Social Security Programs in the United States

This is the latest in a series of reports of the same title that have been published intermittently since the early 1960's.

The term Social Security is popularly used in the United States to refer to the basic national social insurance program—Old-Age, Survivors, Disability, and Health Insurance. The term is used here in a broader sense to describe all types of social insurance, social assistance, and related programs.

Thus, this report provides a description of the history and current program provisions of this country's social insurance systems: Old-Age, Survivors, and Disability Insurance; Medicare; unemployment insurance; workers' compensation; and temporary disability insurance. It describes the major income-support programs—Supplemental Security Income, Aid to Families With Dependent Children, Medicaid, and Food Stamp—as well as the smaller programs, such as Low-Income Home Energy Assistance, public housing, the school lunch program, and general assistance. Finally, it includes three programs for members of special groups: veterans, public employees, and railroad employees.

The report provides a layman's guide to the Nation's network of publicly funded cash and in-kind income-maintenance programs and the health insurance and medical assistance programs of the Social Security Act. The report does not describe the many services provided by the Federal Government and the States to beneficiaries of these programs and to others. Nor does it describe the important system of private retirement and disability pensions.

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All industrialized countries have developed broad public programs of social insurance, health care, and income support. The purpose of these programs is to protect people from the possibility of income loss due to old age, unemployment, disability, work-related injury, or death and to assure access to health care and to an adequate standard of living. The support systems of the agrarian era—the family, private charity, and local government—proved universally insufficient to meet the needs of persons living in a predominantly urban environment and subject to the vicissitudes of a national industrial economy.

Although the social security institutions that have developed in various countries in response to industrialization are broadly comparable, they differ in important ways. It is not surprising that diverse historical, cultural, demographic, political, and economic characteristics of various countries have shaped social security programs that are far from uniform. A number of unique characteristics—including geographic size, ethnic diversity, and a tradition of self-reliance fostered by frontier opportunities—have helped to shape the development of social welfare legislation and institutions in the United States. Their influence may be seen in at least three important areas.

First, the development of social welfare programs in the United States has been strongly pragmatic and incremental. Proposals for change generally are formulated in response to specific problems rather than to a broad national agenda. Actual program experience and evidence of unmet needs or unintended effects subsequently lead to adjustment, extensions, or alternative approaches.

The original Social Security Act did not include the full range of programs that had developed in some European countries; it was anticipated that additional programs of social insurance and income support would be instituted later. The provision of benefits to dependents and survivors, legislated in 1939, and the enactment of assistance programs and insurance for the disabled during the 1950's are two examples of such anticipated extensions. Program developments in other areas followed more of a "problem solving" and incremental pattern. Thus, the Medicare and Medicaid programs were enacted in 1965 in response to the specific medical care needs of the elderly and the widely perceived inadequacy of "welfare medical care" under public assistance. Similarly, the introduction, in 1964, and subsequent extensive growth of the Food Stamp program was a response to evidence of the persistence of hunger and malnutrition among some population subgroups despite general affluence. And the Supplemental Security Income (SSI) program introduced a national minimum income guarantee for the needy aged, blind, and disabled, effective in 1974, to counteract wide differences in benefit levels and eligibility standards applicable to these groups under the Federal-State assistance programs. The Low-Income Home Energy Assistance Program (LIHEAP) incorporates another pragmatic response to demonstrated need caused by the rapid rise of home energy costs during the 1970's.

Both the Food Stamp and Low-Income Home Energy Assistance programs are available to individuals and families who are eligible for payments under the SSI or Aid to Families With Dependent Children (AFDC) programs and to those needy individuals and families who are not eligible for either program. In this way, a pragmatic compromise has led to limited aid for certain groups without complete deviation from a major feature of Federal and federally assisted income support—categorical eligibility.

