coordinated health insurance plans for persons aged 65 or older. The compulsory Hospital Insurance (HI) program is Part A of Medicare, and a voluntary program of Supplementary Medical Insurance (SMI) is Part B. Various legislation has extended HI protection to certain disabled persons under age 65 and to persons of any age with end-stage kidney disease.

Since 1977, the Health Care Financing Administration (HCFA) has had primary program and administrative responsibility for Medicare. Two trust funds (one for HI and one for SMI), which are funded differently, finance the program.

In 1995, more than 37 million persons were enrolled for Part A, and 36 million for Part B. Benefit payments for 1995 totaled $184.2 billion, of which Part A accounted for $117.6 billion and Part B accounted for $66.6 billion.

Of those persons who were entitled to Medicare in 1995,

more than 84% used Part B services, while only 22% used Part A. The combined HI and SMI benefit payments for all Medicare services averaged $4,978 per enrollee.

Medicare: Enrollment and coverage, September 30, 1996

Type of coverage	Persons enrolled (in thousands)		
	All persons	Aged	Disabled
Hospital Insurance and/or Supplementary Medical Insurance	37,980	33,359	4,621
Hospital Insurance	37,567	32,947	4,620
Supplementary Medical Insurance	36,104	31,949	4,155

Eligibility for Benefits

Part A

Persons are eligible for Hospital Insurance protection when they reach age 65 if they are eligible for monthly Social Security benefits. Persons covered by the Railroad Retirement system participate in the HI program on the same basis as those under the Social Security system.

Also eligible are those who would receive a monthly Social Security benefit if their governmental employment were covered work under Social Security. Persons under age 65 who are disabled are eligible for HI if they have been entitled to Social Security disability benefits for more than 24 months or would be entitled to such benefits if their governmental employment were covered work under the Social Security Act. Persons at any age with end stage kidney disease and who meet the special insured status requirements under Social Security are also eligible for HI.

Persons aged 65 or older who are not eligible for benefits may purchase HI coverage for a monthly premium of $187 if they have 30-39 quarters of Social Security coverage. For those with less than 30 quarters of coverage, the monthly premium is $311. Enrollment in Part B is required as a condition for “buying into” the HI program. Another requirement is that the person must be a U.S. resident and either a citizen or alien admitted for permanent residence and have resided in the United States for at least 5 years at the time of application for enrollment in Medicare.

Part B

Supplementary Medical Insurance benefits are available to nearly all resident citizens (and certain aliens) aged 65 or older and to disabled beneficiaries who are entitled to Part A. Part B coverage is optional and must be paid for through a monthly premium ($43.80 in 1997), which is deducted from the enrollees’ Social Security benefit, Railroad Retirement annuity, or Federal Civil Service Retirement annuity. Enrollees not yet receiving such benefits—

generally public assistance recipients—are billed quarterly. They individually pay the premium, or a State social service or medical assistance agency pays the premium on their behalf. Coverage will be terminated for failure to pay the premium. Enrollment in Part B also can be terminated by the individual by filing a notice with the Social Security Administration.

Persons who withdraw from the program before coverage starts incur no premium liability. However, the premium rate is increased by 10% for each full year out of the program for persons who do not enroll as soon as they are eligible. (Special waivers of the premium surcharge are available to employees or spouses who continue coverage under an employer-sponsored health insurance plan.)

Covered Services

Part A covers inpatient hospital services, care in skilled nursing facilities, home health services, and hospice care.

Part B is often thought of primarily as coverage for physician services (in both hospital and nonhospital settings). However, it also covers certain other nonphysician services such as clinical laboratory tests, durable medical equipment, flu vaccinations, drugs that cannot be self-administered (except certain anticancer drugs), most supplies, diagnostic tests, ambulance services, certain other health care services, and blood that is not supplied under Part A. All services must be medically necessary to be covered.

Medicare does not pay for the following: long-term nursing care; most outpatient prescription drugs and patent medicines; dental care; eyeglasses, hearing aids, and examinations to prescribe or fit them; routine physical checkups; routine foot care; cosmetic surgery; or for a telephone, television, or radio in a patient's hospital room. Although these services are not covered under Part A or Part B, they may be covered as part of a managed care plan (described below).

Medicare does not pay for services provided outside the United States and its territories (except for services obtained in Canadian or Mexican hospitals when such facilities are closer to or substantially more accessible from the person's residence than the nearest adequately equipped hospital in the United States).

Private Plans

Managed Care Plans

Most managed care plans are HMOs, but are also referred to as competitive medical plans. Medicare pays these plans a prospectively set capitation payment to provide covered services to enrolled beneficiaries. The enrollees generally pay a fixed monthly premium and a small copayment instead of Medicare's coinsurance and deductibles.

Medicare (Part A): Hospital Insurance Covered Services

Services	Benefit	Medicare pays	Patient pays
Hospitalization			
Semiprivate room and board, general nursing and other hospital services and supplies. (Medicare payments based on benefit periods.)	First 60 days 61st to 90th day 91st to 150th day* Beyond 150 days	All but $760 All but $190 a day All but $380 a day Nothing	$760 $190 a day $380 a day All costs
Skilled nursing facility care			
Semiprivate room and board, skilled nursing and rehabilitation services and other services and supplies.** (Medicare coverage based on benefit periods.)	First 20 days Additional 80 days Beyond 100 days	100% of approved amount All but $92 a day Nothing	
Home health care			
Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare requirements.	100% of approved amount; 80% of approved amount of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
Hospice care			
Pain relief, symptom management and support services for the terminally ill.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
Blood			
When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited during a benefit period if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.***

* 60 reserve days may be used only once.
** Neither Medicare nor Medigap insurance will pay for most nursing home care.
*** To the extent the 3 prints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

Source: Updated for 1997 rates from *1996 Guide To Health Insurance for People with Medicare*, National Association of Insurance Commissioners and the Health Care Financing Administration, U.S. Department of Health and Human Services.

Medicare (Part B): Medical Insurance Covered Services

Services	Benefit	Medicare pays	Patient pays
Medical expenses Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment and other services.	Unlimited if medically necessary.	80% of approved amount (after $100 deductible). 50% of approved amount for most outpatient mental health services.	$100 deductible,* plus 20% of approved amount and limited charges above approved approved amount.** 50% for most mental health services.
Clinical laboratory services Blood tests, urinalysis, and more.	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
Home health care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare require-ments.	100% of approved amount; 80% of amount Medicare approves for durable medical equipment.	Nothing for services; 20% of amount Medicare approves for durable medical equipment (after $100 deductible).
Outpatient hospital treatment Services for the diagonosis or treatment of an illness or injury .	Unlimited if medically necessary.	Medicare payment to hospital based on hospital costs.	20% of billed amount (after $100 deductible).*
Blood	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).***

* Once you have had $100 of expense for covered services, the Part B deductible does not apply to any covered services you receive for the rest of the year.
** Federal law limits charges for physician services.
*** To the extent any of the 3 prints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

Source: Updated for 1997 rates from *1996 Guide To Health Insurance for People with Medicare*, National Association of Insurance Commissioners and the Health Care Financing Administration, U.S. Department of Health and Human Services.

Managed care plans provide Medicare services through either a "risk" or a "cost" contract. Plans with risk contracts provide the services on a predetermined per person basis regardless of the frequency or extent of health care utilization by the enrollees. Generally, those who join a risk plan are locked into receiving all covered care through the plan or through referrals by the plan.

Plans with cost contracts provide Medicare services on a reasonable per person amount based on the actual costs, which are adjusted at year's end. Cost plans do not have lock-in requirements so enrollees can choose a health care provider affiliated with the plan or go outside the plan. However, if the enrollee goes outside the plan, Medicare pays for the services. Medicare pays for it's share of approved charges and the enrollee is responsible for Medicare's coinsurance and deductibles.

Joining a managed care plan and receiving all services through it means the beneficiary's out-of-pocket costs are usually more predictable. Depending on personal health needs, these costs may be less than the beneficiary would have to pay for the regular Medicare deductible and coinsurance amounts. Managed care plans may also offer supplementary benefits not covered by Medicare, such as preventive care, dental care, and products such as hearing aids and eyeglasses. Also, electing to participate in a managed care plan may serve as an alternative to purchasing "Medigap" insurance (described below), which is often wanted if the beneficiary is in a traditional fee-for-service plan.

Medigap

Medigap insurance is specifically designed to supplement health care expenses that are not covered by Medicare. To make it easier for consumers to comparison shop for Medigap insurance, the law limits the number of different policies that can be sold in each State and jurisdiction. The same format, language, and definitions are used to describe the benefits for each of the 10 standard plans that are available.

Other Insurance

Medicare beneficiaries may also have coverage from another source, such as an employer group health plan, veterans benefits, workers' compensation, or black lung benefits. In these cases, Medicare is the secondary payer for health care claims.

Medicare beneficiaries with very low income and resources may get help in paying their cost-sharing portions of Medicare from their States' Medicaid program. (The relationship between Medicaid and Medicare is described in more detail in the Medicaid section.)

Financing and Payments

The financing plan for Part A, Hospital Insurance, is a pay-as-you go system. It requires workers and their employers as well as

Ten Standard Medicare Supplement Plans

A	B	C	D	E	F	G	H	I	J
Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic
		Skilled nursing	Skilled nursing	Skilled nursing	Skilled nursing	Skilled nursing	Skilled nursing	Skilled nursing	Skilled nursing
	Part A	Part A	Part A	Part A	Part A	Part A	Part A	Part A	Part A
		Part B			Part B				Part B
					Part B excess	Part B excess		Part B excess	Part B excess
		Foreign travel	Foreign travel	Foreign travel	Foreign travel	Foreign travel	Foreign travel	Foreign travel	Foreign travel
			At home			At home		At home	At home
				Preventive					Preventive

Note: Basic benefits included in all plans; hospitalization—Part A coinsurance coverage for 365 additional days after Medicare benefits end; medical expenses—Part B coinsurance (generally 20% of Medicare approved expenses), and blood—first 3 pints each year.

Source: [1997] *Guide for Health Insurance for People with Medicare*, National Association of Insurance Commisioners and the Health Care Financing Administration, U.S. Department of Health and Human Services.

self-employed persons to pay taxes on earnings in jobs covered by Social Security. The current tax rate of 1.45% applies equally to employees and employers, and the rate for the self-employed equals the combined employer and employee rate of 2.9%.

Part B, Supplementary Medical Insurance, is financed by a combination of monthly premiums paid by the beneficiaries ($43.80 in 1997) and Federal general revenues. The income for these programs is deposited into two separate trust funds: the Federal Hospital Insurance Trust Fund for Part A, and the Federal Supplementary Medical Insurance Trust Fund for Part B. These funds are managed in the same manner as the Social Security trust funds.

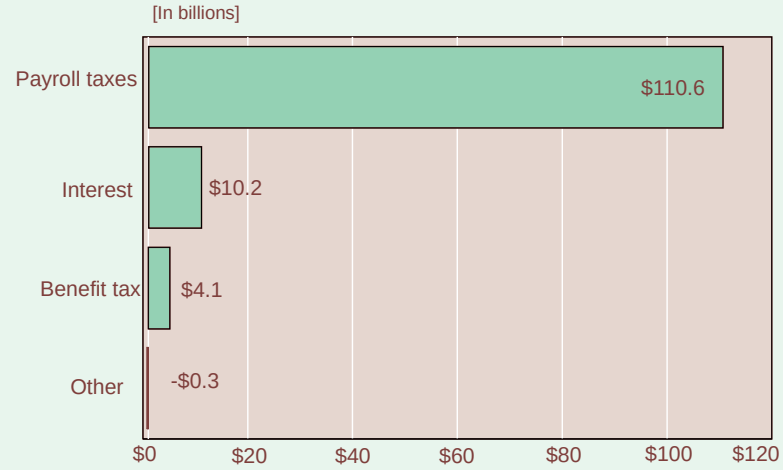
The rising cost of health care is a major consideration for HCFA, for the President, and for Congress. The present schedule for financing the Part A program is sufficient to ensure the payment of benefits only until early in the year 2001, when the funds are expected to be exhausted. And although the Part B program is currently actuarially sound, the past and projected growth in the cost of the program is of grave concern. The long-range intermediate assumptions are: HI program costs are projected to increase

from 1.63% of the GDP in calendar year 1995 to 5.04% of the GDP in calendar year 2070 and the SMI program costs are projected to increase from 0.92% of the Nation's GDP in calendar year 1995 to 3.7% of the GDP in calendar year 2070.

Deductibles and Coinsurance

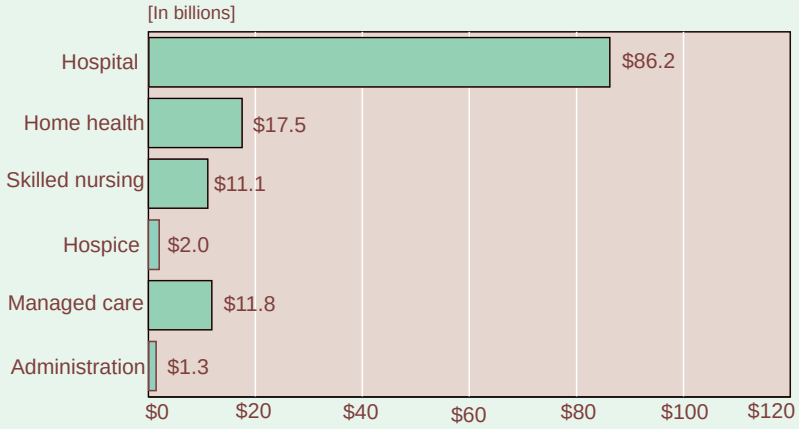
For Part A, a person's use of hospital and skilled nursing services is measured in terms of a benefit period. A benefit period begins the day the beneficiary is hospitalized, with an initial deductible ($760 in 1997) paid by the beneficiary for the first admission of each benefit period. After 60 days of hospitalization within a benefit period (without a continuous break of 60 days), additional coinsurance is required within the benefit period. A benefit period ends only after 60 days has past since discharge from a hospital or other

HI income in calendar year 1996



Source: HI Trustees' Report.

HI expenditures in calendar year 1996



Source: HI Trustees' Report.

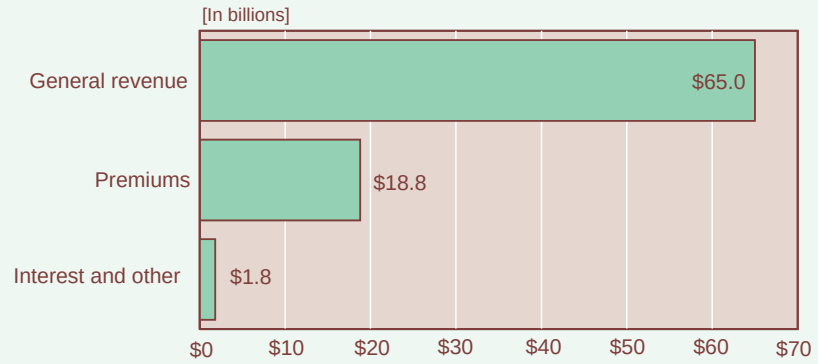
facility that primarily provides skilled nursing or rehabilitation. If the beneficiary is hospitalized again, a new benefit period begins. Most HI benefits are then renewed, and the beneficiary must pay a new inpatient hospital deductible. The number of benefit periods is unlimited.

For most SMI covered services, the beneficiary is liable for the monthly premium, an annual deductible ($100), and 20% of the cost of the services. For outpatient mental health treatment services and a few other specific services, the beneficiary is liable for 50% of the approved charges.

Vendor Payments

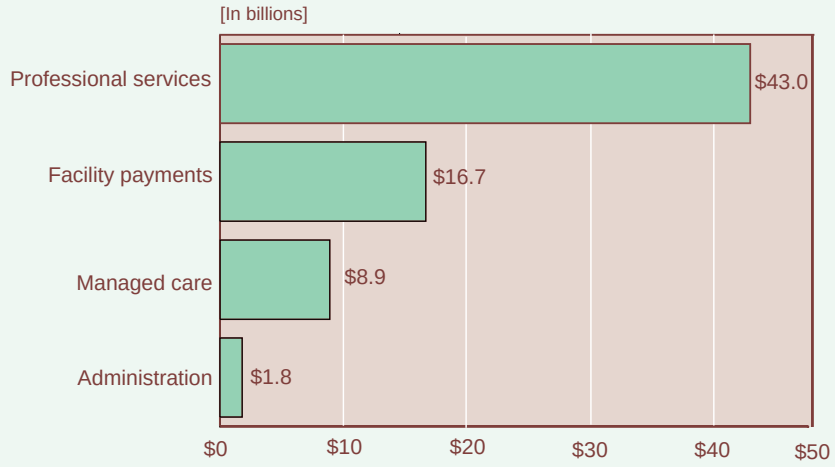
Part A payments for most inpatient hospital care are based on the Prospective Payment System. Under the PPS, a hospital is

SMI income in calendar year 1996



Source: SMI Trustees' Report.

SMI expenditures in calendar year 1996



Source: SMI Trustees' Report.

paid a predetermined rate per discharge. The predetermined rate is based on payment categories called Diagnosis Related Groups, or DRGs. In some cases, the payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. The hospital absorbs the loss or makes a profit. In cases where the costs for necessary care are unusually high or the length of stay is necessarily unusually long, the hospital receives additional payment. Payments for home health services, hospital care, and for skilled nursing care are made on a "reasonable cost" methodology, with each service or type of care having some restrictions and limitations.

Part B payments to physicians are paid on the basis of "reasonable charge," which is defined as the lesser of the submitted charges, or a fee schedule based on a relative value scale. Durable medical equipment and clinical laboratory services are based on a fee schedule. Outpatient services and home health agencies are reimbursed on a reasonable "cost" basis.

If a physician or medical equipment supplier agrees to "take assignment" (that is, agrees to accept the Medicare-approved amount as full payment for services), then Medicare pays 80% of the approved amount directly to the physician or supplier after the beneficiary meets the $100 deductible. The beneficiary pays the other 20%. No added payments may be sought from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess, which may be paid by Medigap insurance. Limits exist on the excess that providers can charge. However, since beneficiaries may select their physicians, they have the option to choose those who take assignment, and thus require no added payments.