A second characteristic of social policy development in the United States is its considerable degree of decentralization. One mechanism for this decentralization is the Federal system of government with its division of responsiblity among the Federal, State, and local governments. Some programs are almost entirely Federal with respect to administration, financing, or both; others involve only the States (with or without the participation of local governments); still others involve all three levels of government. The Federal structure "has exercised

three important political functions in public welfare policy: diffusion of power, mediation of conflicting claims, and facilitation of the flexibility that gives potential for institutional and social change. . . .Public welfare is much too expansive and too complex to be the program of a single government.[1]"

Another aspect of decentralization in the development of American social welfare policy is the important role played by the private sector in the administration of government programs. Thus, reimbursement activities under Medicare, and to a lesser degree under Medicaid, are handled by private organizations, and insurance protection for workers' compensation and temporary disability insurance benefits is underwritten in the private sector.

A further reflection of the decentralization of policymaking is the fact that the various social welfare programs are not necessarily integrated with each other. For example, the Food Stamp and Low-Income Home Energy Assistance programs continue to be administered separately from other income support programs, such as SSI, AFDC, and general assistance.

A third salient characteristic of the Nation's social welfare structure is the private sector's sharing of responsibility for social welfare expenditures. The private sector has a large role in the provision of health, medical care, and income-maintenance benefits in the form of employment-related pensions, group life insurance, and sickness payments. Private provisions are also significant in the areas of education and social services.

The dimensions of the Nation's social welfare structure may be delineated by three measures: The number of beneficiaries under the major programs, total benefit payments, and expenditures in various social welfare categories in relation to the gross national product (GNP).

In December 1988, 38.6 million persons—73 percent of them aged 65 or older—were receiving benefits under the largest single program—Old-Age, Survivors, and Disability Insurance (OASDI). As of July 1, 1987, the Medicare program covered 29.4 million persons aged 65 or older and 3.0 million disabled persons under age 65. Medicaid benefits were paid on behalf of 23.2 million persons in fiscal year 1987, and the Food Stamp program had 18.7 million participants in fiscal year 1988. Finally, AFDC payments were received by 10.9 million children and adults in 3.7 million families in December 1988, and federally administered SSI payments in December 1988 were made to 4.5 million persons, of whom 2.0 million were aged 65 or older.

Total benefit payments under these programs were disbursed as follows:

Program	Total payments
OASDI	$217.2 billion in 1988
Medicare	$80.3 billion in 1987
Medicaid	$45.1 billion in fiscal year 1987
Food stamps	$11.2 billion in fiscal year 1988
AFDC	$16.6 billion in fiscal year 1988
SSI	$13.4 billion in 1988

Total public welfare expenditures of $770.5 billion represented 18.4 percent of the gross national product in 1986. They included Federal expenditures amounting to 11.3 percent of GNP, and State and local government expenditures that were 7.1 percent of GNP. Social insurance benefit payments, excluding Medicare, totaled $314.5 billion; total spending for health and medical care, including Medicare and Medicaid, accounted for $186.6 billion; and income-support programs, excluding expenditures for health and medical care, came to $55.1 billion.

Estimated private expenditures for social welfare in 1986 were $474.6 billion, representing 11.2 percent of GNP. This total includes expenditures of $268.5 billion for health and medical care; $37.7 billion for welfare and other services; $45.9 billion for education; and $122.5 billion for income-maintenance programs (employee benefits), including employment-related pension benefits, group life insurance, and sickness benefits.

[1] See Andrew W. Dobelstein, **Politics, Economics, and Public Welfare**, Prentice-Hall, Inc., 1980, pages 96-97.

Section I: Social Insurance Programs

By the mid-1920's, both the States and the Federal Government had begun to recognize that certain risks in an increasingly industrialized nation could best be met through the application of social insurance principles. In social insurance programs, certain risks—injury, disability, unemployment, old age, and death—are pooled; premiums, or contributions, are paid by employees and employers; and benefits are paid as an earned right, without regard to a beneficiary's resources other than his or her earnings. In the United States, as in most industrialized countries throughout the world, social insurance began with workers' compensation (or industrial accident insurance). A Federal law covering the Federal Government's civilian employees engaged in hazardous jobs was enacted 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.