Fiscal Intermediaries

HCFA contracts with public or private agencies or organizations to process Part A claims for institutional services and Part B claims for outpatient claims. These "intermediaries" include the Blue Cross/Blue Shield Association (which uses Blue Cross plans in various States) and commercial insurance companies. The fiscal intermediary determines reasonable costs for covered items and services, makes payments, and guards against unnecessary use of covered services.

Medicare "carriers" handle Part B claims for services by physicians and medical suppliers. They determine reasonable charges, make payments, determine whether claims are covered, and deny noncovered claims and unnecessary use of services. Carriers include State Blue Shield plans and commercial insurance carriers.

To improve the quality and effectiveness of Medicare services, each State has a Peer Review Organization (PRO) that the Federal Government pays to determine, for payment purposes, whether the

care is reasonable, necessary, and provided in the most appropriate setting. The PROs are composed of groups of practicing physicians. To receive Medicare payments, a hospital must have an agreement with a Peer Review Organization.

Administration

The Health Care Financing Administration, an agency of the Department of Health and Human Services, is responsible for setting policy and administering the Medicare program. The day-to-day operational work of the program is performed under contract by commercial insurance companies and nonprofit insurers, such as the Blue Cross and Blue Shield plans. These organizations have the responsibility for reviewing and processing benefit claims and making payments to the health care providers. The Social Security Administration does the initial determination of Medicare entitlement. It also provides certain claims-taking and record maintenance services its network of field offices. SSA also provides computer support for the Medicare program.

Medicaid

Title XIX of the Social Security Act (part of the Social Security Amendments of 1965) established the Medicaid program to provide medical and health related services for individuals and families with low incomes through direct payment to suppliers of the program. Medicaid is the largest source of funds for medical care and related services to our Nation's poorest people.

Participation is optional; but all States and the District of Columbia have Medicaid programs. Puerto Rico, Guam, the Northern Mariana Islands, American Samoa, and the Virgin Islands also have some participation in Medicaid. (These other jurisdictions are included when the word "States" is used.)

Medicaid is a cooperative endeavor between each State and the Federal Government, and is financed by shared Federal and State funds. Each Medicaid policy and program plan is also a joint endeavor. Within broad national guidelines established by Federal statutes, regulations, and policies each of the States (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility and services are therefore complex, and vary considerably from State to State and within each State over time.

In 1995, more than 36 million persons received Medicaid services. Total outlays amounted to $159.5 billion ($85.5 billion in Federal and $66.3 billion in State funds). Of the total amount, $120 billion was for vendor payments; $14 billion for premium

payments (for example, to HMOs and Medicare); and $19 billion was for payments to disproportionate share hospitals.

Eligibility and Coverage

Once eligibility for Medicaid is determined, coverage generally is retroactive to the third month prior to application. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any eligibility group.

Low income is only one test for Medicaid eligibility; assets and resources also are tested against established thresholds determined by each State. For instance, Medicaid rules for the treatment of income and resources of married couples when one spouse requires nursing home care and the other remains living at home are intended to prevent the impoverishment of the spouse remaining in the community. Before the institutionalized person's money is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted for bringing the income of the spouse living in the community up to a moderate level; and a State-determined level of resources is preserved.

Within Federal guidelines, States have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for eligibility. States must cover "categorically needy" individuals (which usually includes recipients of SSI and families with dependent children receiving cash assistance, as well as other mandatory low-income groups such as pregnant women, infants, and children with incomes less than specified percent of the Federal poverty level) and certain low-income Medicare beneficiaries.

Mandatory Eligibility Groups

States are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. The following (effective July 1997) displays the mandatory Medicaid eligibility groups:

- Recipients of AFDC.
- Recipients of TANF. (In those States with TANF programs, those individuals who would have met the State's AFDC program's eligibility requirements under rules in effect on July 16, 1996 generally are eligible.)
- Children under age 6 who meet the State's AFDC financial requirements or whose family income is at or below 133% of the Federal poverty level.
- Pregnant women whose family income is below 133% of the Federal poverty level (services are limited to pregnancy, complications of pregnancy, delivery, and 3 months of post-partum care).
- Certain Medicare beneficiaries.

- SSI recipients (or aged, blind, or disabled individuals in States that apply more restrictive eligibility requirements).
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance from AFDC or SSI due to earnings from work or increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children born after September 30, 1983, in families with incomes at or below the Federal poverty level who are under age 19. (This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered).

Medicare Beneficiaries.—Medicaid provides help for certain Medicare beneficiaries. This assistance allows low-income beneficiaries to maintain full Medicare coverage.

There are three groups who receive at least some help from the Medicaid program: (1) QMBs (Qualified Medicare Beneficiaries)—persons who have incomes at or below 100% of the Federal poverty level and resources at or below 200% of the SSI limit. (The QMB group includes those who are fully eligible for Medicaid also.) For QMBs, the State pays the Medicare cost sharing expenses subject to the limits that States may impose on payments rates. (2) SLIMBs (Specified Low-Income Medicare Beneficiaries)—persons who meet all QMB requirements except that their incomes are slightly higher. For those persons, the State plan pays only the Medicare Part B premium. (3) QDWIs (Qualified Disabled and Working Individuals)—persons who were formerly qualified as disabled Medicare beneficiaries but whose incomes exceed the maximum for that program because they returned to work (despite their disability) and thus they are no longer eligible for monthly Social Security benefits. Medicaid must pay the Medicare Part A premium for QDWIs whose income does not exceed 200% of the Federal poverty level.

Optional Eligibility Groups

States also have the option of providing Medicaid coverage for certain other "categorically related" groups of persons receiving Federal matching monies. These optional groups share the characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. These "permissible" groups, for whom Federal matching monies are allowed, include:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185% of the Federal poverty level guidelines. (The exact percentage is set by each State.)
- Children under age 21 who meet the AFDC income and resources requirements.

- Recipients of State supplementary payments.
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community based services waivers.
- Institutionalized individuals eligible under a special income level (the amount is set by each State—up to 300% of the SSI Federal benefits rate).
- Tuberculosis (TB) infected persons who would be financially eligible for Medicaid at the SSI level. (Eligibility is only for TB-related ambulatory services and drugs.)
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level.
- "Medically needy" persons.

Medically Needy.— These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by the State. Medically needy income levels are higher than the regular Medicaid eligibility levels; thus, persons may qualify immediately, or may "spend down" by incurring medical and/or remedial care expenses that cause them to be at or below their State's level for this medically needy program.

The medically needy program does not have to be as extensive as the program for the categorically eligible groups, and may be quite restrictive in rules as to who is covered and/or as to what services are offered. Federal matching monies are available. However, if a State elects to have any medically needy program, there are Federal requirements that certain groups and certain services must be included. Children under age 19 and pregnant women must be covered; and prenatal and delivery care for pregnant women, and ambulatory care for children must be provided. A State may elect to provide eligibility to certain additional groups, and may elect to provide certain additional services. In 1995, 43 States elected to have a medically needy program, and provided at least some services for at least some medically needy recipients. The remaining States utilized the "special income level" option (above) to assist other low-income persons who are aged and institutionalized.

Recent Changes to Eligibility Requirements

Welfare reform legislation enacted in 1996 (The Personal Responsibility and Work Opportunity Reconciliation Act) will change Medicaid eligibility requirements as States implement the new legislation. Many noncitizens (who might otherwise qualify for Medicaid) entering the country on or after August 22, 1996, are not eligible. However, the States have the option to continue coverage

for most noncitizens who were already receiving Medicaid and to receive Federal matching funds.

The new legislation also eliminates the AFDC cash assistance program and replaces it with a block grant program called Temporary Assistance for Needy Families (TANF). However, families who met the AFDC eligibility criteria prior to welfare reform will usually continue to be eligible for Medicaid.

In most States, individuals who are eligible for SSI are also eligible for Medicaid. The law will result in some children losing SSI. Many of the children affected will still continue to be covered under Medicaid because they meet other Medicaid eligibility criteria.

Services

In order to receive Federal matching funds, the State programs must offer certain *basic* services. Within broad Federal guidelines, the States determine the amount and duration of services offered under their programs. They may limit, for example, the days of hospital care or the number of physician visits covered. However, some restrictions apply: Limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits. Limits on required (nonoptional) services may not discriminate among beneficiaries based on medical diagnosis or conditions.

With certain exceptions, the States must allow Medicaid recipients freedom of choice among participating providers of health care services. States may pay for the services through

Basic Medicaid Services

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for individuals aged 21 or older
- Home health care for persons eligible for skilled nursing services
- Family planning services and supplies
- Rural health clinic services
- Laboratory and X-ray services
- Pediatric and family nurse-practitioner services
- Federally qualified health center (FQHC) services and ambulatory and services of an FQHC that would be available in other settings.
- Nurse-midwife services
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21

various prepayment arrangements, such as an HMO. In general, States are required to provide comparable services to all categorically needy eligible persons.

The States may also receive Federal funding for providing other approved optional services. There are currently 34 optional services which may be provided with Federal support. The most common of these are diagnostic services, prescription drugs and prosthetic devices, clinic services, nursing facility services for the aged and disabled, intermediate care facilities for the mentally retarded, optometrist services and eyeglasses, rehabilitation and physical therapy services, and transportation services.

Additionally, States may also pay for home and community based care to certain persons with chronic impairments. Another option allows eight States (as a demonstration project) to pay for community supported living arrangement services for persons with mental retardation or a related condition.

Payment for Services

Medicaid operates as a vendor payment program, with payments made directly to providers who must accept the Medicaid reimbursement level as payment in full. Each State has broad discretion in determining (within federally imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with two exceptions: For institutional services, payment may not exceed amounts that would be paid under Medicare payment rates; and for hospice care services, rates cannot be lower than Medicare rates.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients. However, certain recipients are excluded: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy HMO enrollees. Emergency services and family planning services are exempt from copayments for all recipients.

The amount of total Federal outlays for Medicaid has no set limit (cap); rather, the Federal Government must match (at a predetermined percentage) the mandatory services plus the optional services the State decides to provide, and matches (at the appropriate administrative rate) necessary and proper administrative costs.

In 1995, total Medicaid payments averaged $3,311 per recipient. However, many Medicaid recipients require relatively small expenditures per person per year. For example, data indicate that Medicaid vendor payments for over 17 million children under age 21 averaged $1,047 per child. Other groups have very large expenditures per person. Over 151,000 recipients requiring ICF/MR care had average vendor payments of more than $68,600 per person (plus the cost of other services and acute care provided outside of

the ICF/MR facility). Medicaid pays the medical costs of approximately 50% of persons with AIDS. A relatively small number of patients requiring very specialized and intensive medical care (for example, very premature babies and severely burned victims) can have expenses amounting to $4,000 per person per day. A few persons with continuing, extensive medical care needs (for example, high spinal cord or massive brain injuries) can require $100,000 of Medicaid vendor payments per person per year after year for decades.

Medicaid's compound rate of growth is projected to be 7.5% per year. If current expenditure trends continue, total payments (Federal and State) could increase to $230 billion by the year 2000.

Number of Medicaid recipients and total and average vendor payment amounts, by eligibility category and type of service, fiscal year 1995

Category and service	Number of recipients (in thousands)	Total payments (in millions)	Average payment
Category			
All recipients	36,282	$120,141	$3,311
Dependent children under age 21	17,164	17,976	1,047
Adults in families with dependent children	7,604	13,511	1,777
Persons aged 65 or olde	4,119	36,527	8,868
Blind persons	92	848	9,256
Disabled persons	5,767	48,570	8,422
Other (unknown included)*	1,537	2,708	1,762
Service			
General hospital	5,581	26,331	4,735
Mental hospital	84	2,511	29,847
Nursing facility	1,667	29,052	17,424
CF/MR	15,326	10,383	68,613
Prescribed drugs	23,723	9,791	413
Physician	23,789	7,360	309
Outpatient hospital	16,712	6,627	397
Home health	1,639	9,406	5,740
Other care	11,416	9,214	807
Clinical services	5,322	4,280	804
Laboratory and X-rays	13,064	1,180	90
Dental	6,383	1,019	160
Other practitioner	5,528	986	178
Family planning	2,501	514	206
Rural health clinic	1,242	216	174
EPSDT	6,612	1,169	177
Unknown	6	101	17,549

*Unknown numbers are high because Section 1115 (health care reform demonstrations) waiver data for Oregon and Tennessee were placed in the Unknown category.

Financing and Administration

The portion of the Medicaid program that is paid by the Federal Government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each State by a formula that compares the State's average per capita income level with the national average. By law, the FMAP cannot be lower than 50% nor greater than 83%. In 1997, the FMAPs vary from 50% (13 States and the District of Columbia) to 77.2% (Mississippi), with the average Federal share among all States being 57.0%. The Federal Government also reimburses States for 100% of the cost of services povided through facilities of the Indian Health Services.

The Federal Government also shares in the State's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50% for all States. Depending on the complexities and need for incentives for a particular service, higher matching rates are authorized for certain functions and activities.

Medicaid, FY '95
[in billions]

Total outlays	**159,479**
Federal share	89,029
State share	70,450
Medical assistance payments	**151,817**
Federal share	85,486
State share	66,331
Administrative payments	**7,662**
Federal share	3,543
State share	4,119

The Health Care Financing Administration (HCFA) within the Department of Health and Human services is the Federal agency that purchases health care services for the Medicaid program. HCFA administers the program from its headquarters in Baltimore, Maryland, and through 10 regional offices nationwide.

Programs for Specific Groups

Veterans' Benefits

Benefit programs for military veterans had their origins in the earliest days of the Nation's history. Pensions for disabled veterans of the Revolutionary War were paid by the Federal Government in 1789, and shortly thereafter for widows and orphans of men who died in service. The initial scope of the veterans' benefit system was broadened early in the 19th century with the introduction of programs for medical and hospital care.

America's involvement in World War I triggered the establishment of several new programs that provided disability compensation, life insurance, and vocational rehabilitation. Significant provisions for veterans were added in 1944 as a result of the World War II GI Bill of Rights, including extensive educational benefits and a home loan program.

During fiscal year 1994, total benefits to veterans and their dependents, exclusive of career retirement and Social Security benefits, was $36.2 billion. This amount included $19.5 billion for disabled veterans, their dependents, and survivors; $15.6 billion for medical programs; and $1.1 billion for educational programs. In September 1994, disability compensation or pension payments were being made to 2,659,000 veterans. Of these, 2,218,000 had service-connected disabilities and 441,000 were receiving nonservice-connected pensions. In addition, benefits were payable to survivors of 683,000 deceased veterans (based on service- and nonservice-connected deaths).

Eligibility for Benefits

Eligibility for most benefits is based on discharge from active military service under other than dishonorable conditions for a minimum period specified by law. Active service generally means full-time service as a member of the Army, Navy, Air Force, Marines, Coast Guard, or as a commissioned officer of the Public Health Service, the Environmental Services Administration, or the National Oceanic and Atmospheric Administration. Completion of at least 6 years of honorable service in the Selected Reserves also provides for home-loan benefits for those not otherwise eligible. Persons serving in the reserves also may be eligible for educational benefits. Men and women veterans with similar service are entitled to the same benefits. Service in 28 organizations during special periods that include World Wars I and II has been certified as active military service by the Defense

Department. Members of these groups may be eligible for veterans' benefits if the Defense Department certifies their service and issues a discharge under honorable conditions.

Types and Amounts of Benefits

Many of the benefits and services provided to veterans were adopted to help war veterans readjust to civilian life. These benefits include but are not limited to disability compensation, benefits for survivors, health care, and educational assistance and training.

Disability Compensation

There are two major cash payment programs for veterans. The first program provides benefits to the veteran with service-connected disabilities and, on the veteran's death, benefits are paid to the eligible spouse and children. These benefits are not means tested. The second program provides benefits to veterans who have nonservice-connected disabilities. These benefits, however, are means tested.

Service-Connected Disabilities.—The disability compensation program pays monthly cash benefits to veterans whose disabilities resulted from injuries or diseases incurred or aggravated by active military duty, whether in wartime or peacetime. The amount of monthly compensation depends on the degree of disability, rated as the percentage of normal function lost. Payments range from $94 a month for a 10% disability to $1,924 a month for total disability. Additional amounts may be paid when a veteran suffers severe disabilities. Veterans who have at least a 30% service-connected disability are entitled to an additional allowance for dependents. The amount, up to $240 a month for a spouse and two children, is based on the number of dependents and the degree of disability.

Nonservice-Connected Disabilities.—Monthly benefits are provided to wartime veterans with limited income and resources who are totally and permanently disabled because of conditions not

1997 compensation rates*

Disability	Monthly rate
10%	$94
20%	$179
30%	$274
40%	$391
50%	$558
60%	$703
70%	$887
80%	$1,028
90%	$1,157
100%	$1,924

*Effective December 1, 1996. For single veterans without dependents.

attributable to their military service. To qualify for these pensions, a veteran must have served in one or more of the following designated war periods: the Mexican Border Period, World War I, World War II, the Korean Conflict, the Vietnam Era, or the Persian Gulf War. Generally, the period of service must have lasted at least 90 days and the discharge or separation cannot have been dishonorable.

Effective December 1, 1996, maximum benefit amounts for nonservice-connected disabilities range from $707 per month for a single veteran without a dependent spouse or child to $1,350 per month for a veteran in need of regular aid and attendance and who has one dependent. For each additional dependent child, the pension is raised by $120 per month. Benefits to veterans without dependents are reduced to $90 per month if they are receiving long-term domiciliary or medical care from the Department of Veterans Affairs (VA). Benefits are reduced by $1 for each $1 the beneficiary has in other income.

Benefits for Survivors

The Dependency and Indemnity Compensation (DIC) program provides monthly benefits to surviving spouses, children (younger than age 18, disabled, or students), and low-income parents of servicemembers or veterans who died from: (1) a disease or injury incurred or aggravated while on active duty or active duty for training; or (2) any injury incurred or aggravated in the line of duty while on inactive duty training; or (3) a disability compensable by VA.

1997 Improved Death Pension

Recipient	Maximum annual income
Surviving spouse with—	
No dependent children	$5,688
One dependent child	$7,450
Surviving spouse in need of regular aid and attendance with—	
No dependent child	$9,096
One dependent child	$10,854
Surviving spouse permanently housebound with—	
No dependent children	$6,954
One dependent child	$8,712
Increase for each additional dependent child	$1,445
Pension rates for each surviving child	$1,445

The DIC program also provides for spouses and children of veterans who were totally service-connected disabled at the time of their death but whose deaths were not the result of their service-connected disability, if: (1) the veteran was continuously rated totally disabled for a period of 10 or more years immediately preceding death; or (2) the veteran was so rated for a period of not less than 5 years from the date of discharge from military service.

Surviving spouses of veterans who died before January 1, 1993, receive a benefit amount that is based on the veterans' pay grade. In 1997, for pay grades E-1 through E-6, a monthly rate of $833 is paid to surviving spouses. For grades E-7 through E-10, the amount ranges from $861 to $1,774 a month. If the veteran died on or after January 1, 1993, a basic monthly rate of $833 is payable. A surviving spouse receives an additional $182 a month if the deceased veteran had been entitled to receive 100% service-connected compensation for at least 8 years immediately preceding death and the surviving spouse was married to the veteran for those 8 years. The monthly amounts payable to eligible parents depend upon the income of the parents. The 1997 maximum for two parents is $12,977; the maximum for one parent is $9,654.

In addition to their regular benefit, surviving spouses and parents may be granted a special allowance for the aid and attendance of another person if they are patients in a nursing home or require the regular assistance of another person.

Death Pension.—Surviving spouses and unmarried children of deceased veterans with wartime service may be eligible for a nonservice-connected pension based on need. The pension amount depends on the composition of the surviving family and the physical condition of the surviving spouse. Pensions range in 1997 from $474 a month for a surviving spouse without dependent children to $904 a month for a surviving spouse who is in need of regular aid and attendance and who has a dependent child. The pension is raised by $120 a month for each additional dependent child.

Health Care Benefits

The Department of Veterans Affairs provides a nationwide system of hospital and other medical care.

Many health care benefits are provided to veterans who need certain types of care but not hospitalization—for example, nursing and domiciliary care, outpatient medical and dental treatment, treatment for alcohol and drug dependence, prosthetic services, and services and aids for the blind. Medical care is also provided for dependents and survivors of veterans.

Hospital and Outpatient Care.—Eligibility for VA hospital and outpatient care is divided into two categories: In the first category,

VA provides any needed care to the extent and in the amount that Congress appropriates funds. In the second category, VA provides any needed care to the extent resources and facilities are available, if the veteran makes a copayment.

Category 1 is composed of the following veterans—

- veterans in need of care for a service-connected condition;
- veterans who have a compensable service-connected disability;
- veterans whose discharge or release from active military service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoners of war;
- veterans of the Mexican Border period or World War I;
- veterans who were exposed to Agent Orange in Vietnam, ionizing radiation, or environmental hazards in the Persian Gulf; and
- veterans whose annual income and net worth is below the means test threshold, which is adjusted annually and published in January.

Category 2 includes all other veterans (including nonservice connected veterans with incomes and net worth above the means test threshold and zero percent service-connected veterans needing care for any nonservice-connected disability). These veterans must agree to make copayments. These patients are responsible for the Medicare deductible for the first 90 days of care during any 365-day period. For each additional 90 days of hospital care, the patient pays one-half the deductible. In addition to these charges, the patient is charged $10 a day for hospital care and $5 a day for VA nursing home care. For outpatient care, the copayment is 20% of the cost of an average outpatient visit.

Medical Care for Dependents and Survivors.—CHAMPVA, the VA Civilian Health and Medical Program, shares the cost of medical care for dependents and survivors of veterans. The following are eligible for the program provided they are not eligible for CHAMPUS (the health program administered by the Department of Defense for dependents of active duty personnel, and military retirees and their dependents) or Medicare: (1) The spouse or child of a veteran who has a permanent and total service-connected disability, (2) the surviving spouse or child of a veteran who died as a result of a service-connected condition, or

who, at the time of death, was permanently and totally disabled from a service-connected condition, and (3) the surviving spouse or child of a person who died in the line of duty within 30 days of entry into active service.

Beneficiaries covered by CHAMPVA may be treated at VA facilities when space is available. Usually, however, they receive treatment at a community hospital of their choice. The VA pays for part of the bill and the beneficiary is responsible for a copayment.

Educational Assistance and Training

Educational assistance is available to veterans under three acts. The GI Bill of Rights provides assistance to those who served on active duty between January 31, 1955, and January 1, 1977. The Veterans' Educational Assistance program is available to those who have served since January 1, 1977, and who enrolled in the program before July 1, 1985. Since July 1, 1985, veterans have been entitled to aid under the Veterans' Educational Assistance Act of 1984.

Individuals who elect to participate in the Veterans' Educational Assistance Program (VEAP) have their contributions matched $2 for $1 by the Department of Defense. A veteran will receive a monthly payment for the number of months contributed or for 36 months, whichever is less. A typical VEAP payment is $150. For example, a participant contributes $1,800 over a 36-month period and the Government adds $3,600 ($2 for $1 match). This results in a total entitlement amount of $5,400. This amount would be divided by 36 months, yielding a monthly benefit of $150 for full-time schooling for the veteran. A veteran has 10 years from the date of last discharge or release from active duty to use VEAP benefits.

Educational assistance is also provided for the spouse and for children (aged 18-26) of veterans who are permanently and totally disabled from a service-related cause. Servicemembers, veterans, and dependents of deceased and totally disabled veterans may receive a wide range of vocational and educational counseling services throughout the period they are eligible for an educational assistance program administered by the VA.

Administration

The Department of Veterans Affairs was established March 15, 1989, with Cabinet rank, succeeding the Veterans' Administration. Its responsibilities are carried out through nationwide programs that are administered through the Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery System. Each organization has field facilities as well as a central office component.

Government Employee Retirement Systems

The Federal Government, the 50 States, and many localities maintain programs that provide retirement, disability, and survivor benefits for their employees. Many of these jurisdictions also provide medical benefits and paid sick leave and workers' compensation.

In addition to coverage under the Social Security program, members of the Armed Forces with 20 or more years service receive military retirement benefits and medical care through the Department of Veterans Affairs.

Federal Government

The first retirement program for Federal civilian workers was enacted in 1920. The program covered about 330,000 persons and provided benefits to those who retired because of age or disability after at least 15 years of service. In September of 1996, 2.6 million Federal workers were covered. This figure included workers covered by the Civil Service Retirement System (CSRS) and those under the more recently established Federal Employees Retirement System (FERS).

In general, employees hired before January 1, 1984, are covered by CSRS and those hired on or after that date are covered under FERS. Several separate retirement systems cover special classes of employees, such as those in the Foreign Service or the Central Intelligence Agency.

Generally speaking, the CSRS is a defined benefit plan, financed through joint employer-employee contributions, that provides annuities in the event of the retirement, disability, or death of a covered worker. FERS is a three-tiered system including Social Security, a Federal pension, and a tax-deferred savings plan. All workers enrolled in FERS are covered by Social Security. They contribute to it at the current tax rate and are eligible for the same benefits as all other workers covered by the program.

In addition, a worker who meets the full age and service requirements for an annuity under FERS, but at an age when Social Security benefits are not yet payable, may receive a Special Retirement Supplement until he or she attains age 62. This benefit approximates the Social Security benefit earned during Federal service, and stops when the retiree begins to receive the Social Security benefit.

The third and final tier of FERS is a tax-deferred savings plan known as the Thrift Savings Plan. Under this plan, workers may contribute up to 10% of their salaries to the plan, with the Government matching up to 5% of the salary. Contributions and interest earnings are not taxable until they are withdrawn, usually at retirement. These funds may be invested in U.S. Government securities, in a private sector fixed-income fund, or in a common stock index fund.

Under the CSRS, workers and their employing agencies each contribute 7% of the worker's salary. Under FERS, workers and their agencies each contribute 7.65% of salary to Social Security and 0.8% to the pension fund. In both cases, the Government assumes the balance of the cost, including unfunded liabilities.

In addition, all Federal civilian workers are covered by the Hospital Insurance program (Part A of Medicare), and contribute 1.45% of their salaries to that program.

The Federal pension segment of FERS is administered by the Civil Service Retirement and Disability Trust Fund, as is the CSRS. In 1996, the fund paid $33.0 billion to 1.7 million retired and disabled annuitants, and $5.7 billion to 621,000 survivor annuitants. About 98% of all annuitants received benefits under the CSRS.

The group life and health insurance programs available to Federal employees are optional and are financed by joint contributions from the worker and his or her employing agency. The Gov-

Federal pension qualifications and amount of annuity based on age and service

Type of pension	Qualifications	Amount of annuity
	CSRS	
Retirement	Age 55 with 30 years of service, Age 60 with 20 years of service, or Age 62 with 5 years of service	1.5% of high-three average earnings* for each of the first 5 years of service, 1.75 for each of the next 5, and 2% thereafter
Disability	Any age with 5 years of service	The lesser of 40% of high-three average earnings* or the projection of service to age 62
Survivorship	Death of an employee or annuitant	Employee: 55% of disability guarantee Annuitant: 55% of benefit amount
	FERS	
Retirement	Same as CSRS	1.1% of high-three average earnings* for each year of service for those retiring at age 62 with at least 20 years of service; 1% for all others
Disability	Any age with 18 months of service	60% of high-three average earnings the first year, and 40% thereafter
Survivorship	Same as CSRS	Employee: With 18 months to 10 years of service, a lump-sum payment; with 10 or more years of service, 50% of projected annuity Annuitant: 50% of benefit amount

* The average of a worker's three highest-salaried years, normally the last three before retirement.

ernment pays one-third of the cost of basic life insurance and an average of 70% of the cost of health insurance. Workers receive 13 days of paid sick leave each year, which may be accumulated without limit. Under CSRS (but not under FERS) this accumulated sick leave may be credited toward length of service at retirement.

The Federal Employees Compensation Act (workers' compensation) provides benefits in the event of job-related injury, illness, or death. Unemployment insurance for Federal workers is paid for by Government employer contributions to the Federal-State unemployment insurance system.

Armed Forces

Since 1957, all members of the U.S. Armed Forces have been covered by the Social Security program. Those individuals with 20 or more years of service are also eligible for retirement benefits under the military retirement system.

Military retirement pay is noncontributory, and is equal to 2.5% of a servicemember's final basic pay for each year of service. For those who entered the Armed Forces after September 8, 1980, the formula uses the average of the highest paid 3 years instead of final pay. Persons who entered the Armed Forces after August 1, 1986, have this basic benefit reduced for each year under 30 years of service at the time of retirement. An unreduced pension (30 years or more) provides 75% of pre-retirement basic pay, although the retiree may elect to have this amount reduced in order to provide a survivor benefit for his or her spouse. This survivor benefit is a proportion (up to 55%) of the retired service member's unreduced benefit at the time of death. During 1996, 1.8 million retired service members and their survivors received $28.5 billion in military retirement benefits.

The Department of Defense provides medical care for active duty personnel, retirees and their dependents. In addition to care in the hospitals and clinics maintained by the Department, the dependents of active duty personnel and retirees and their dependents are eligible for a program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This program shares the cost of civilian medical services when care is not available at a military facility. Direct care facilities and CHAMPUS are both funded through the Department of Defense.

The Federal Government contributes to the Federal-State unemployment insurance system on behalf of military personnel. Ex-servicemembers are qualified for unemployment insurance on the same basis as other workers in their States.

State and Local Government

The majority of State and local government employees are covered by retirement systems maintained by the States and localities. The provisions of these plans vary from one jurisdiction to another. However, nearly all require contributions from their

employees and nearly all guarantee benefits at least equal to the amount of those contributions.

Most State and local plans permit retirement because of disability or age, and provide for early retirement at a reduced benefit. It is usual for employees in high-risk jobs, such as police officers and firefighters, to be eligible for retirement based only on length of service, regardless of age. Normally, other workers must meet both age and length of service requirements.

Benefits under State and local retirement systems are usually calculated on a 3- to 5-year average salary and a 1.5- or 2.0% multiplier for each year of service. The multiplier is lower in plans where workers are covered by Social Security and benefits are integrated with the Social Security programs. Although relatively few systems provide survivor benefits per se, retiring workers are commonly given the option of electing a smaller benefit in order to provide for a surviving spouse.

Paid sick leave is often provided by State and local governments to their employees. Group life and health insurance plans are also commonly offered. Government workers are usually covered by their State's unemployment insurance and workers' compensation programs.

Railroad Retirement

At the time of the Great Depression of the early 1930's, few of the Nation's elderly were covered under any type of retirement plan. The situation was better for workers in the railroad industry: 80% were covered by some type of private pension plan by 1927. However, these plans were inadequate to the demands made by the general deterioration of employment conditions in the 1930's. While the Social Security system was in the planning stage, railroad workers sought a separate Railroad Retirement system to continue and broaden the existing railroad programs under a uniform national plan. As a result, legislation was enacted in 1934, 1935, and 1937 establishing a railroad retirement system separate from the Social Security program legislated in 1935.

Also based on social insurance principles, the Railroad Retirement program provides monthly benefits to retired and disabled workers and their dependents and to survivors of deceased workers. Coverage under the Railroad Retirement system has declined in the years since the program was established, paralleling the decline in the railroad industry itself. In 1939, the system covered 1.2 million employees: by the mid-1990's that number was 266,000. There were 799,000 beneficiaries on the rolls at the end of fiscal year 1995, of whom 548,000 were employee or spouse annuitants and 251,000 were survivor annuitants.

The specific benefit provisions of the program have changed a number of times since 1937, as the shrinking of the railroad system caused various financial problems. The structure of the current system was established by the Railroad Retirement Act of 1974, although amendments were made in 1981 and later years.

Eligibility for Benefits

To be eligible for Railroad Retirement benefits, an employee must have 10 years (120 months) of creditable railroad service. Those with less time in service have their railroad employment credited under the Social Security system.

A special minimum guarantee provision ensures that railroad families will not receive less in monthly benefits than they would have if their earnings had been covered under Social Security. In addition, persons covered by the Railroad Retirement program participate in Medicare on the same basis as those covered by Social Security.

Annuities are calculated under a two-tier formula. The first tier is calculated generally the same as for a Social Security benefit and is based on railroad credits and any Social Security credits an employee has accrued. This Tier I portion is the equivalent of a Social Security benefit. The second tier is based on railroad credits only, and it may be compared to pensions paid over and above Social Security benefits to workers in other industries.

Types and Amounts of Benefits

When the employee's annuity begins, the amount of Railroad Retirement benefits payable is limited to a family maximum based on the highest 2 years of creditable earnings in the previous 10-year period. Benefits are subsequently increased for the cost of living, and the maximum increases every year as the amounts of creditable earnings rise.

For workers first entitled to a railroad annuity and a Federal, State, or local government pension after 1985, the Tier I amount is reduced for receipt of a public pension based on employment not covered by Social Security. There is a guarantee that the Tier I amount cannot be reduced by more than 50% of the public pension amount. Similar provisions apply to spouse annuities.

The Tier I and vested dual benefit components of employee and spouse annuities may also be subject to limitations based on any earnings outside the railroad industry, although no reduction is made after the annuitant attains age 70. In 1997, annual earnings of up to $13,500 for those aged 65-69 and $8,640 for those under age 65 are exempt from such work deductions.

The Tier I portion of a disability annuity may, under certain circumstances, be reduced for receipt of workers' compensation or public disability benefits. The annuity is not payable for any month in which the annuitant earns more than $400 from employment or self-employment, although withheld payments will be restored if earnings for the year are less than $5,000.

Types of benefits and qualifying conditions

Employee and spouse annuities
Age 62 with 10-29 years of service, with actuarial reduction for annuities awarded before age 65.

or

Age 60 with 30 or more years of service, with actuarial for annuities awarded before age 62.

Total disability annuities
Ten years service and permanent disability for all regular work.

Occupational disability annuities
Age 60 with 10 years of service, or any age with 20 or more years of service, a current connection to the railroad industry,* and permanent disability for one's regular railroad occupation.

Vested dual benefits
Qualification for both Railroad Retirement and Social Security benefits as of December 31, 1975, and a current connection to the railroad industry.*

Supplemental annuities
Age 65 with 25-29 years of service, or age 60 with 30 or more years service of service, and a current connection to the railroad industry.*

Survivor annuities
Ten or more years of service and a current connection to the railroad industry.* Paid to widows, widowers, children, and certain other dependents of the deceased employee.

Lump-sum benefits
Ten or more years of service and a current connection to the railroad industry.* Paid when there is no survivor eligible for an annuity.

* An employee with 12 or more months of service in the 30 months preceding retirement or death is deemed to have a current connection to the railroad industry.

The Tier I portion of railroad annuities is usually increased for the rise in the cost of living at the same time, and by the same percentage, as are Social Security benefits. Tier II annuities are normally increased annually by 32.5% of the increase in the Consumer Price Index.

Financing and Administration

The financial interchange between the Railroad Retirement and Social Security programs is intended to put the Social Security trust funds in the same position they would have been in if railroad employment had been covered under the Social Security Act. It follows that all computations under the financial interchange are performed according to Social Security law.

If a retired or disabled railroad annuitant is also awarded Social Security benefits, the amount of his or her Tier I payment is

Benefits and beneficiaries under the Railroad Retirement system, January 1996

Type of benefit	Number	Average benefit amount
Total	7,900,100	...
Regular employee annuities	349,300	$1,173
Age	271,000	1,163
Disability		
Age 65 or older	43,300	1,017
Under age 65	35,000	1,440
Spouses and divorced spouses	192,400	467
Widow(ers)s–aged and disabled	216,900	697
Widowed mothers and fathers	1,600	865
Widow(er)s–remarried and divorced	14,600	491
Children	15,300	605
Other survivors	100	465

Note: Data are on a cash basis (unaudited) and are partly estimated. Detail may not add to total due to rounding. Total for regular retirement and survivor benefit payments totals includes Hospital Insurance benefits for services in Canada.

Source: U.S. Railroad Retirement Board, *Benefits and Beneficiaries Under the Railroad Retirement and Unemployment Insurance Systems-January 1996.*

reduced by the amount of the Social Security benefit. This reduction occurs because the Tier I portion is based on combined railroad and Social Security credits, figured under Social Security formulas, and reflects what Social Security would pay if railroad work were covered by that system. This dual benefit reduction follows the principles of Social Security, under which the beneficiary receives only the higher of any two benefits payable.

Railroad Retirement Tier I taxes are coordinated with Social Security taxes and are increased at the same time. Employers and employees pay Tier I taxes at the Social Security rate—7.65% in 1996. In addition, both employers and employees pay Tier II taxes to finance the industry pension segment of the annuities. In 1996, the employer tax rate was 16.10%, and the employee tax rate was 4.90%. The earnings base for Tier I taxes is the same as for Social Security—$62,700 in 1996. The Tier II earnings base for the same year was $46,500. As of 1993, tax contributions to the Medicare program are levied on all earnings. Tier I benefits are taxed like Social Security benefits; Tier II benefits are taxed like other private pensions.