The severe depression of the 1930's dramatized the fact that many American workers were now almost totally dependent on factors beyond individual control for their economic security. Previous methods used to meet the economic risks of unemployment, old age, death, and disability no longer provided adequate or guaranteed security in the face of nationwide economic disaster.

Federal action became a necessity, as neither the States, local communities, nor privately organized charities had the financial resources to cope with the growing needs of citizens. Beginning in 1932, the Federal Government instituted programs of direct relief and work relief. In January 1935, President Franklin D. Roosevelt proposed to Congress his long-range economic security recommendations, embodied in the report of a specially created Cabinet-level Committee on Economic Security. The introduction of identical legislation in the House and Senate was followed by passage of the Social Security Act, which was signed into law on August 14, 1935.

The 1935 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 commerce or industry 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 resulting from the Great Depression that had wiped out much of the lifetime savings of the aged and had reduced the opportunities for gainful employment.

Title II of the Social Security Act created an Old-Age Reserve Account and authorized payments of old-age benefits from this account to eligible individuals upon attainment of age 65 or on January 1, 1942, whichever was later. The monthly benefit was to be determined by the total amount of wages earned in covered employment after 1936 and before age 65. The initial benefit formula was designed to give greater weight to the earnings of lower-paid workers and persons already middle-aged or older. The minimum monthly benefit was $10 and the maximum was $85.

Benefits were to be financed by payroll taxes imposed on covered employers and employees in equal shares under title VIII of the act. The first $3,000 of annual salary from one employer was taxable and considered as counting toward the total of annual wages on which benefits would be computed. This amount covered the total earnings of 97 percent of those in the labor force. Although all wage and salary workers in commerce and industry were covered by the new program, many individuals were not covered—such as self-employed persons, agricultural and domestic service workers, casual laborers, and employees of nonprofit organizations. Railroad workers were excluded from title II coverage by the Railroad Retirement Act of 1935.

As discussed in detail below, the Social Security Act of 1935 was significantly amended in 1939. Among the revisions enacted that year was the extension of protection to a worker's dependents and survivors. In 1956, the scope of the program was broadened through the addition of the Disability Insurance program. Initially, benefits were provided for severely disabled workers aged 50-64 and for adults disabled before the age of 18 who were children of deceased or retired workers.

Unemployment compensation, which provided temporary cash payments to the involuntarily unemployed, was conceived by the Committee on Economic Security as

the "front line of defense" from dependency resulting from the loss of earnings and as a means of maintaining purchasing power. The act set up a Federal-State program, modeled on a similar program enacted in Wisconsin in 1932, to be administered by the States, and provided financial assistance from the Federal Government to those States with laws approved by the Social Security Board. By means of a tax offset, the act offered an inducement to the States to enact unemployment insurance programs and, by 1937, all 48 States, the then territories of Alaska and Hawaii, and the District of Columbia had done so.

In 1946, the unemployment insurance program was amended to permit States whose employees made contributions to that program to use some or all of those contributions for the payment of temporary disability insurance benefits. Three States took advantage of this provision; four other jurisdictions subsequently enacted temporary disability insurance laws without supplemental funds from the unemployment insurance program.

Old-Age, Survivors, and Disability Insurance

The national Old-Age, Survivors, and Disability Insurance (OASDI) program, popularly referred to as Social Security, is the largest income-maintenance program in the United States. Based on social insurance principles, the program provides monthly cash benefits designed to replace, in part, the income that is lost to a worker and his or her family when the worker retires in old age, becomes severely disabled, or dies. Coverage is nearly universal: About 95 percent of the jobs in this country are covered. Workers in covered jobs and self-employed persons pay Social Security taxes on their earnings that, along with matching taxes paid by the employers of workers, constitute the primary source of revenue to finance benefits and pay for administrative expenses.