The Railroad Retirement Board is an independent agency in the Executive Branch of the Federal Government. It is administered

by three members appointed by the President, with the advice and consent of the Senate. One member is appointed on the recommendation of railroad labor organizations, one on the recommendation of railroad employers, and the third—the chairman—represents the public interest. The term of office is 5 years and the three terms are arranged to expire in different calendar years.

Unemployment Insurance and Sickness Benefits

Like the retirement system, the railroad unemployment insurance system was established in the 1930's. The Great Depression demonstrated the need for unemployment compensation programs, and State programs were established under the Social Security Act.

State unemployment programs generally covered railroad workers, but railroad operations that crossed State lines caused special problems. Because of differences in State laws, railroad employees working in the same jobs on the same railroad in different States received different treatment and different benefits when they became unemployed. Workers whose jobs required that they cross State lines sometimes found that they were not eligible for benefits in any of the States in which they worked.

It was therefore recommended that railroad workers be covered by a separate plan. Congress enacted the Railroad Unemployment Insurance Act in June 1938. The Act established a system of benefits for unemployed railroad workers, financed by railroad employers and administered by the Railroad Retirement Board.

In 1946, Congress extended the railroad unemployment insurance program to include cash payments for temporary sickness and special maternity benefits. Both programs are financed by the contributions of railroad employers only, based on the taxable earnings of their employees. In 1996, the taxable earnings base was the first $865 of each employee's monthly salary.

Assistance Programs

Supplemental Security Income

In 1972, Congress replaced the categorical Federal-State programs for the needy aged, blind, and disabled with the Federal Supplemental Security Income (SSI) program, which is administered by the Social Security Administration (SSA). This ended the multiplicity of eligibility requirements and benefit levels that had characterized the assistance programs formerly administered at the State and local levels. The program went into effect in January 1974.

The SSI program consists of two parts—the Federal program, and State supplementation of the Federal payment. Under the Federal program the eligibility requirements are nationally uniform for age, the limits on income and resources allowed, and the definitions of disability or blindness. Federal benefit payments are also nationally uniform so that regardless of where qualified individuals live, they are guaranteed the same minimum payment.

Anyone who received assistance under the former State assistance programs before January 1, 1974, could not receive lower benefits under the new program. States whose previous assistance levels were higher than the Federal SSI payment were required to supplement it in order to maintain that assistance level. In addition, States were given the option of supplementing the Federal payment for all, or certain categories, of their recipients. As of January 1997, all but two States offered supplementary payments to at least some of their recipients.

In December 1996, 6.7 million people received Federal SSI payments, State supplementation, or both. These payments averaged $366 that month.

Eligibility

Basic requirements for SSI eligibility involve citizenship, income, financial resources, age, and disability.

Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, SSI eligibility is generally restricted to U.S. citizens residing in one of the 50 States, the District of Columbia, or the Northern Mariana Islands. However, eligibility is still possible for noncitizen members of certain classes of refugees or asylees, active duty or retired military personnel and their families, and lawful permanent residents who have earned or can be credited with 40 quarters of Social Security covered employment.

The SSI program provides monthly cash payments to aged, blind, or disabled persons whose countable income is less than $5,808 per year (or is less than a combined income of $8,712 for a couple with both eligible), as of January 1, 1997. In most cases ownership of financial assets is limited to $2,000 for an individual or $3,000 for a couple.

To qualify as aged, an individual must be at least 65 years old. Qualifying standards for SSI payments based on disability are almost the same as those used for the Social Security Disability Insurance program. That is, an individual is considered to be disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or which has lasted (or can be expected to last) for a continuous period of 12 months. This 12-month requirement does not apply to the blind in SSI.

The substantial gainful activity criterion does not apply to children under age 18. The standard for them is a medically determinable physical or mental impairment *which results in marked and severe functional limitations.*

An individual is considered to be blind if he or she has a central visual acuity of 20/200 or less in the better eye with the use of correcting lenses, or has tunnel vision of 20 degrees or less.

As of January 1, 1997, persons for whom drug addiction or alcoholism is a contributing factor material to the finding of disability ceased to be eligible for SSI.

Inmates of public institutions, including prisoners, are not eligible for SSI. There are some exceptions to this general rule: those in medical institutions where the Medicaid program pays more than half of the cost of their care may receive up to $30 monthly; and those who live in certain public emergency shelters and community based residences for 16 persons or less may, if otherwise eligible, receive SSI.

Benefits and Factors Affecting Benefits

For the year beginning January 1, 1997, a maximum Federal monthly SSI payment of $484 is payable to eligible individuals living in their own households. To receive the maximum, individuals generally must have no more than $20 in other income. Couples, in which both husband and wife are eligible for SSI may receive a maximum Federal monthly payment of $726. The SSI Federal benefit rate is increased annually by the same cost of living factor applicable to Social Security benefits.

In December 1996, 6.3 million persons were receiving Federal SSI payments averaging $339 per month.

Income

The maximum SSI payment is reduced to reflect other income

and in-kind support and maintenance. If a recipient lives in another person's household and receives both food and shelter from the person in whose household he or she is living, the Federal benefit is reduced by one-third. This is done instead of determining the actual dollar value of the in-kind support and maintenance. When recipients have other income, SSI payments are reduced by the amount of that income determined to be countable. The first $20 per month of unearned income generally is not counted. Additional unearned income (most often a Social Security benefit) reduces SSI payments dollar for dollar. SSI recipients are required to apply for any other benefits to which they may be entitled, such as Social Security, unemployment insurance, or workers' compensation.

If a child recipient under age 18 lives with parents, or an adult lives with a spouse who is not eligible for SSI, some of the income of the parent or spouse may be counted as unearned income to the eligible person. This process is called "deeming".

To encourage SSI recipients to work, $65 of earned income in any month is excluded in addition to the initial $20 exclusion. Thereafter, SSI payments are reduced by $1 for every $2 earned.

Other income excluded when determining payment amounts includes certain scholarships, certain student earnings, work expenses of blind persons, impairment-related work expenses of the disabled, payments for providing foster care to a child not eligible for SSI, and the Earned Income Tax Credit. Income necessary for an approved plan for achieving self-support for blind and disabled recipients is also disregarded. Irregular and infrequent income is not counted as long as it does not exceed $20 per month if unearned or $10 a month if earned.

The Employment Opportunities for Disabled Americans Act of 1986 provided additional work incentives—special SSI benefits and Medicaid coverage—to blind and disabled individuals eligible for SSI payments who work despite severe impairments. This legislation made permanent and revised section 1619 of the Social Security Act which was enacted as a temporary demonstration project in 1980.

Under section 1619(a), a disabled recipient who loses Federal SSI eligibility because of earnings over the substantial gainful activity level may continue to receive SSI payments under a special benefit status and retain eligibility for Medicaid under Title XIX of the Social Security Act. This special benefit status may continue as long as the recipient has the disabling impairment and until his or her earnings exceed the amount that would reduce the cash benefit to zero.

In addition, under section 1619(b), blind or disabled recipients who are no longer eligible for either regular or special SSI payments because of their earnings usually may retain Medicaid eligibility if they: (1) continue to have the disabling impairment;

(2) meet all nondisability eligibility criteria except for earned income; (3) would be seriously inhibited from continuing employment without Medicaid services; and (4) have earnings insufficient to provide a reasonable equivalent of SSI payments and Medicaid.

Individuals institutionalized for medical care whose institutional stay at the time of admission is not expected to exceed 3 months, and for whom the receipt of benefits is necessary to maintain living arrangements to which they may return, may continue to receive full SSI payments for up to 3 months at the rate that was applicable to them in the month prior to the first full month of institutionalization. Continued payments may also be made for up to 2 months after entering certain medical or psychiatric institutions for individuals who were eligible under section 1619 of the Social Security Act provided that the institution had agreed to permit the individual to retain these benefits.

Resources

Although the amount of assets a person may hold to be eligible for SSI is fixed at $2,000 for an individual ($3,000 for a couple), certain resources are excluded from consideration. The most important of these is a home occupied by the recipient. Also excluded are personal goods and household effects with an equity value of up to $2,000.

An automobile may be excluded, regardless of its value, if the individual or a member of the individual's household uses it for transportation for employment or medical treatment, if it is modified to be operated by or used for transportation of a handicapped person, or if it is needed for essential daily activities. If an automobile cannot be excluded based on the nature of its use, a current market value of up to $4,500 may be excluded.

Life insurance policies are not countable if the face values do not exceed $1,500. Under certain circumstances, real property can be excluded for as long as the owner's reasonable efforts to sell it are not successful.

Special exclusions are applicable to the resources necessary for an approved plan of self-support for blind or disabled recipients and for property essential to self-support. The value of burial spaces for a recipient, spouse, and immediate family members is excluded, as is up to $1,500 of funds set aside for burial of the individual and spouse.

State Supplementation

States are permitted a great deal of discretion in their supplementation. A State may administer its supplemental payments or choose to have them administered by the Federal Government. States that elect Federal administration of their supplementary

programs may vary the amount of the supplement by reason for eligibility (aged, blind, or disabled) and by status (individual or couple). They may differentiate between various living arrangements (living alone, living with relatives, or living in a domiciliary care facility), although not more than five such arrangements may be recognized in one State. A sixth living arrangement variation is permitted provided it applies only to individuals in Medicaid facilities—that is, facilities receiving Title XIX payments with respect to such persons for the cost of that care. States may also differentiate among geographic regions, although not more than three may be recognized in one State. States that administer their own supplementary programs have even greater discretion over their supplementation criteria.

Financing and Administration

Federal SSI payments and administrative costs are financed from Federal Government general revenues. When a State chooses Federal administration of its supplementation, SSA maintains that State's payment records and issues the Federal payment and the State supplement in one check. Since passage of the Omnibus Budget Reconciliation Act (OBRA) of 1993, States are required to pay fees for Federal administration. Until then SSA assumed the cost of administering these supplements and was reimbursed by the State only for the amount of the supplementary payments.

Applications for federally administered SSI payments are taken at SSA field offices where the supporting documentation is examined, and the field office staff determines whether the appli

Supplemental Security Income, December 1996

Type of SSI payment	Reason for eligiblity			
	Total	Aged	Blind	Disabled
Total	6,677	1,446	*83	**5,146
Federally administered:				
Federal payment	6,326	1,296	76	4,953
Federal payment only	4,192	774	45	3,372
Federal and federally administered State supplement	2,133	522	31	1,580
State supplement only:				
Federally administered	288	116	6	166
State administered	***63	33	1	27
	Number of persons (in thousands)			
Total	$366	$268	$383	$394
Federal	339	229	334	368
Federally administered State supplement	105	112	154	101
State administered State supplement	152	169	172	143

*Includes 20,002 persons aged 65 or older.
**Includes 656,517 persons aged 65 or older.
***Includes persons from whom reason for eligiblity was not available.

cant meets the citizenship, age, income, and asset criteria. When disability or blindness is involved, medical determinations of eligibility are generally made by Disability Determination Services, which are agencies of each individual State. Computation of federally administered benefit amounts is made through SSA's central computer operations and certification is then made to the Treasury Department for the issuance of monthly checks.

SSA field offices may make emergency payments of up to $484 to an eligible individual and $726 to a couple (plus the federally administered State supplementary payments, if any) if severe financial difficulty is evident.

If a State chooses to administer its own supplementation, it processes applications and makes eligibility determinations separately from the Federal Government. As of December 1996, about half the States were administering their own supplementary payments.

Temporary Assistance to Needy Families

Temporary Assistance for Needy Families (TANF) provides assistance and work opportunities to needy families. It replaced the Aid to Families with Dependent Children program (AFDC) as soon as the State submitted a complete plan implementing TANF, but no later than July 1, 1997. AFDC provided cash assistance based on need, income, resources, and family size.

TANF was created by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193). The law contains strong work requirements, a performance bonus to reward States for moving welfare recipients into jobs, State maintenance of effort requirements, comprehensive child support enforcement, and supports for families moving from welfare to work, including increased funding for child care and guaranteed medical coverage.

Nearly all recipients must work after 2 years of assistance. Each State is required to have a fourth of families working or off the rolls by September 30, 1997, and half by 2002. Parents must work a prescribed number of hours per week: single parents, 20 hours the first year and 30 by 2000; couples, 35 hours. Work can be unsubsidized or subsidized employment, on-the-job training, work experience, community service, 12 months of vocational training, or child care provided to individuals participating in community service. Exceptions are allowed for 6 weeks of job search time, parents with a child under age 6 who cannot find child care, and single parents with children under age one.

States must make an initial assessment of recipients' skills, and can develop personal responsibility plans that identify needed education, training, and job placement services. Various incentives

are provided to States to encourage maintaining program spending levels.

Families cannot spend more than five cumulative years on TANF. States can specify fewer years, and exempt up to 20% of the caseload from the time limit. After the time limit is exceeded, they can elect to provide noncash assistance and vouchers to families using Social Services Block Grant or State funds.

Child care funding is provided to help more mothers move into jobs. Women on welfare continue to receive health coverage for their families, including a year or more of transitional Medicaid when they leave welfare for work.

To be eligible for TANF block grants, States must operate a child support enforcement program meeting Federal requirements. The Federal Case Registry and National Directory of New Hires will be used to track delinquent parents across State lines. Child support can be withheld directly from wages, and paternity establishment is streamlined; cash assistance will be reduced by at least 25% in cases of failure to cooperate with paternity establishment. The law establishes uniform interstate child support laws, central registries of child support orders and collections, and toughened enforcement of child support.

Unmarried minor parents are required to live with a responsible adult or in an adult-supervised setting and participate in educational and training activities in order to receive assistance. Efforts are to be undertaken to prevent nonmarital teen pregnancy.

Food and Nutrition Assistance

The U.S. Department of Agriculture provides children and needy families access to a more healthful diet through its food assistance programs and comprehensive nutrition education efforts, and provides farmers an outlet for the distribution of food purchased under farmer assistance authorities.

USDA's Food and Consumer Service administers 15 Federal food and nutrition assistance programs. These programs serve 1 in 6 Americans. This section describes the Food Stamp program, the cornerstone of the USDA food assistance programs; the National School Lunch and School Breakfast programs, which provide pre-school and school-aged children with nutritious meals that are free or provided at a greatly reduced price; and WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), which provides food supplements, nutrition education, and health care referrals.

FCS programs are operated in a State-Federal partnership, in which the Federal Government is generally responsible for food costs for the programs and shares administrative costs with the States. FCS is responsible for interpreting Federal statutes,

issuing program regulations and instructions, establishing nationwide standards, and ensuring program integrity. FCS regional offices monitor State agencies to ensure the adequacy of their administration. States are responsible for determining the eligibility of needy persons to participate in nutrition assistance programs, as well as the delivery of services. States are also generally responsible for coordinating USDA nutrition programs with other local welfare, health care, and assistance programs. For example, in most States the welfare department operates the Food Stamp program, the education department operates the child nutrition programs, and the health department operates WIC.

For FY 1997, Congress appropriated $43 billion for the 15 food and nutrition assistance programs, which represents 75% of the entire USDA budget of $59.1 billion.

Food and Nutrition Assistance Programs

- Food Stamp Program
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- WIC Farmers Market Nutrition Program
- National School Lunch Program
- School Breakfast Program
- Summer Food Service Program
- Emergency Food Assistance Program
- Child and Adult Care Food Program
- Commodity Supplemental Food Program
- Special Milk Program
- Food Distribution Program on Indian Reservations
- Nutrition Program for the Elderly
- Commodity Distribution to Charitable Institutions and to Soup Kitchens and Food Banks
- Nutrition Education and Training Program
- Nutrition Assistance Program in Puerto Rico and the Northern Mariana Islands

Food Stamp Program

The Food Stamp program was begun in its modern form in 1961 as a pilot program and made permanent in 1964, but it originated as the Food Stamp Plan in 1939 to help the needy. Expansion of the program occurred most dramatically after 1974, when Congress required all States to offer food stamps to low-income households. Program growth has continued since then. Participation generally peaks in periods of high unemployment, inflation, and recession.

The program issues monthly allotments of coupons that are redeemable at retail food stores, or provides benefits through electronic benefit transfer (EBT). The EBT system allows food stamp customers, using a plastic card similar to a bank card, to buy

groceries by transferring funds directly from a food stamp benefit account to a retailer's account. Recent welfare reform legislation (The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193)) requires all States to convert to EBT issuance by the year 2002.

Food stamp eligibility and allotments in all 50 States, the District of Columbia, Guam, and the Virgin Islands are based on household size, income, assets, and other factors.

Benefits

In FY 1996, the Food Stamp program served an average of more than 25 million persons each month. The average monthly benefit was more than $73 per person and more than $172 per household.

Eligibility

To participate in the program households may have no more than $2,000 in countable resources, such as a bank account ($3,000 if at least one person in the household is age 60 or older). Certain resources are not counted, such as a home and lot. Special rules apply to the resource value of vehicles owned by household members.

The gross monthly income of most households must be 130% or less of the Federal poverty guidelines ($20,280 for a family of four in 1997). Gross income includes all cash payments to the household, with few exceptions specified in the law or the program regulations.

Net Income Computation.— Net monthly income must be 100% or less of the Federal poverty guidelines. Net income is figured by adding all of a household's gross income, and then taking a number of approved deductions for child care, extra shelter costs, and other expenses. Households with an elderly or disabled member are subject only to the net income test. The welfare reform legislation of 1996 placed caps on the amount of extra shelter costs that could be deducted.

Net income is computed by deducting the following from monthly gross income:

(1) Twenty percent of earned income.

(2) A standard deduction of $134 for FY 1997.

(3) The amount paid for dependent care (up to $200 a month for children under age 2 and $175 for all other dependents) while the dependent's caretaker is working or looking for work.

(4) Any out-of-pocket medical expenses in excess of a $35 deductible for a person aged 60 or older or a disabled person.

If more than one person in the household is aged or disabled, $35 is subtracted once before deducting combined medical expenses.

(5) A child support deduction for legally obligated child support paid for a nonhousehold member.

(6) An excess shelter expense deduction, which is total shelter costs including utilities minus 50% of income after all the above deductions have been subtracted. Effective January 1, 1997, the cap on the excess shelter expense deduction is $250 for households without aged or disabled persons. Households with an aged or disabled person do not have a limit on this deduction.

Most able-bodied adult applicants must meet certain work requirements. All household members must provide a Social Security number or apply for one.

Certification.— Households are certified to receive food stamps for varying lengths of time, depending on their income sources and individual circumstances. Recertification is required at least annually. Households whose sole income is from SSI or Social Security are certified for a 1-year period. However, many States have waivers authorizing 24-month certification periods for these households.

Welfare reform legislation of 1996 placed time limits on benefits for able-bodied, childless adults. Time limits are imposed for childless unemployed adults aged 18-50. Those who are not disabled are limited to 3 months of benefits in any 36-month period, unless they are working 20 hours per week, participating in a work training program for at least 20 hours per week, or participating in workfare. States may request waivers to delay implementation for areas with at least 10% unemployment or insufficient jobs.

Noncitizens.—The welfare reform legislation also prohibits most immigrants from receiving food stamp benefits. Illegal immigrants have always been barred from receiving benefits, but the welfare reform act extended that prohibition to most legal immmigrants as well. Exceptions include veterans or active duty military personnel and their spouses and children, and persons who have 40 quarters of qualified work history in the United States. Refugees, asylees, and certain aliens subject to deportation can receive benefits for up to 5 years after their receive their status.

Determination of Food Stamp Allotment

Households are issued a monthly allotment of food stamps based on the Thrifty Food Plan, a low-cost model diet plan. The TFP is based on the National Academy of Sciences' Recommended Dietary Allowances, and on food choices of low-income households.

An individual household's food stamp allotment is equal to the maximum allotment for that household's size, less 30% of the

household's net income. Households with no countable income receive the maximum allotment.

There are higher allotment levels in Alaska, Hawaii, Guam, and the Virgin Islands. These separate allotment levels reflect higher food prices in those areas.

Households can use food stamps to buy any food or food produce for human consumption, and seeds and plants for use in home gardens to produce food. Though in some remote areas of Alaska, recipients may use food coupons to purchase some kinds of hunting and fishing equipment for procurement of food.

Households Cannot Use Food Stamps to Buy:

- Alcoholic beverages and tobacco
- Lunch counter items or foods to be eaten in the store
- Vitamins or medicines
- Pet foods
- Nonfood items (except seeds and plants)

Restaurants can be authorized to accept food stamps in exchange for low-cost meals from qualified homeless, elderly, or disabled people. Food stamps cannot be exchanged for cash.

Block Grant Program

In Puerto Rico, the Northern Mariana Islands, and American Samoa, the Food Stamp program was replaced in 1982 by a block grant program. The territories now provide cash and coupons to participants rather than food stamps or food distribution. The grant can also be used for administrative expenses or special projects related to food production and distribution.

Congress appropriated the same amount of money for FY 1997 as in FY 1996 for Puerto Rico, $1.1 billion; the Northern Marianas, $5.1 million; and for American Samoa, $5.3 million.

Financing and Administration

In most States, the Food Stamp program is operated through State welfare agencies and local welfare offices. However, Social Security offices notify Social Security and SSI applicants/recipients of the benefits under the Food Stamp program and make food stamp applications available to them. The Social Security offices forward the applications and any supporting documents to the local food stamp offices, where eligibility is determined.

The Federal Government, through general revenues, pays the entire cost of the food stamp benefit, but Federal and State agencies share administrative costs. In FY 1996, the total Federal Food Stamp program cost was $24.4 billion.

Special Supplemental Food Program for Women, Infants, and Children (WIC)

The WIC program provides a combination of food, nutrition counseling, and access to health services to low-income women, infants, and children who are at nutritional risk. WIC seeks to improve fetal development and reduce the incidence of low birthweight, short gestation, and anemia through intervention during the prenatal period. Participants receive food supplements, nutrition education, and access to health care services to maintain and improve their health and development.

Generally, most States provide WIC vouchers that can be used at authorized retail food stores for specific foods that are rich sources of nutrients. WIC foods include iron-fortified infant formula and infant cereal, iron-fortified adult cereal, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, peanut butter or dried beans or peas. Special therapeutic infant formulas are provided when prescribed by a physician for a specified medical condition.

The WIC program, which originated under the Child and Nutrition Act of 1966, was established as a pilot program in 1972 and made permanent in 1974. It is available in each State, the District of Columbia, 32 Indian Tribal Organizations, Puerto Rico, the Virgin Islands, American Samoa, and Guam.

Benefits

In FY 1996, average monthly participation in the WIC program was 7.2 million individuals (1.6 million women, 1.8 million infants, and 3.7 million children). The average monthly benefit was about $31.24 for food per person. Approximately 45% of the infants born in the United States participate in the program.

Eligibility

Pregnant and postpartum women, infants, and children up to age 5 are eligible. They must meet income guidelines, a State residency requirement, and be individually determined to be at "nutritional risk" by a health professional.

Income.—The applicant's income must fall below 185% of the Federal poverty guidelines ($28,860 for a family of four in 1997). While most States use the maximum guidelines, they may set lower income limit standards. A person who participates in certain other benefit programs such as the Food Stamp program or Medicaid automatically meets the income eligibility requirement.

Nutritional Risk.—Two major types of nutritional risk are recognized for WIC eligibility: (1) Medically based risks (designated as high priority) such as anemia, underweight, maternal age, history of pregnancy complications, or poor pregnancy outcomes and (2) diet-based risks such as inadequate dietary pattern. Nutritional risk is determined by a health professional such as a physician,

nutritionist, or nurse, and is based on Federal guidelines. This health screening is free to program applicants.

Financing and Administration

WIC is a Federal grant program that provides each State with a set amount of money to serve its most needy WIC population. Local public or nonprofit private health or welfare agencies, which operate the program, apply to their respective States or jurisdictions to qualify for funds. Individual participants apply to one of the approximately 10,000 local clinics that provide WIC services.

In FY 1996, Federal program costs were $3.69 billion. (This amount includes the cost for the WIC Farmers Market Nutrition Program. This program, which was established in 1992, provides WIC participants additional coupons to purchase locally grown fresh fruits and vegetables at farmers markets.)

National School Lunch Program

The National School Lunch program is a federally assisted meal program, which operates in public and private schools and residential child care institutions, provides nutritionally balanced, low-cost or free lunches to children.

The National School Lunch Act of 1946 created the modern school lunch program. By the end of its first year, about 7.1 million children were participating in the program. Since the program began, more than 180 billion lunches have been served.

Benefits

More than 94,000 schools and residential child care institutions participate in the National School Lunch program. In FY 1996, more than 25 million children each day got their lunch through the program.

Most of the support USDA provides to schools comes in the form of cash reimbursements for meals served. Schools in the lunch program get cash subsidies and donated commodities from USDA for each meal they serve. The reimbursement is highest for meals served to students who qualify to receive their meals free, and the lowest reimbursement is for students who pay full price. The current cash reimbursement rates are: Free meals, $1.8375 reduced-price meals, $1.4375; and full-price meals, $0.1775.

Schools can charge no more than 40 cents for a reduced-price lunch. USDA sets no limit on the amount they can charge for full-price meals. Higher reimbursement rates are in effect for Alaska and Hawaii.

In addition to cash reimbursements, schools receive commodity foods, called “entitlement” foods, at an annually adjusted per meal rate (15 cents in 1997) for each meal they serve. Schools can also receive “bonus” commodities when they are available from surplus stocks purchased by USDA under price support programs. About 17% of the total dollar value of food for

the lunch program is provided directly by USDA as commodities. Schools purchase the remaining 83% from their own vendors.

Eligibility

Any child at a participating school (94,000) may purchase a meal through the lunch program. Children from families with incomes at or below 130% of the poverty level are eligible for free meals. Those between 130% and 185% of the poverty level are eligible for reduced-price meals.

Children from families with incomes over 185% (currently $28,860 for a family of four) pay full price, though their meals are still subsidized to some extent. Local school food authorities set their own prices for full-price meals.

Financing and Administration

The National School Lunch program is usually administered by State education agencies, which operate the program through agreements with local school districts. USDA's Food and Consumer Service administers the program at the Federal level. School districts and independent schools that choose to take part in the lunch program receive cash subsidies and donated commodities from USDA for each meal they serve. In FY 1996, total programs costs were approximately $5.3 billion, exclusive of State administrative costs and bonus commodity donations.

School Breakfast Program

The School Breakfast program is a Federal program that provides States with cash assistance for nonprofit breakfast programs in schools and residential child care institutions. The program began as a pilot project in 1966, and was made permanent in 1975.

Benefits

Over 6 million children in more than 65,000 schools start their day with the School Breakfast program. In 1996, an average of 6.6 million children participated in the program every day. Of those, 5.7 million received their meals free or at a reduced price. The schools submit a claim for meals served to their State agency. USDA reimburses the State, which in turn reimburses the local school food authority. For school year 1996-97, the Federal Government reimburse schools at the following rates: $1.0175 per meal for free breakfasts; 71.75 cents for reduced-price breakfasts; and 19.75 cents for paid breakfasts.

Schools may qualify for higher "severe need" reimbursements if a specified percentage of their meals are served free or at a reduced price. The severe need payments are 20 cents higher than the normal reimbursements for free and reduced-price breakfasts. More than 60% of the breakfasts served in the School

Breakfast program receive the severe need subsidy. Reimbursement payments for all meals are higher in Alaska and Hawaii.

Schools may charge no more than 30 cents for a reduced-price breakfast. USDA places no limit on the amount a school may charge for breakfasts served to students who pay the full meal price.

Eligibility

Any child at a participating school may purchase a meal through the breakfast program. A child whose family meets income criteria may receive a free or reduced-price breakfast. The Federal Government then reimburses the schools for each meal served that meets program requirements.

Children from families with incomes at or below 130% of the poverty level (currently $20,280 for a family of four) are eligible for free meals. Those between 130% and 185% of the poverty level (currently $28,860 for a family of four) are eligible for reduced-price meals. Children from families over 185% of the poverty level pay a full price, though their meals are subsidized to some extent.

Public schools or nonprofit private schools of high school grade or under, and residential child care institutions are eligible to participate in the program. Participating schools and institutions must serve breakfasts that meet Federal nutritional standards, and must provide free and reduced-price breakfasts to eligible children.

Financing and Administration

The School Breakfast Program is administered by the State education agencies and local school food authorities at the local level. At the Federal level, it is administered by USDA's Food and Consumer Service. For FY 1997, Congress appropriated $1.198 billion for the School Breakfast program.

Housing Assistance

The U.S. Department of Housing and Urban Development (HUD) gives grants to Public Housing Agencies (PHAs, including Indian Housing Authorities (IHAs)) to finance the capital cost of the construction, rehabilitation, or acquisition of public housing developed by PHAs to provide decent shelter for low-income residents at rents they can afford. The first low-rent public housing projects in the United States were constructed as the result of the vast public works program set in motion in 1933 by the National Industrial Recovery Act. The Housing Act of 1937 marked the earliest of the Federal housing programs designed to meet the direct concerns for the well-being of individuals. The housing acts of 1949 and 1954 created the massive urban renewal programs of

the 1950's, and Section 8 programs provided hundreds of thousands of new public housing units for the poor.

In most communities, there are three kinds of housing assistance available:

- Public housing, which is low-income housing that is actually operated by the housing authority.
- Section 8 in which the housing authority gives the tenant a certificate or voucher that says the government will subsidize your rent payments and then you go find your own housing.
- Privately owned subsidized housing, where the government provides subsidies directly to the owner who then applies those subsidies to the rents he/she charges low-income tenants.

In rural communities, the Department of Agriculture provides rental assistance programs, home improvement and repair loans and grants, and self-help housing loans to low-income individuals and families.

Public Housing

Public housing was established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered site single family houses to highrise apartments for elderly families. HUD administers Federal aid to local PHAs that manage and operate the housing program for low-income residents at rents they can afford.

Beginning in FY 1998, the Indian component of the Public and Indian Housing program will be removed and folded into the Native American Housing Block Grant program.

Benefits

In FY 1996, HUD distributed more than $6.2 billion to approximately 3,350 PHAs and IHAs provided public housing and services to 1.4 million households.

Eligibility

Public housing is limited to low-income families and individuals. The PHA determines the individual's eligibility based on (1) annual gross income; (2) whether the applicant qualifies as elderly, a person with a disability, or as a family; and (3) U.S. citizenship or eligible immigration status.

PHAs use income limits developed by HUD. HUD sets the lower income limits at 80% and very low income limits at 50% of the median income for the county or metropolitan area in which the recipient chooses to live. Income limits vary from area to area so an individual may be eligible at one PHA but not at another.

Determination of Rental Amount.—Rent, which is referred to as the Total Tenant Payment (TTP) in the public housing program, is based on the family's gross annual income less deductions, if any.

HUD regulations allow PHAs to exclude from annual income the following allowances: $480 for each dependent; $400 for any elderly family, or a person with a disability; and some medical deductions for families headed by an elderly person or a person with disabilities. Based on the person's application, the PHA representative determines if any of the allowable deductions should be subtracted from annual income. Annual income is the anticipated total income from all sources received from the family head and spouse, and each additional member of the family aged 18 or older.

The formula used to determine the TTP is the highest of the following, rounded to the nearest dollar:

(1) 30% of monthly adjusted income (monthly adjusted income is annual income less deductions allowed by the regulations);

(2) 10% of monthly income;

(3) welfare rent, if applicable; or

(4) a $25 minimum rent or higher amount (up to $50) set by a PHA.

Section 8 Programs

The Section 8 rental voucher and rental certificate programs are the Federal Government's major programs for assisting very low-income families, the elderly, and the disabled to rent decent, safe, and sanitary housing in the private market. Since the rental assistance is provided on behalf of the family or individual, participants are able to find and lease privately owned housing, including single-family homes, townhouses, and apartments. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

Rental Vouchers and Rental Certificates

The Section 8 rental voucher and rental certificate programs place the choice of housing in the hands of the individual family. When a rental voucher or certificate holder finds a unit that the family wishes to occupy, the PHA inspects the dwelling and reviews the lease prior to executing a housing assistance contract with the owner.

The major difference is how the subsidy is calculated. Under the rental certificate program, the rent for the unit usually may not exceed a maximum rent, determined by the PHA, based on HUD standards established for each county and metropolitan area. Most rental certificate families must lease a unit in which the total rent including utilities does not exceed this maximum rent. The rental certificate holder generally pays 30% of its monthly adjusted income towards the rent and utilities.

In the rental voucher program, the PHA determines a payment standard for its jurisdiction. The payment standard is used to calculate the amount of assistance a family will receive, but it does

not affect the amount of rent a landlord may charge or the family may pay. A family who receives a rental voucher may selected a unit that rents above or below the payment standard. The family pays more than 30% of its monthly adjusted income for rent and utilities if the rent is greater than the payment standard. If the unit rent is less than the payment standard, the family will pay less than 30% of its monthly adjusted income. The advantage of the rental voucher is that the family generally has a greater choice of housing opportunities. The disadvantage is that most families under the voucher program pay more than 30% of their monthly adjusted income for rent.

The rental certificate program started in the 1970's. The rental voucher program came about in the 1980's and was specifically developed as an alternative to the certificate program.

The Department and Congress both recognize that running two very similar programs is administratively burdensome to PHAs and confusing the program participants. In 1995, HUD issued a final rule that conformed the regulations of the certificate and voucher programs so the only differences between the programs are those that are in the law. The Department has proposed legislation that would eliminate these remaining statutory differences and merge the two programs into a single tenant-based program.

Facts About Public Housing

Household

Total number	1,250,000
Average size	2.4
Race/ethnicity	
White Non-Hispanic	37%
Black Non-Hispanic	47%
Hispanic	13%
Asian	3%
Native American	1%
Age of household head	
Under 25	7%
Composition	
Families with children	49%
Elderly	34%
Disabled	9%
Other	8%
Median income	$6,420
Average monthly rent	$169
Number of public housing developments	13,741

Source: "Tenant data from: "Characteristics of Households," *PD&R Recent Research Results.* HUD, December 1995. Public housing development data from HUD System Information—Retrieval Public Housing, September 1995.

Benefits.—In FY 1996, 4.7 million families received rental assistance (1.4 million in public housing and the rest in privately owned units).

Eligibility.—Eligibility for a rental voucher or certificate is determined by the PHA based on total annual gross income and family size and is limited to U.S. citizens and specified categories of noncitizens who have eligible immigration status. In general, the family's income may not exceed 50% of the median income for the county or metropolitan area in which the family chooses to live.

The program regulations require that the PHA must use the same waiting list for admission to its tenant-based certificate and voucher programs. When a family's name reaches the top of the list, the family is offered the form of assistance that first becomes available. If a family refuses the form of assistance the PHA offers, the family may remain on the list and wait for the other form of assistance. If a family refuses offers of both certificate and voucher assistance, the PHA may then remove the family's name from the waiting list.

PHAs have discretion over whether to allow participating families to switch forms of assistance. Some PHAs permit families to switch if the PHA has the other form of assistance available at the time of the request, many PHAs do not.

Special Needs Assistance Programs (Homeless)

HUD administers a number of programs that offer housing and supportive services for homeless persons. These programs provide a range of housing, from emergency to transitional to permanent housing for persons with disabilities. A brief description of three of these programs follow.

Shelter Plus Care

S+C is a program designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and AIDS) and their families who are living in places not intended for human habitation (for example, cars, parks, and abandoned buildings) or in emergency shelters. The program allows for a variety of housing choices, and a range of supportive services funded by other sources, in response to the needs of the hard-to-reach homeless population with disabilities.

Program grants are used for the provision of rental assistance payments. The supportive services may be funded by other Federal, State, or local sources, as well as private sources.

Section 8 Single Room Occupancy

SRO housing assistance is designed to bring more standard single room dwelling units into the local housing supply and to use those units to assist homeless persons. The SRO units might be in run down hotels, old schools, or even in large abandoned homes that have been rehabilitated.

HUD contracts with PHAs to rehabilitate residential properties for SRO housing. The PHAs make Section 8 rental assistance payments to participating owners on behalf of homeless individuals who rent the rehabilitated dwellings. The rental assistance payments cover the difference between a portion of the tenant's income (normally 30%) and the unit's rent, which must be within the fair market rent established by HUD.