In 1988, about 130 million individuals were engaged in work covered by the Social Security program. At the end of 1988, about 38.6 million persons were receiving cash benefits totaling about $18.7 billion per month. These beneficiaries included 27.4 million retired workers and their dependent family members, 7.2 million survivors of deceased workers, and 4.1 million disabled workers and their family members. Social Security is an important source of retirement income for almost everyone; in 1986, nearly 3 in 5 beneficiaries aged 65 or older relied on Social Security benefits for at least one-half of their income. Social Security is also an important source of continuing income for young survivors of deceased workers: 95 percent of young children and their surviving parents are eligible for benefits should the family breadwinner die. Finally, 4 in 5 persons aged 21-64 have protection in the event of the worker's long-term severe disability.

Origins and Development of OASDI

Background.—The Social Security program has been shaped by both long-standing traditions and changing economic and social conditions. It was created in 1935, at the height of the Great Depression. Because American society had changed from primarily agricultural to primarily industrial and urban, many families were devastated by the loss of cash wages that accompanied the widespread unemployment of that era. For vast numbers of the aged and those nearing old age, the loss of savings brought with it the prospect of living their remaining years in destitution.

During the worst years of the Depression, many old persons were literally penniless. In fact, less than 10 percent of the aged left estates large enough to be probated at the time of their death. The "poor houses" and other public and private relief efforts of the time were totally inadequate to respond to the needs of the elderly. Although, by 1934, 30 States had enacted laws providing pensions for the needy aged, total expenditures for State programs for some 180,000 needy aged that year amounted to only $31 million. Many needy older persons were not served by such programs and the waiting lists were long. As the Depression worsened, benefits to individuals were cut to enable States to spread limited funds among as many individuals as possible.

Meanwhile, both the States and the Federal Government had begun to recognize that in such an increasingly industrialized country, workers and their dependents could be effectively protected from certain economic risks through social insurance. In the United States, as in most industrialized countries throughout the world, social insurance began with workers' compensation (in effect in all but four States by 1929). President Franklin Roosevelt's Committee on Economic Security, formed in June 1934, recommended that two new national social insurance systems be established: A Federal/State system of unemployment insurance and a Federal system of old-age benefits for retired workers who had been employed in industry and commerce. The Committee's recommendations, as modified by the Congress, were embodied in the Social Security Act signed by President Roosevelt on August 14, 1935. The law also provided for Federal matching grants-in-aid to the States to help them give financial assistance to needy persons in three categories: The aged, the blind, and dependent children. In addition, the law authorized Federal grants to the States for social services, public health, and vocational rehabilitation.

Major milestones in the development of OASDI.—Under the 1935 law, workers in commerce and industry would earn retirement benefits through work in jobs covered by the system. Benefits were to be financed by a payroll tax paid by employees and their employers on wage and salary earnings up to $3,000 per year (the wage base). Monthly benefits would be payable at age 65 to workers with a specified minimum amount of cumulative wages in covered jobs. The amount of benefits payable also varied with the worker's cumulative earnings in covered jobs. Individuals who continued to work beyond age 65 would not be eligible for benefits until their earnings ceased. Lump-sum refunds, in amounts somewhat larger than the total taxes paid by deceased workers, were to be paid to the estates of workers who died before attaining age 65 or before receiving benefits. Collection of taxes was scheduled to begin in 1937, but monthly benefits would not be payable until 1942.

Before the old-age insurance program was actually in full operation, important changes were adopted based largely on the recommendations of the first Advisory Council on Social Security. In 1939, Congress significantly expanded the old-age insurance program by extending monthly benefits to workers' dependents and survivors. Also, the basis for computing benefits was changed from cumulative lifetime earnings after 1936 to average monthly earnings in covered work, making it possible to pay reasonably adequate benefits to many workers then approaching retirement age and to their dependents. The 1939 law also established the concept of "quarter of coverage" as the basis for measuring if an individual had sufficient covered employment to qualify for a benefit. Also, individuals who continued to work after age 65 could receive full benefits as long as their earnings did not exceed a specified amount. The 1939 amendments made monthly benefits first payable in 1940 instead of 1942 as originally planned.

No major changes were made in the program from 1939 until 1950, when benefit levels were substantially increased, the wage base was increased, and a new schedule of gradually increasing tax rates was provided in the law. Coverage was broadened to include 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. Among the groups covered by the 1950 amendments were regularly employed farm and household employees and self-employed persons other than farmers and professional people. Coverage was made available on a group voluntary basis to employees of State and local governments not under public employee retirement systems and to employees of nonprofit organizations.