Rental assistance for SRO units is provided for a period of 10 years. Owners are compensated for the cost of some of the rehabilitation (as well as the other costs of owning and maintaining the property) through the rental assistance payments. To be eligible for assistance, a unit must receive a minimum of $3,000 of rehabilitation.

Military Base Redevelopment Planning

For over three decades the Department of Defense has been closing domestic military installations to reduce overhead. Communities where these bases were located are charged with the

responsibility of finding alternative uses for them once they have been closed.

In 1987, Congress passed the McKinney Homeless Assistance Act, which made servicing the homeless the first priority for use of all surplus Federal properties, including military facilities.

In 1994, the Base Closure Community Redevelopment and Homeless Assistance Act was passed, superseding the McKinney Act for most base closure building and properties. This legislation was designed to accommodate the impacted communities' multiple reuse as well as to meet national priorities for homeless assistance.

Low-Income Home Energy Assistance

Through LIHEAP, the Federal Government provides grants to States, territories, Indian tribes and tribal organizations to help low-income households meet home heating and cooling costs and to weatherize and make energy saving repairs. The program was established under Title XXVI of the Omnibus Reconciliation Act of 1981 and has been in effect since FY 1982. It is administered at the Federal level by the Administration for Children and Families in the Department of Health and Human Services.

For fiscal year 1996, a total of $1.08 billion (including $180 million in emergency contingency funds released because of abnormally cold weather during the 1995-96 winter) was appropriated by the Congress for low-income home energy assistance.

Benefits

Eligible households may receive funds for heating and cooling costs and for weather-related and supply shortage emergencies. Grantees may also spend a portion of the funds on weatherization or energy-related home repairs. The number of households receiving assistance from the 50 States and the District of Columbia in FY 1995 is shown below. (An unduplicated total of households assisted cannot be derived from these estimates because the same household may be included under more than one type of energy assistance.)

Type of assistance	Number of households (in thousands)
Heating	5,148
Cooling	34
Crisis intervention:	
Winter	932
Summer	78
Low-cost residential weatherization/ energy-related home repair	103

Eligibility

The unit of eligibility for energy assistance is the household, defined as any individual or group of individuals who are living as one economic unit, for whom residential energy is customarily purchased in common either directly or through rent. Payment is limited to households with income under 150% of the poverty income guidelines or 60% of the State's median income, whichever is greater, or to those households with members receiving AFDC, SSI, Food Stamps, or means-tested veterans' benefits. States are permitted to set more restrictive criteria as well.

No household may be excluded from eligibility on the basis of income if its income is less than 110% of the poverty guidelines, but States may give priority to those households with the highest home energy costs or needs in relation to income. Owners and renters are treated equitably.

The States must provide a program plan to HHS that describes eligibility requirements, benefit levels, and estimated amount of funds to be used for each type of LIHEAP assistance. Timely and meaningful public participation in the development of the plan is required. The States must also conduct outreach activities to assure that eligible households, especially those with elderly or disabled individuals or young children, and households with high home energy burdens, are made aware of this assistance.

Administration

LIHEAP is a block grant program. The States have broad discretion in administering the programs. However, they submit program plans to the Department of Health and Human Services, which provides technical assistance and ensures that States follow Federal requirements.

States make payments directly to eligible households or to home energy suppliers on behalf of the households. Payments may be provided in cash, vouchers, or payments to third parties, such as utility companies or fuel dealers.

General Assistance

General assistance is a term used to describe aid provided by State and local governments to needy individuals or families who do not qualify for major assistance programs and to those whose benefits from other assistance programs are insufficient to meet basic needs. In fact, general assistance is not usually known by that name, although both Maryland and Rhode Island call it "General Public Assistance". More common is the term "General Relief", but very different names are used in some jurisdictions. Thus New Jersey calls the program "State Aid", Indiana uses "Township Poor Relief", and Tennessee has three equivalent terms: "Poor Relief", "Emergency Relief", and "Paupers Relief".

General assistance is often the only resource for individuals who cannot qualify for unemployment insurance, or whose ben-

efits are inadequate or exhausted. Help may either be in cash or in kind, including such assistance as groceries and rent.

The eligibility requirements and payment levels for general assistance vary from State to State, and often within a State. Payments are usually at lower levels and of shorter duration than those provided by federally financed programs. General assistance is administered and financed by State and local governments under their own guidelines.

General assistance*

Year	Average number (in thousands)	Total payment (in thousands)	Average amount of payments
1940	3,618	$404,963	$8.30
1950	866	298,262	22.25
1960	1,071	322,465	25.10
1970	957	618,319	53.82
1980	945	1,442,278	127.18
1990	1,220	NA	NA
1994	1,125	NA	NA

* Data partly estimated. Number of States reporting: 1960, 53; 1970, 45; 1980, 41; 1990, 37; 1994, 32.

In fiscal year 1994, 32 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands reported general assistance data to the Federal Government. About 1.1 million persons received general assistance.

In almost a fourth of the States, assistance was financed from local funds only.

Earned Income Tax Credit

The Earned Income Tax Credit (EITC) is a special Federal income tax credit for low-income workers. The credit reduces the amount of tax they owe (if any) and is intended to offset some of the increases in living expenses and Social Security taxes. Eligible persons who owe no taxes, or whose tax liability is smaller than their tax credit, receive all or part of the EITC as a direct payment. Some workers are prepaid their credits through their employers as "negative withholding" from paychecks. EITC is administered by the Internal Revenue Service as part of its responsibility for collection of Federal income taxes. For tax returns filed through April 1995, 18.3 million of a total of 109.3 million returns (16.7%) claimed earned income tax credits totaling $24.8 billion.

The EITC was initially enacted as a temporary measure in the Tax Reduction Act of 1975 and made permanent in the Revenue Act of 1978. The intent was to aid the working poor—families with

children who had an income below the poverty level despite having working members. The 1975 Act emphasized two long-term objectives: (1) to offset the impact of payroll taxes on low-income workers; and (2) to encourage low-income persons, who might otherwise receive welfare benefits, to seek employment.

Benefits

The earned income credit amount depends on the taxpayer's number of qualifying children, amount of earning, and modified adjusted gross income (AGI), which includes items such as taxable Social Security benefits and unemployment benefits.

The amount a person can earn in 1997 and still receive a credit must be less than:

- $25,760 with one qualifying child,
- $29,290 with more than one qualifying child, or
- $9,770 without a qualifying child.

The maximum amount of the credit is:

- $2,210 with on qualifying child,
- $3,656 with more than one qualifying child, or
- $332 without a qualifying child.

Income from working is considered earned income even if it is not taxable. This includes wages, salaries, and tips; union strike benefits; long-term disability benefits received prior to minimum retirement age; net earnings from self-employment; voluntary salary deferrals; voluntary salary reductions; and basic quarters and subsistence allowances from the U.S. military.

The EITC amounts are determined by multiplying income by a credit rate. For example, for 1997, the maximum credit an eligible taxpayer with two or more qualifying children can claim is $3,656, based on a credit percentage of 40% applied to an earned income threshold of $9,140. This maximum is payable for earned income (or AGI, if greater) up to a phaseout income of $11,930. Above this income, a phaseout percentage (21.06% for those with two or more children) is applied to the difference between the actual and phaseout income. The result of this calculation, subtracted from the maximum credit, yields the EITC amount.

The EITC amount can be affected by receipt of other types of public program benefits when they are counted in determining AGI and thus serve to reduce the benefit (for example, unemployment insurance benefits are included in AGI). Conversely, the credit has no effect on certain welfare benefits. The earned income credit cannot be used to determine eligibility or benefit amounts for AFDC, Medicaid, SSI, food stamps, and low-income housing.

Eligibility

EITC eligiblity and credit amounts generally are determined according to the tax filer's earned income and whether they have

qualifying children who meet age, relationship, and residency tests or meet other requirements.

Relationship Test

The child must be the tax filer's son, daughter, adopted child, grandchild, stepchild, or eligible foster child (this could include a niece, nephew, brother, sister, or cousin).

Residency Test

The child must have lived with the tax filer for more than half the year (the whole year if the child is an eligible foster child). The home must be in one of the 50 States or District of Columbia. For purposes of the credit, U.S. military personnel stationed outside the United States on extended active duty are considered to live in the United States during that duty period.

Age

The child must be under age 19 at the end of the year, be a full-time student under age 24 at the end of the year, or be permanently and totally disabled at any time during the tax year, regardless of age.

Persons without a qualifying child must be age 25 or older but less than age 65, and not be a dependent for whom a dependency exemption is allowable to another taxpayer.

Persons with investment income of more than $2,200 cannot claim the earned income credit. Investment income if taxable interest and dividends, tax-exempt interest, and capital gain net income.

For 1997, a Social Security number is required for each person listed on the tax return.

Earned income tax credit provisions for 1997

Provisions	Families with— One child	Two or more children	No children
Earned income threshold	$6,500	$9,140	$4,340
Credit percentage	34.0	40.0	7.65
Maximum credit	2,210	3,656	332
Phaseout income	11,930	11,930	5,430
Phaseout percentage	15.98	21.06	7.65
Breakeven income (credit reduced to zero)	25,760	29,290	9,770

Appendices

Appendix I: Public Social Welfare Expenditures

Social welfare expenditures, that is, the cash benefits, services, and administrative costs of public programs that directly benefit individuals and families, accounted for just 3.9% of the gross national product (GNP) in 1929. By far, the largest component of the expenditures—60% of the total—was accounted for by public education, which then, as now, came primarily from State and local funds. Federal expenditures were mostly for veterans' benefits and staff retirement systems, and accounted for only 20% of the social welfare expenditures total. In 1993 (the latest year for which complete data are available), social welfare spending reached 21.1% of the gross domestic product (GDP). Nearly half of the total was spent on social insurance programs. The following table presents a summary of social welfare expenditures under public programs for selected fiscal years beginning with 1970.

It was the Depression of the 1930's that brought the Federal Government into the social welfare field. In 1933, the Federal Emergency Relief program began to take over the mounting cost of support for the unemployed, and in 1935 the Social Security Act established a national system of old-age insurance, a Federal-State system of unemployment insurance, and Federal programs of grants-in-aid to develop and strengthen the State public assistance and other programs.

The first year in which expenditures for public aid outstripped those for education was 1934, and the bulk of that aid came from the Federal Government. This pattern continued throughout the 1930's and early 1940's, but by fiscal year 1943, education was once more the largest spending category. In the post-World War II years veterans' benefits became the largest category of expenditures, accounting for about one-third of the total through 1949. In the 1950's, education resumed its primacy, although it was now closely followed by social insurance. The latter had begun to increase in importance in the 1940's. At that time, the Federal-State system of unemployment insurance accounted for 45-60% of all social insurance spending.

It was in 1951 that the Old-Age and Survivors Insurance (OASI) program first became the leading component of the social insurance category. With the addition of Disability Insurance (DI) to OASI in 1956, that lead grew, and it has been increasing ever

since. The year 1965 brought the introduction of Health Insurance (HI) for the Aged (Medicare), and by 1967 social insurance had become indisputably the largest of the social welfare categories, a position it continues to hold. In the succeeding years, coverage under the OASDI and HI programs was expanded, most notably by the inclusion in 1972 of the disabled in the Medicare program. This expansion of the Medicare program, the aging of the insured population, and the rapidly rising cost of health care ensured the social insurance category's continued growth. By the 1980's, social insurance expenditures accounted for half of the social welfare total, and the OASDI and HI programs alone represented a larger share of Federal spending than any category except defense. This remained true in 1993.

There have been changes in the area of public aid. On the eve of World War II the exigencies of the Depression had increased public aid spending to more than 40% of the social welfare total. After the war, that percentage dropped sharply and by 1960 had fallen to 8%. The programs that accompanied the 1960's War on Poverty increased both the amount and the share of public money spent in this area.

The Food Stamp program began paying benefits in 1961. In 1964, Congress passed the Economic Opportunity Act, and the 1965 Amendments to the Social Security Act created the Medicaid program. By 1970, public aid accounted for 11% of all social welfare spending, and by 1993 it accounted for more than 16%.

The increase in public aid spending involved the State and local governments, due to the matching funds required by several of the Federal programs. Whereas State and local governments provided only 15-20% of the social insurance funds spent between 1965 and 1993, their share of the public aid bill ran between 30% and 40%. The largest State and local insurance expenditures are for employee pensions, unemployment insurance, and the workers' compensation program; assistance programs such as Aid to Families with Dependent Children and Medicaid account for the bulk of State and local public aid funds.

Despite the public aid increases, education has remained the largest social welfare expense for the States and localities. In 1929, 77% of all State and local social welfare funds were spent on education. Even with the growth of social insurance and the poverty programs over the years, in 1993 nearly 53% of State and local social welfare spending went for education.

Governments at all levels have spent somewhat more of their funds for social welfare purposes since the 1960's. During the years from 1929 to 1965 the percentage of all government expenditures that went for social welfare was between 32% and 50%, with the exception of the war years, when the percentage fell as low as 9%. In 1965-70, the range was 42% to 47%; and since 1971 more than half of all government spending has been for social welfare.

Appendix I: Social welfare expenditures under public programs, selected fiscal years 1970-93[1]

[In millions]

Program	1970	1980	1990 [2]	1993 [2]
	Total expenditures			
Total	$145,555.2	$492,212.7	$1,048,808.6	$1,363,884.4
Social insurance	54,691.2	229,754.4	513,822.6	657,328.2
Old-Age, Survivors, Disability, and Health Insurance (OASDHI)	36,835.4	152,110.4	355,264.5	449,276.8
OASDI	29,686.2	117,118.9	245,555.5	301,183.3
HI (Medicare) [3]	7,149.2	34,991.5	109,709.0	148,093.5
Railroad Retirement [4]	1,609.9	4,768.7	7,229.9	7,920.6
Public employee retirement [5]	8,658.7	39,490.2	90,392.0	112,631.6
Unemployment insurance and employment services [6]	3,819.5	18,326.4	19,973.7	40,720.8
Railroad unemployment insurance	38.5	155.4	64.6	60.3
Railroad temporary disability insurance	61.1	68.7	40.3	25.9
State temporary disability insurance [7]	717.7	1,377.4	3,224.2	3,316.0
Hospital and medical benefits [8]	62.6	49.6	62.5	53.7
Workers' compensation [9]	2,950.4	13,457.2	37,633.4	43,376.2
Hospital and medical benefits [8]	985.0	3,725.0	14,305.5	17,712.3
Public aid	16,487.8	72,703.1	146,811.1	221,064.8
Public assistance [10]	14,433.5	45,064.3	105,093.8	160,695.0
Medical payments	5,212.7	27,570.1	76,175.1	125,138.0
Social services	712.6	2,342.8	2,753.2	3,712.9
Supplemental Security Income	...	8,226.5	17,230.4	26,501.2
Food stamps	577.0	9,083.3	16,254.5	24,496.7
Other [11]	1,477.3	10,329.0	8,232.4	9,371.9
Health and medical programs [12]	9,606.0	26,762.0	61,488.0	74,503.0
Hospital and medical care	4,983.0	12,286.0	25,971.0	30,508.0
Civilian programs	3,301.0	8,097.0	14,809.0	17,099.0
Defense Department [13]	1,682.0	4,198.0	11,286.0	13,409.0
Maternal and child health programs [14]	450.0	870.0	1,865.0	2,172.0
Medical research	1,684.0	4,924.0	10,848.0	12,780.0
School health (education agencies)	247.0	575.0	1,113.0	1,407.0
Other public health activities	1,312.0	6,484.0	19,354.0	24,978.0
Medical facilities construction	930.0	1,623.0	2,337.0	2,658.0
Veterans' programs	9,078.1	21,465.5	30,916.2	36,605.5
Pensions and compensation [15]	5,393.8	11,306.0	15,792.6	17,205.2
Health and medical programs	1,784.1	6,203.9	12,004.1	15,640.8
Hospital and medical care	1,651.4	5,749.9	11,321.4	14,382.3
Hospital construction	70.9	323.0	445.0	979.9
Medical and prosthetic research	61.8	131.0	237.7	278.6
Education	1,018.5	2,400.7	522.8	937.7
Life insurance [16]	502.3	664.5	1,037.8	904.7
Welfare and other	379.4	890.4	1,558.9	1,917.1

See footnotes at end of table.

Appendix I: Social welfare expenditures under public programs, selected fiscal years 1970-93[1] —*Continued*

[In millions]

Program	1970	1980	1990 [2]	1993 [2]
	Total expenditures—*Continued*			
Education [17]	50,845.5	121,049.6	258,384.6	331,909.8
Elementary and secondary	38,632.3	87,149.9	199,277.3	252,419.5
Construction	4,659.1	6,524.0	10,636.0	22,288.0
Higher	9,907.0	26,175.9	57,424.3	77,558.1
Construction	1,566.9	1,528.1	3,953.0	8,990.3
Vocational and adult [18]	2,144.4	7,375.2	1,293.3	1,494.9
Housing	701.2	6,879.0	19,468.5	19,803.1
Public housing	459.9	4,680.5	14,521.8	15,302.0
Other social welfare	4,145.4	13,599.1	17,917.6	22,670.0
Vocational rehabilitation	703.8	1,251.1	2,126.6	2,379.1
Medical services	133.8	279.4	531.6	594.8
Medical research [19]	29.6	13.5	...	...
Institutional care [20]	201.8	482.4	629.4	721.5
Child nutrition [21]	896.0	4,852.3	7,165.4	9,392.4
Child welfare [22]	585.4	800.0	252.6	294.6
Special OEO and ACTION programs [23]	752.8	2,302.7	169.4	208.3
Social welfare, not elsewhere classified [24]	1,005.6	3,910.6	7,574.2	9,674.1
	Federal expenditures			
Total	$77,130.2	$303,152.5	$616,641.4	$804,701.9
Social insurance	45,245.6	191,162.0	422,257.4	534,310.1
Old-Age, Survivors, Disability, and Health Insurance (OASDHI)	36,835.4	152,110.4	355,264.5	449,276.8
OASDI	29,686.2	117,118.9	245,555.5	301,183.3
HI (Medicare) [3]	7,149.2	34,991.5	109,709.0	148,093.5
Railroad Retirement [4]	1,609.9	4,768.7	7,229.9	7,920.6
Public employee retirement [5]	5,516.7	26,982.9	53,541.2	61,703.7
Unemployment insurance and employment services [6]	1,036.1	4,407.6	3,096.2	12,123.6
Railroad unemployment insurance	38.5	155.4	64.6	60.3
Railroad temporary disability insurance	61.1	68.7	40.3	25.9
Workers' compensation [9]	147.9	2,668.3	3,020.7	3,199.2
Hospital and medical benefits [8]	20.7	129.5	456.6	596.6
Public aid	9,648.6	49,394.2	92,858.5	151,850.5
Public assistance [10]	7,594.3	23,542.1	54,746.6	95,339.9
Medical payments	2,607.1	14,550.2	40,690.1	77,367.1
Social services	522.0	1,757.1	2,064.9	2,784.7
Supplemental Security Income	...	6,439.8	13,625.0	22,642.0
Food stamps	577.0	9,083.3	16,254.5	24,496.7
Other [11]	1,477.3	10,329.0	8,232.4	9,371.9

See footnotes at end of table.

Appendix I: Social welfare expenditures under public programs, selected fiscal years 1970-93[1]—*Continued*

[In millions]

Program	1970	1980	1990 [2]	1993 [2]
	Federal expenditures			
Health and medical programs [12]	4,568.0	12,827.0	27,206.0	33,209.0
Hospital and medical care	1,973.0	6,619.0	14,816.0	18,844.0
Civilian programs	291.0	2,430.0	3,654.0	5,435.0
Defense Department [13]	1,682.0	4,189.0	11,162.0	13,409.0
Maternal and child health programs [14]	190.0	351.0	492.0	595.0
Medical research	1,515.0	4,428.0	9,172.0	10,690.0
Other public health activities	589.0	1,215.0	2,311.0	3,153.0
Medical facilities construction	301.0	214.0	415.0	(73.0)
Veterans' programs	8,951.6	21,253.6	30,427.7	36,033.5
Pensions and compensation [15]	5,393.8	11,306.0	15,792.6	17,205.2
Health and medical programs	1,784.1	6,203.9	12,004.1	15,640.8
Hospital and medical care	1,651.4	5,749.9	11,321.4	14,382.3
Hospital construction	70.9	323.0	445.0	979.9
Medical and prosthetic research	61.8	131.0	237.7	278.6
Education	1,018.5	2,400.7	522.8	937.7
Life insurance [16]	502.3	664.5	1,037.8	904.7
Welfare and other	252.9	678.5	1,070.4	1,345.1
Education [17]	5,875.8	13,452.2	18,374.0	20,454.9
Elementary and secondary	2,956.8	7,429.6	9,944.3	13,238.0
Construction	35.9	40.9	22.9	5.3
Higher	2,154.6	4,467.5	6,746.7	5,284.7
Construction	466.3	42.1	...	35.3
Vocational and adult [18]	602.6	1,206.5	1,293.3	1,494.9
Housing	581.6	6,277.6	16,612.4	18,005.6
Public housing	459.9	4,680.5	14,521.8	15,435.4
Other social welfare	2,259.0	8,785.9	8,905.4	10,838.3
Vocational rehabilitation	567.5	1,006.1	1,660.8	1,830.1
Medical services	107.0	223.5	415.2	457.5
Medical research [19]	29.6	13.5	...	...
Institutional care [20]	22.5	74.2	143.4	142.6
Child nutrition [21]	710.9	4,209.3	5,469.8	7,139.4
Child welfare [22]	44.7	57.0	252.6	294.6
Special OEO and ACTION programs [23]	752.8	2,302.7	169.4	208.3
Social welfare, not elsewhere classified [24]	160.6	1,136.6	1,209.4	1,223.3
	State and local expenditures			
Total	$68,425.0	$189,060.2	$432,167.2	$559,182.5
Social insurance	9,445.6	38,592.4	91,565.2	123,018.1
Public employee retirement [5]	3,142.0	12,507.3	36,850.8	50,927.9
Unemployment insurance and employment services [6]	2,783.4	13,918.8	16,877.5	28,597.2

See footnotes at end of table.

Appendix I: Social welfare expenditures under public programs, selected fiscal years 1970-93[1] —*Continued*

[In millions]

Program	1970	1980	1990 [2]	1993 [2]
	State and local expenditures			
State temporary disability insurance [7]	717.7	1,377.4	3,224.2	3,316.0
Hospital and medical benefits [8]	62.6	49.6	62.5	53.7
Workers' compensation [9]	2,802.5	10,788.9	34,612.7	40,177.0
Hospital and medical benefits [8]	964.3	3,595.5	13,848.9	17,115.7
Public aid	6,839.2	23,308.9	53,952.6	69,214.3
Public assistance [10]	6,839.2	21,522.2	50,347.2	65,355.1
Medical payments	2,605.6	13,019.9	35,485.0	47,770.9
Social services	190.6	585.7	688.3	928.2
Supplemental Security Income	...	1,786.7	3,605.4	3,859.2
Health and medical programs [12]	5,038.0	13,935.0	34,282.0	41,294.0
Hospital and medical care	3,010.0	5,667.0	11,155.0	11,664.0
Maternal and child health programs [14]	260.0	519.0	1,373.0	1,577.0
Medical research	169.0	496.0	1,676.0	2,090.0
School health (education agencies)	247.0	575.0	1,113.0	1,407.0
Other public health activities	723.0	5,269.0	17,043.0	21,825.0
Medical facilities construction	629.0	1,409.0	1,922.0	2,731.0
Veterans' programs	126.5	211.9	488.5	572.0
Education [17]	44,969.7	107,597.4	240,010.6	311,454.9
Elementary and secondary	35,675.5	79,720.3	189,333.0	239,181.5
Construction	4,623.2	6,483.1	10,613.1	22,282.7
Higher	7,752.4	21,708.4	50,677.6	72,273.4
Construction	1,100.6	1,486.0	3,953.0	8,955.0
Vocational and adult [18]	1,541.8	6,168.7	...	...
Housing	119.6	601.4	2,856.1	1,797.5
Other social welfare	1,886.4	4,813.2	9,012.2	11,831.7
Vocational rehabilitation	136.3	245.0	465.8	549.0
Medical services	26.8	55.9	116.4	137.3
Institutional care [20]	179.3	408.2	486.0	578.9
Child nutrition [21]	185.1	643.0	1,695.6	2,253.0
Child welfare [22]	540.7	743.0	...	...
Social welfare, not elsewhere classified [24]	845.0	2,774.0	6,364.8	8,450.8

[1] Expenditures from Federal, State, and local revenues and trust funds under public law; includes capital outlays and administrative expenditures unless otherwise noted. Includes some payments abroad. Through 1976, fiscal year ended June 30 for the Federal Government, most States, and some localities. Beginning in 1977, Federal fiscal years end on September 30.

[2] Revised data.

[3] Includes Hospital Insurance and Supplementary Medical Insurance.

[4] Excludes the financial interchange between OASDI and the Railroad Retirement system.

[5] Includes the military retirement system; excludes refunds of employee contributions. Administrative expenses not available for some programs.

[6] Includes unemployment compensation under State programs, programs for Federal employees, trade adjustment and training allowances, and payments under the extended, emergency, disaster, and special unemployment insurance programs.

[7] Cash and medical benefits in five areas. Includes private plans where applicable and State administrative costs. Data for Hawaii not available.
[8] Included in total directly above.
[9] Cash and medical benefits paid under public law by private insurance carriers. Administrative costs of carriers and self-insurers not available. Beginning 1960, includes data for Alaska and Hawaii; beginning 1970, includes the Federal "Black Lung" program.
[10] Cash payments and medical assistance under the Aid to Families with Dependent Children; Medicaid; emergency assistance; Women, Infants, and Children (WIC); and General Assistance programs. Also includes social services and work incentive activities.
[11] Work relief, other emergency aid, surplus food for the needy, repatriate and refugee assistance, and work-experience training programs. Beginning in 1981, includes Low-Income Home Energy Assistance.
[12] Excludes State and local expenditures for domiciliary care in institutions other than those for tuberculosis. Also excludes medical services connected with the OASDHI; State temporary disability insurance; workers' compensation; public assistance; veterans'; and vocational rehabilitation programs, which are included in the expenditures for those programs.
[13] Includes medical care for military dependents.
[14] Includes services for disabled children.
[15] Includes burial awards, special allowances for the survivors of veterans who did not qualify for OASDI, and clothing allowances.
[16] Excludes the servicepersons' group life insurance program.
[17] Federal administrative expenditures (Department of Education) and research costs included in total only.
[18] State and local expenditures for vocational and adult education not available after 1985.
[19] No longer available separately after 1980.
[20] Federal expenditures represent primarily surplus food for institutions.
[21] Surplus food for schools and programs under the National School Lunch and Child Nutrition Acts.
[22] Represents primarily child welfare services under the Social Security Act. State and local data not available after 1980.
[23] Includes domestic programs consolidated in 1972 under ACTION and special Office of Economic Opportunity programs. After 1987, represents ACTION funds only.
[24] Federal expenditures include the administrative and related expenses of the Secretary of Health and Human Services; Indian welfare and guidance, aging and juvenile delinquency, and certain manpower and human development programs. State and local expenditures include amounts for anti-poverty and manpower programs, day care, child placement and adoption services, foster care, legal assistance, care of transients, and other unspecified welfare services.
Source: Data taken or estimated from Federal Budgets, reports of the Census of Governments, and reports of administrative agencies.

Appendix II: Private Social Insurance Expenditures

SSA's private social welfare expenditures series provides estimates of private sector financing of social welfare programs in the United States. The data presented here are from that series and cover the period 1972 to 1994 (the latest year for which complete data are available).

Private expenditures are grouped in four categories: health and medical care, welfare services, education, and income maintenance.

Viewed as a gross domestic product (GDP), private sector social welfare has gradually but substantially increased from 7.7% in 1972 to 13.3% in 1994. In the latter year, total expenditures were $921,465 billion.

In 1994, health and medical care expenditures claimed the largest dollar amount—$528.6 billion (57.4% of total private spending). Private sector funds paid 5.5% of all personal health care expenditures, mostly private health insurance and out-of-pocket spending. From 1972 through 1994, health expenditures declined slightly from 58.5% to 57.4% of total private social welfare spending.

The welfare services category includes individual and family social services, residential care, child day care, recreation and group work, and job training and vocational rehabilitation. In 1994, expenditures for these items were $86.3 billion, or 9.4% of the year's private social welfare total.

Private social welfare expenditures,[1] by category: Public and private social welfare expenditures as a percent of gross domestic product, selected years, 1972-94

[Amounts in millions]

		Private spending[3]					Percent of gross domestic product		
Year	Public spending total[2]	Total	Health	Income maintenance	Education	Welfare services	Total[4]	Public spending[5]	Private spending[6]
1972	$190,315	$95,362	$55,800	$17,123	$14,894	$7,545	23.5	16.6	7.7
1975	288,458	128,556	75,700	23,336	19,453	10,067	25.2	18.2	7.9
1980	491,598	250,534	142,500	53,564	31,694	22,776	26.1	18.1	9.0
1985	730,897	462,283	253,900	118,871	50,513	38,999	27.6	17.8	11.1
1990	1,046,355	720,718	413,100	164,772	78,263	64,583	29.7	18.5	12.5
1994	…	921,465	528,600	204,736	101,832	86,297	…	…	13.3

[1]In current dollars.
[2]Fiscal year basis.
[3]Calendar year basis.
[4]Sum of public and private expenditures as a percent of gross domestic product, after adjustment to eliminate overlap that occurs when payments received under public or private income-maintenance programs are used to purchase medical care, educational services, or residential care.
[5]Represents fiscal year expenditures as a percent of Federal fiscal year gross domestic product.
[6]Represents calendar year expenditures as a percent of calendar year gross domestic product.
Source: *Social Security Bulletin*, Vol. 60, No. 1, 1997.

Private expenditures for education were $101.8 billion, or 11.1% of all private social welfare expenditures. Of this amount, $59.7 billion was spent on higher education, $21.2 billion on elementary and secondary school education, and $15.5 billion on commercial and vocational schools. Outlays for education have declined from 15.6% of total private sector spending in 1972 to 11.1% in 1994.

Income-maintenance expenditures are payments made by private sector employee benefit plans. These include private plans, group life insurance, cash disability insurance, paid sick leave, and supplemental unemployment benefits. Of the $204.7 billion in such expenditures, pension benefits accounted for $174.5 billion.

Health and medical care: Expenditures under private and public programs, by source of expenditure and percent of gross domestic product, selected calendar years, 1972-94

[Amounts in billions]

Expenditure	1972	1975	1980	1985	1990	1994
Source						
National health expenditures	$90.9	$130.7	$247.2	$428.2	$697.5	$949.4
Private expenditures	55.8	75.7	142.5	253.9	413.1	528.6
Health services and supplies	52.5	72.3	138.0	247.4	402.9	517.1
Noncommercial medical research	.2	.3	.3	.5	1.0	1.3
Medical facilities construction	3.1	3.2	4.2	6.0	9.3	10.3
Public expenditures	35.1	55.0	104.8	174.3	284.3	420.8
Percent of gross domestic product						
National health expenditures	7.4	8.0	8.9	10.2	12.1	13.7
Private expenditures	4.5	4.6	5.1	6.1	7.2	7.6
Public expenditures	2.8	3.4	3.8	4.2	4.9	6.1

Note: Numbers and percents may not add to totals because of rounding.
Source: Health Care Financing Administration, Office of the Actuary, Office of National Health Statistics.

Appendix III:—Significant provisions of State unemployment insurance laws, January 5, 1997

State and taxable wage base	Weekly benefit amount for total unemployment [1]			Duration of benefits (weeks)	
	Computation (fraction of high-quarter wages unless otherwise indicated) [2]	Minimum	Maximum	Minimum [4]	Maximum
Alabama ($8,000)	1/24 of average of two highest quarters	$22	$180	15+	26
Alaska ($24,200)	4.4–0.9% of annual wages, plus $24 per dependent up to $72	44–68	248–320	[3] 16	[3] 26
Arizona ($7,000)	1/25	40	185	12+	26
Arkansas ($9,000)	1/26 up to 66 2/3% of State average weekly wage	49	273	9	26
California ($7,000)	[5] 1/23–1/33	40	230	[3] 14+	[3] 26
Colorado ($10,000)	60% of 1/26 of two highest quarters, up to 50% of 1/52 of base period wages	25	283	13+	26
Connecticut ($12,000)	1/26 of two highest quarters, up to 60% of State average weekly wage, plus $10 per dependent up to 1/2 weekly benefit amount or five dependents	15–25	353–403	[3] 26	[3] 26
Delaware ($8,500)	(5)	20	[6] 300	24	26
District of Columbia ($10,000)	1/26 up to 50% of State average weekly wage, plus $5 per dependent up to $20	50	[1] 359	[3] 20	[3] 26
Florida ($7,000)	1000	32	250	26	26
Georgia ($8,500)	1/50 of two highest quarters [5]	37	215	9+	26
Hawaii ($26,000)	1/21 up to 70% of State average weekly wage	5	351	[3] 26	[3] 26
Idaho ($22,800)	1/26 up to 60% of State average weekly wage	44	259	10	26
Illinois ($9,000)	49.5% of claimant's average weekly wage in two highest quarters, up to 49.5% of State average weekly wage [5]	51	257–341	26	26
Indiana ($7,000)	5% of first $1,750 in high quarter, 4% of remaining high quarter wages	87	217	8+	26
Iowa ($15,200)	(2,5)	34–41	231–283	11+	26
Kansas ($8,000)	4.25% of high quarter wages, up to 60% of State average weekly wage	67	270	10	26
Kentucky ($8,000)	1.185% of base period wages, up to 55% of State average weekly wage	22	246	15	26
Louisiana ($7,700)	1/25 of 4 quarters [7]	10	[6] 193	26	26
Maine ($7,000)	1/22 up to 52% of State average weekly wage, plus $10 per dependent up to 1/2 weekly benefit amount	36–54	210–315	26	26
Maryland ($8,500)	1/24 plus $8 per dependent up to $40	25–33	[1] 250	26	26

See footnotes at end of table.

Appendix III:—Significant provisions of State unemployment insurance laws, January 5, 1997—*Continued*

State and taxable wage base	Weekly benefit amount for total unemployment [1]			Duration of benefits (weeks)	
	Computation (fraction of high-quarter wages unless otherwise indicated) [2]	Minimum	Maximum	Minimum [4]	Maximum
Massachusetts ($10,800)	1/21–1/26 up to 57.5% of State average weekly wage, plus $25 per dependent up to 1/2 weekly benefit amount [2]	14–21	362–543	10+–30	30
Michigan ($9,500)	70% of claimant's after-tax earnings, up to a maximum of 58% of State average weekly wage	60	300	15	26
Minnesota ($16,300)	[5] 1/26	38	314	10+	26
Mississippi ($7,000)	1/26	30	180	13+	26
Missouri ($8,000)	4.5%	45	175	11+	26
Montana ($16,000)	1% of base period wages or 1.9% of wages in two highest quarters, up to 60% of State average weekly wage	57	230	8	26
Nebraska ($7,000)	1/20–1/24	20	184	20	26
Nevada ($17,200)	1/25 up to 50% of State average weekly wage	16	247	12+	26
New Hampshire ($8,000)	0.8–1.1% of annual wages	32	228	26	26
New Jersey ($18,600)	60% of claimant's average weekly wage, plus dependents' allowance, up to 56 2/3% of State average weekly wage	60	[1] 374	[3] 15	[3] 26
New Mexico ($14,200)	1/26, not less than 10% nor more than 50% of State average weekly wage	43	218	19	26
New York ($7,000)	50% of claimant's average weekly wage	40	300	26	26
North Carolina ($12,100)	1/26 of high quarter wages, up to 66 2/3% of State average weekly wage	25	310	13-26	26
North Dakota ($14,200)	1/65 of two highest quarters and 1/2 total wages in third quarter, up to 60% of State average weekly wage [7]	43	251	12	26
Ohio ($9,000)	1/2 claimant's average weekly wage, plus dependents' allowance of $1-$83 based on the claimant's average weekly wage and number of dependents [2,7]	66	257-345	20	26
Oklahoma ($11,000)	[6] 1/25	16	[6] 251	[9] 20+	[9] 26
Oregon ($20,000)	1.25% of base period wage, up to 64% of State average weekly wage	73	314	[3] 4+	[3] 26
Pennsylvania ($8,000)	1/23–1/25 up to 66 2/3% of State average weekly wage plus $5 for one dependent; $3 for second	35–40	[6] 362–370	16	26

See footnotes at end of table.