In 1950, when coverage under the program was extended, the law was amended to allow a worker's average monthly earnings to be figured on the basis of his or her earnings after 1950. Similar consideration was given to the groups newly covered by the program in 1954 and 1956 (including members of the Armed Forces, most self-employed professional persons, and State and local employees under a retirement system under certain conditions) by providing that the 5 years of lowest earnings be dropped from the computation of average earnings. To assure that persons already covered by the program would not be treated less favorably than the newly covered groups, these special provisions were made available to all persons who worked in covered employment after 1950, regardless of when their jobs were first covered. Similarly, insured-status requirements were modified to relate the amount of work required to the time a worker could have been expected to have worked after

1950; further liberalization of the work requirements (on a short-term basis) accompanied the extensions of coverage under the 1954 and 1956 amendments.

The scope of the basic national social insurance system was significantly broadened in 1956 with the addition of the Disability Insurance program. Monthly cash benefits were provided for disabled workers aged 50-64 who had severe disabilities of "long-continued and indefinite duration" and for adult disabled children—if disabled before age 18 (later changed to age 22)—of deceased and retired workers. In 1958, the act was further amended to provide benefits for dependents of disabled workers similar to the benefits already provided for dependents of retired workers.

In 1960, the age-50 requirement for disability benefits to disabled workers was removed, and benefits became payable at any age before 65. A trial work period was provided by the 1956 amendments and was liberalized by the 1960 amendments. The 1965 amendments modified the definition of disability to permit a severely disabled person to qualify if his or her impairment was expected to last at least 12 months. The 1967 amendments provided disability benefits for certain disabled widows and widowers, starting at age 50.

Also during this period, further refinements were made in the benefit and financing provisions of the OASI program. The age of first eligibility for retirement benefits was lowered from age 65 to age 62 for women in 1956 and for men in 1961—benefits claimed before age 65 are reduced to take into account the longer period over which they will be paid. Additional categories of dependent and survivor benefits were added throughout the 1950's and 1960's and gradually the conditions for receipt of such benefits were modified so that additional persons were eligible and dependents and survivors of female workers could qualify under more nearly the same circumstances as those of male workers. Also, the earnings test—the provision that limited the amount of benefits payable to persons with substantial earnings—was modified to take into account persons with noncovered earnings or income from self-employment. From time to time throughout this period, general benefit levels were increased to adjust for rising prices, and tax rates and the applicable wage base were raised.

By 1972, however, concern was expressed that beneficiaries continued to be vulnerable to substantial declines in purchasing power between benefit adjustments. In 1972, the Congress enacted a 20-percent benefit increase—which provided a real increase in the purchasing power of benefits—and provided for future annual automatic cost-of-living benefit increases equivalent to the increase in the Consumer Price Index (CPI) whenever the CPI had increased by at least 3 percent. The wage base and the maximum amount a beneficiary could earn before experiencing a reduction in his or her benefits (the earnings test exempt amount) would also be subject to automatic increases based on increases in average wages in the economy. The 1972 amendments also created the delayed retirement credit, under which initial benefit amounts are increased for those who delay their entitlement or continue to have earnings above the amount exempted under the retirement test after they reach normal retirement age (currently age 65).

The 1977 amendments made significant changes in the benefit computation provisions of the Social Security law. Under the 1972 amendments, future levels of initial benefits relative to preretirement earnings—or replacement rates—depended on the performance of the economy. Under conditions of relatively high inflation or low real earnings gains, the cost-of-living adjustments would cause replacement rates to rise. Both conditions prevailed following the 1973 energy crisis. The 1977 amendments replaced the technically flawed benefit formula with a new benefit formula for those attaining age 62 in 1979 or later. (An alternative transitional formula can be used for workers attaining age 62 during the period 1979-83 if higher benefits result.) Under the rules enacted in 1977, earnings for past periods are updated, or "indexed," to account for changes in average wages in the economy since they were earned. In contrast with the former rules, the cost-of-living adjustments now apply only after a person becomes eligible for benefits; the benefit formula is also updated automatically to reflect changes in the general wage level. These changes ensured stable replacement rates over time. The 1977 amendments also provided for increases in tax rates and the wage base to improve the program's financial stability.