Appendix III:—Significant provisions of State unemployment insurance laws, January 5, 1997—*Continued*

State and taxable wage base	Computation (fraction of high-quarter wages unless otherwise indicated) [2]	Weekly benefit amount for total unemployment [1] Minimum	Maximum	Duration of benefits (weeks) Minimum [4]	Maximum
Puerto Rico ($7,000)	1/11–1/26 up to 50% of State average weekly wage	7	152	[3] 26	[3] 26
Rhode Island ($17,600)	4.62% of high quarter wages up to 67% of State average weekly wage, plus greater of $10 or 5% of the benefit rate per dependent up to five dependents	41–51	336–420	15+	26
South Carolina ($7,000)	1/26 up to 66 2/3% of State average weekly wage	20	221	15	26
South Dakota ($7,000)	1/26 up to 50% of State average weekly wage	28	187	15+	26
Tennessee ($7,000)	1/26 of average two highest quarters	30	220	12+	26
Texas ($9,000)	[8] 1/25	44	266	9+	26
Utah ($17,800)	1/26 up to 60% of State insured average fiscal year weekly wage	17	272	10	26
Vermont ($8,000)	(5)	31	217	26	26
Virgin Islands ($14,000)	1/26 up to 50% of State average weekly wage	32	231	13+	26
Virginia ($8,000)	1/50 of wage in two highest quarters	65	[10] 224	12	26
Washington ($21,300)	1/25 of average of two highest quarters, up to 70% of State average weekly wage	78	365	16+–30	30
West Virginia ($8,000)	1.0% of annual wage up to 66 2/3% of State average weekly wage	24	296	26	26
Wisconsin ($10,500)	4% of high-quarter wages up to maximum weekly benefit amount	53	282	12	26
Wyoming ($12,200)	4% of high-quarter wages up to 55% of State average weekly wage [6]	17	236	12–26	26

[1] When two amounts are given, the higher includes dependents' allowances. In the District of Columbia, Maryland, and New Jersey the maximum is the same with or without dependents' allowances. Higher for minimum weekly benefit amount includes maximum allowance for one dependent.

[2] When States use a weighted high quarter, annual wage, or average weekly wage formula, approximate fractions or percentages are figured at midpoint of lowest and highest normal wage brackets. When dependents' allowances are provided, the fraction applies to the basic weekly benefit amount. In some States, variable amounts above maximum basic benefits are limited to claimants with specified number of dependents and earnings in excess of amounts applicable to maximum basic weekly benefit amount. In Indiana, dependents' allowances are paid only to claimants with earnings in excess of that needed to qualify for a basic weekly benefit amount and who have one to three dependents. In Iowa and Ohio, claimants may be eligible for an augmented amount at all benefit levels but benefit amounts above the basic maximum are available only to claimants in dependency classes whose high-quarter wages or average weekly wage are higher than that required for a maximum basic benefit. In Massachusetts, for claimants with an average weekly wage in excess of $66 the weekly benefit amount is computed at 1/26 of the two highest quarters of earnings or 1/13 of highest quarter if the claimant has no more than two quarters work.

[3] Benefits extended under State program when unemployment in State reaches specified levels: Alaska and California by 50%; Oregon by 25%; Connecticut by 13 weeks; District of Columbia by 10 weeks. In Hawaii, benefits extended by 13

weeks when man made or natural disaster causes damages to either the State as a whole or any of its counties and creates an unemployment problem involving a substantial number of persons and families. In Puerto Rico, benefits extended by 32 weeks in certain industries, occupations, or establishments when special unemployment situations exist. In all States, benefits may be extended during periods of high unemployment by 50% for up to 13 weeks under the Federal-State Extended Unemployment Compensation Program.

[4] For claimants with minimum qualifying wages and minimum weekly benefit amount. When two amounts are shown, range of duration applies to claimants with minimum qualifying wages in base period; longer duration applies with minimum weekly benefit amount; shorter duration applies with maximum possible concentration of wages in the high quarter; therefore the highest weekly benefit amount possible for such base period earnings.

[5] To 58.5% State average weekly wage if claimant has nonworking spouse; 65.5% if claimant has dependent child, Illinois; 1/19-1/23 up to 65% of the State average weekly wage for claimants with dependent, Iowa; 1/46 of wages in highest two quarters if the trust fund balance is at least $90 million or is 1/52 of wages in highest two quarters if the trust fund balance is less than $90 million, Delaware; a State average weekly wage ranging from 60% to 66-2/3% depending on the balance of the fund, Minnesota; wages in the two highest quarters divided by 45, Vermont; if high quarter wages exceed $4,966.99, the maximum weekly benefit amount will be 39% of these wages divided by 13, California; 1/25 of highest quarter if alternative qualifying wages are used, Georgia.

[6] Weekly benefit amount will be reduced by 5% or by the reduction determined by a trigger mechanism, but the weekly benefit amount may not be reduced to less than half the maximum weekly benefit amount, Pennsylvania; weekly benefit amount over $90 will be reduced to 85% of the computed amount when revenues in the fund are inadequate to pay benefits, Wyoming; the greater of $197 or 60%, 57.5%, 55%, 52.5%, or 50% of State average weekly wage of the second preceding calendar year depending on the condition of the fund, Oklahoma; if the trust fund balance is less than $165 million but more than $150 million, the maximum weekly benefit amount will be $245, if the trust fund balance is less than $150 million but equal to or greater than $90 million, the maximum weekly benefit amount will be $225, and if the trust fund balance is less than $90 million the maximum weekly benefit amount will be $205, Delaware; weekly benefit amount reflects a 7% decrease and a 5% discount from the computed maximum of $205, Louisiana.

[7] Up to 66-2/3% of State average weekly wage, Louisiana; 62% of State average weekly wage depending on the trust fund reserves or 65% of State average weekly wage depending on trust fund reserves and the State's average contribution rate if below the nationwide average for the preceding year, North Dakota.

[8] Maximum amount adjusted annually: by same percentage increase as occurs in State average weekly wage, Ohio; by $7 for each $10 increase in average weekly wage of manufacturing production workers, Texas.

[9] Duration can be much less than 26 weeks for individuals with only one base period employer, Oklahoma.

[10] On July 8, 1996, the maximum weekly benefit amount increased to $224 in Virginia.

Source: *Significant Provisions of State Unemployment Insurance Laws*, Department of Labor, Washington, DC, January 5, 1997.

Appendix IV:—Benefits for temporary total disability provided by workers' compensation statutes, January 1, 1996

Jurisdiction	Percentage of worker's wages	Payments per week: Minimum	Payments per week: Maximum	Percentage of State average weekly wage (SAWW)	Maximum period
Alabama	66-2/3	$122—27-1/2% of SAWW of worker's average wage if less	$443.00	100	Duration of disability
Alaska	80% of worker's spendable earnings	$110 or $154 if employee shows proof of wages, or worker's spendable weekly wage if less	[1] $700.00	. . .	Duration of disability until date of medical stability
Arizona	66-2/3	Payable, but not statutorily prescribed	[2] $323.10	. . .	Duration of disability
Arkansas	66-2/3	$20	$337.00	85	450 weeks
California	66-2/3	$126	$448.00	. . .	Duration of disability
Colorado	66-2/3	. . .	[3] $451.22	91	Duration of disability
Connecticut	75% of worker's spendable earnings	$131.20—20% of SAWW, or an amount not to exceed 80% of worker's average wage if less	[1] $656.00	100	Duration of disability
Delaware	66-2/3	$119.07—22-2/9% of SAWW, or actual wage if less	$357.19	66-2/3	Duration of disability
District of Columbia	66-2/3 or 80% of spendable earnings, whichever is less	$180.84—25% of SAWW	$723.34	100	Duration of disability
Florida	66-2/3	$20 or actual wage if less	[4] $465.00	100	104 weeks
Georgia	66-2/3	$25 or average wage if less	$275.00	. . .	400 weeks[5]
Hawaii	66-2/3	$124—25% of SAWW, or worker's average wage if less, but not less than $38	$496.00	100	Duration of disability
Idaho	67	$186.75—45% of SAWW	$373.50 for first 52 weeks; thereafter $220.55	90	52 weeks, thereafter 67% of SAWW for duration of disability
Illinois	66-2/3	$100.90 to $124.30, or worker's average wage if less, according to the number of dependents	$760.51	133-1/3	Duration of disability
Indiana	66-2/3	$50 or worker's average wage if less	$428.00	. . .	500 weeks or $214,000

See footnotes at end of table.

Appendix IV:—Benefits for temporary total disability provided by workers' compensation statutes, January 1, 1996—*Continued*

Jurisdiction	Percentage of worker's wages	Payments per week: Minimum	Payments per week: Maximum	Percentage of State average weekly wage (SAWW)	Maximum period
Iowa	80% of worker's spendable earnings	$148—35% of SAWW, or actual wage if less	$846.00	200	Duration of disability
Kansas	66-2/3	$25	$326.00	75	Duration of disability
Kentucky	66-2/3	$83.19—20% of SAWW	[7] $415.94	100	Duration of disability
Louisiana	66-2/3	$88—20% of SAWW, or actual wage if less	[8] $330.00	75	Duration of disability
Maine	80% of worker's after tax earnings	. . .	[9] $441.00	90	Duration of disability
Maryland	66-2/3	$50 or actual wage if less	$540.00	100	Duration of disability
Massachusetts	60	$120.81—20% of SAWW, or worker's average wage if less	[10] $604.03	100	156 weeks
Michigan	80% of worker's spendable earnings	. . .	[3] $524.00	90	Duration of disability
Minnesota	66-2/3	$104 or actual wage if less	$615.60	. . .	104 weeks, or 90 days after maximum medical improvement [11]
Mississippi	66-2/3	$25	$264.55	66 2/3	450 weeks or $119,047
Missouri	66-2/3	$40	$491.19	105	400 weeks
Montana	66-2/3	Payable, but not statutorily prescribed	[1] $380.00	100	Duration of disability
Nebraska	66-2/3	$49 or actual wage if less	$409.00	100	Duration of disability
Nevada	66-2/3	. . .	$473.69	100	Duration of disability
New Hampshire	60	$146.10—30% of SAWW not to exceed employee's after tax earnings	$730.50	150	Duration of disability
New Jersey	70	$128—20% of SAWW	$480.00	75	400 weeks
New Mexico	66-2/3	$36 or actual wage if less	$353.33	85	Duration of disability
New York	66-2/3	$40 or actual wage if less	$400.00	. . .	Duration of disability

See footnotes at end of table.

Appendix IV:—Benefits for temporary total disability provided by workers' compensation statutes, January 1, 1996—*Continued*

Jurisdiction	Percentage of worker's wages	Payments per week: Minimum	Payments per week: Maximum	Percentage of State average weekly wage (SAWW)	Maximum period
New York	66-2/3	$40 or actual wage if less	$400.00	. . .	Duration of disability
North Carolina	66-2/3	$30	$492.00	110	Duration of disability
North Dakota	66-2/3	$226—60% of SAWW, or employee's actual wage if less	[12] $376.00	100	Duration of disability, or until claimant is age 65 and eligible for Social Security retirement benefits
Ohio	72% for first 12 weeks; thereafter 66-2/3	$170.33—33-1/3% of SAWW or actual wage if less	[13] $511.00	100	Duration of disability
Oklahoma	70	$30 or actual wage if less	$307.00	75	300 weeks
Oregon	66-2/3	$50 or 90% of actual wage if less	$494.44	100	Duration of disability
Pennsylvania	66-2/3	$292.78 or 90% of employee's average weekly wage if less	$527.00	100	Duration of disability
Puerto Rico	66-2/3	$20	$65.00	. . .	312 weeks
Rhode Island	75% of workers spendable earnings	. . .	[14] $485.00	100	Duration of disability
South Carolina	66-2/3	$75 or average wage if less	$437.79	100	500 weeks
South Dakota	66-2/3	$181—50% of SAWW, or worker's average wage if less	$362.00	100	Duration of disability
Tennessee	66-2/3	$68.40	$415.87	. . .	400 weeks or $166,348
Texas	70% of worker's earnings over $8.50 per hour; 75% for all others	$72—15% of SAWW	$480.00	100	104 weeks, or upon reaching maximum medical improvement, whichever is sooner
Utah	66-2/3	$45	[15] $429.00	100	312 weeks
Vermont	66-2/3	$219—50% of SAWW or worker's average wage if less	$655.00	150	Duration of disability
Virgin Islands	66-2/3	$60 or actual wage if less	$287.00	66-2/3	Duration of disability

See footnotes at end of table.

Appendix IV footnotes

[1] Workers' compensation benefits subject to Social Security benefit offsets.

[2] Additional $25 monthly added to benefits of dependents residing in the United States.

[3] Workers' compensation benefits subject to Social Security benefit offsets and to reduction by benefits under an employer pension or disability plan.

[4] Workers' compensation benefits subject to Social Security and unemployment insurance benefit offsets.

[5] Maximum weekly benefit in catastrophic cases shall be paid until such time as employee undergoes a change in condition for the better.

[6] Total amount payable is $100,000. Workers' compensation benefits subject to unemployment insurance and Social Security benefit offsets.

[7] Benefit payment frozen until 1997.

[8] Workers' compensation benefits subject to unemployment insurance benefit offsets.

[9] Workers' compensation benefits subject to unemployment insurance benefit offsets, except if benefits started prior to date of injury, or if benefits are a spouse's entitlement.

[10] Additional $6 will be added per dependent if weekly benefits are below $150.

[11] Compensation stops if employee withdraws from labor market, is released to work without any physical restrictions, or refuses offer to work that is consistent with a rehabilitation plan.

[12] Additional $10 per week for each dependent child, not to exceed worker's net wage. Benefits are reduced by 50% of Social Security disability benefits.

[13] Workers' compensation benefits subject to Social Security benefit offsets and if concurrent and/or duplicate, with those under employer nonoccupational benefit plan.

[14] Additional $9 for each dependent, including a nonworking spouse; aggregate not to exceed 80% of worker's average weekly wage.

[15] Additional $5 for dependent spouse and each dependent child up to four under age 18, but not to exceed 100% of State's average weekly wage.

[16] Additional $10 will be paid for each dependent under age 21.

[17] Minimum benefits may not exceed the level of benefits determined by use of the applicable Federal minimum hourly wage.

[18] Federal Employee's Compensation Act.

[19] Maximum weekly benefit is based on the pay of a specific grade level in the Federal civil service; benefits calculated are at 75% of worker's wage where there are one or more dependents.

[20] Longshore and Harbor Workers' Compensation Act.

Appendix V: Poverty Guidelines

The Federal poverty guidelines are used to determine financial eligibility for assistance or services under certain Federal programs. The guidelines are a simplified version of the Federal Government's official statistical poverty thresholds, which were originally developed in the mid-1960's by the Social Security Administration. The thresholds are now updated annually by the Census Bureau and are used for statistical purposes (for example, to determine the number of persons in poverty and to present data classifying them by type of residence, race, and other social, economic, and demographic characteristics). The poverty guidelines, which are derived from the poverty thresholds, are issued by the Department of Health and Human Services and are used for administrative purposes (for example, as an eligibility criterion for a number of Federal programs).

Both thresholds and guidelines are a series of income levels, with different values for family units of different sizes, below which the family units are considered poor.

Since 1973, the guidelines have been computed by increasing the Census Bureau's weighted average poverty thresholds by the most recently available year-to-year percentage change in the Consumer Price Index for All Urban Consumers (CPI-U). For a family of four, the resulting value is rounded to the next higher multiple of $50; for family sizes above and below four, guidelines are computed by adding or subtracting equal dollar amounts derived from the average difference between adjusted threshold figures for different family sizes (rounded to the nearest multiple of $20).

Federal poverty guidelines, March 1997[1]

Family size	The 48 contiguous States and the District of Columbia	Alaska	Hawaii
1	$7,890	$9,870	$9,070
2	10,610	13,270	12,200
3	13,330	16,670	15,330
4	16,050	20,070	18,460
5	18,770	23,470	21,590
6	21,490	26,870	24,720
7	24,210	30,270	27,850
8	26,930	33,670	30,980

[1] For family units with more than eight members, add the following amount for each additional family member: $2,720 in the 48 contiguous States and District of Columbia; $3,400 in Alaska; and $3,130 in Hawaii.

Federal Poverty Guidelines

A single set of guidelines applies to the 48 contiguous States and the District of Columbia. There are separate sets of poverty guidelines for Alaska and for Hawaii reflecting Office of Economic Opportunity administrative practice beginning in the 1966-70 period. (Note that the poverty thresholds—the original version of the poverty measure—have never had separate figures for Alaska and Hawaii.)

Some programs use the poverty guidelines as only one of several eligibility criteria, or use a modification of the guidelines. For example, the eligibility level may be set at 130% or 185% of the guidelines rather than 100%. Other programs, although not using the guidelines as a criterion of individual eligibility, use them for the purpose of targeting assistance or services. The guidelines become effective on the date they are published in the *Federal Register* (unless an office administering a program using the guidelines specifies a different effective date for that particular program) and remain in effect until the next update is issued.

Poverty guidelines, or percentage multiples of them, are used as an eligibility criterion by a number of Federal programs, including the following:

Department of Health and Human Services

Community Services Block Grant

Head Start

Low-Income Home Energy Assistance

Hill-Burton Uncompensated Services Program (in connection with previous medical facilities construction and modernization assistance to hospitals or other health care facilities)

AIDS Drug Reimbursments (under Title II of the Ryan White Act)

Medicaid (The guidelines are used only for certain parts of Medicaid; however, the rest of the program—which probably still accounts for a majority of Medicaid eligibility determinations—does not use the poverty guidelines.)

Department of Agriculture

Food Stamps

Special Supplemental Food Program for Women, Infants, and Children (WIC)

National School Lunch Program

School Breakfast Program

Child and Adult Care Food Program

Special Milk Program for Children

Department of Energy
Weatherization Assistance for Low-Income Persons

Department of Labor
Job Corps
Migrant and Seasonal Farmworkers
Native American Employment and Training Programs
Senior Community Service Employment Program

Corporation for National Service
Foster Grandparent Program
Senior Companion Program

Legal Services Corporation
Legal services for the poor

The following Federal programs do not use the poverty guidelines in determining eligibility:

Aid to Families with Dependent Children and Temporary Assistance for Needy Families

Supplemental Security Income

Social Services Block Grant

Department of Housing and Urban Development's means-tested housing assistance programs