The 1980 disability amendments contained a number of provisions designed to remove possible work disincentives for the disabled and to improve program administration. They required that the continued eligibility of Disability Insurance beneficiaries with nonpermanent disabilities be reviewed at least once every 3 years.

In the late 1970's and early 1980's, benefit costs were driven up

rapidly by inflation while slow growth in wages and high unemployment held down payroll tax income to the system. The resulting short-term financing crisis, along with growing awareness of a long-run problem caused primarily by declining birth rates and increasing life expectancy, led to the formation of a National Commission on Social Security Reform in late 1981. Based on the recommendations of this bipartisan Commission, the 1983 Amendments to the Social Security Act included a number of changes to increase program revenues: The effective dates for scheduled tax rate increases in prior law for employees and employers were advanced, self-employment tax rates were permanently increased, and up to one-half of benefits to certain upper-income beneficiaries were included in taxable income. Resulting revenues are appropriated to the OASI and DI Trust Funds. In addition, coverage was expanded to include Federal civilian employees hired after December 31, 1983, and all employees of nonprofit organizations (on a mandatory basis). To address the long-term outlook of the system, the Congress approved a gradual increase in the age of eligibility for full benefits from age 65 to age 66 by 2009 and to age 67 by 2027. Actuarially reduced benefits will continue to be available at age 62, but with a greater reduction than under previous law.

In 1984, further refinements of the changes made in 1980 were enacted as the Social Security Disability Benefits Reform Act of 1984. These amendments established a medical improvement standard for determining if a disability beneficiary's payments should be terminated because he or she is no longer disabled.

In 1986, Congress eliminated the requirement that the CPI had to rise by at least 3 percent before a cost-of-living benefit increase would take effect. Under the 1986 law, any rise in the CPI in the preceding 12-month measurement period calls for an equivalent percentage increase in benefits, applicable to persons eligible for benefits.

Program Principles

Certain basic principles have been adhered to throughout the development of the OASDI program.

Work related.—Economic security for the worker and his or her family grows out of the individual's own work history. A worker's entitlement to benefits is based on past employment, and the amount of cash benefits the worker and his or her family will receive is related to earnings in covered work. In general, the higher the worker's average amount of taxable earnings, the greater the protection.

No means test.—Benefits are an insured worker's earned right and are paid regardless of income from savings, pensions, private insurance, or other forms of nonwork income. A worker knows beforehand that he or she will not have to prove the existence of need to receive benefits. The absence of a means test in turn encourages the building of additional protection for the worker and his or her family on the foundation that Social Security benefits provide.

Contributory.—The concept of an earned right is reinforced by the fact that workers pay earmarked Social Security taxes to help finance current benefits. The contributory nature of the program encourages a responsible attitude toward the program. Knowing that the financing of the present program and any improvements made in it depend on Social Security taxes that he or she helps to pay, the worker has a personal interest and stake in the soundness of the program.

Universal compulsory coverage.—Another important principle is that, with minor exceptions, coverage is universal and compulsory. As in private insurance systems, spreading the insured risks among the broadest possible group helps to stabilize the cost of the protection for each participant by making the probability of random fluctuations in insured risks smaller. In addition, nearly universal coverage is desirable for a social insurance system because it assures virtually everyone in society a base of economic security.

Rights clearly defined in law.—An additional principle is that a person's rights to Social Security benefits—how much he or she 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 thus severely limited. A person who meets the conditions in the law must be paid. If a claimant disagrees with a decision, he or she may appeal to the courts after all administrative appeals have been exhausted.

Coverage

The Social Security Act of 1935 covered employees in nonagricultural industry and commerce only. Since 1935, coverage has been extended to include additional employment: Today the Old-Age, Survivors, and Disability Insurance program

approaches universal coverage. About 95 percent of the jobs in this country are covered under the program, compared with less than 60 percent when the program began in 1937. Except for special provisions applicable to only a few kinds of work, coverage is compulsory. The wide applicability and compulsory nature of the program are essential to its effectiveness in preventing dependency and want and in assuring American workers and their families of continuous protection during all phases of their working careers.

Nearly all work performed by citizens and noncitizens, regardless of age or sex, is covered if it is performed within the United States (defined for Social Security purposes to include American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands).

In addition, the program covers work performed outside the United States by American citizens or resident aliens who are (1) employed by an American employer, (2) employed by a foreign affiliate of an American employer electing coverage for its employees, or (3) self-employed, under certain circumstances. Employment on American vessels or aircraft outside the United States is usually covered, without regard to the worker's citizenship.

The majority of workers excluded from coverage are in four major categories: (1) Federal civilian employees hired before January 1, 1984, (2) railroad workers (who are covered under the railroad retirement system, coordinated with Social Security), (3) employees of State and local governments not covered by a voluntary agreement, (4) household workers and farm workers whose earnings do not meet certain minimum requirements (workers in industry and commerce are covered regardless of the amount of earnings), and (5) persons with very low net earnings from self-employment (generally less than $400 per year). The remaining few groups excluded from coverage by law are very small. An example is certain nonresident, nonimmigrant aliens temporarily in the United States to carry out the functions for which they are admitted (such as teaching, studying, or conducting research). Certain family employment is also excluded (such as employment of a child under age 18 by his or her parent).

Employees of State and local governments may be covered under agreements between the States and the Secretary of Health and Human Services. Each State decides what groups of eligible employees, if any, will be covered subject to provisions in the Federal law that assure retirement system members a voice in any decisions to cover them under the OASDI program. States are prohibited from terminating such coverage agreements. At present, more than two-thirds of all State and local employees are covered.

The professional services of ministers, members of religious orders who have not taken a vow of poverty, and Christian Science practitioners are covered automatically under the provisions applicable to the self-employed unless, within a limited period, an exemption is claimed on grounds of conscience or religious principles. Religious orders whose members have taken a vow of poverty may make an irrevocable election to cover their members as employees.

Since 1957, the basic pay of uniformed members of the military service has been covered under the regular contributory provisions of the law. In addition, deemed (noncontributory) wage credits of up to $1,200 per year are provided to take account of remuneration received in kind—such as quarters, meals, and medical services.

Gratuitous (noncontributory) wage credits of $160 a month are also provided, with certain restrictions, to veterans for each month of active military service from September 1940 through December 1956. In general, these wage credits may not be used if another Federal periodic retirement or survivor benefit (other than a benefit from the Department of Veterans Affairs) is being paid based on the same period of service. However, individuals who continued in the military service after 1956 are given credit for service during the period 1951-56 even if such service is also used in calculating their benefits from the uniformed services. The Social Security trust funds are reimbursed from Federal general revenues to finance noncontributory wage credits.

Benefit Eligibility

Insured status.—To qualify for his or her own benefit payments and payments for eligible family members or survivors, a worker must have demonstrated labor-force attachment with a specified amount of work in covered employment or self-employment. The required amount of covered work generally relates to how long a person could be expected to have worked under the program, subject to a maximum requirement of 10 years and a minimum of 1-1/2 years. Persons attaining age 62 in 1991 or later will need credit for 10 years of work in covered jobs to qualify for retirement benefits.

The period of time a person must have spent in covered work to be insured for benefits is measured in

Social Security credits. A worker can acquire up to four credits per year, depending on his or her annual covered earnings. In 1989, one credit will be acquired for each $500 in covered earnings. This earnings figure is updated annually, based on changes in average wages.

For most types of benefits, the worker must be fully insured. In general, a fully insured person is one who has at least as many credits (acquired at any time after 1936) as the number of years elapsing between age 21 and age 62 or death or disability, whichever occurs first. For those 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.

If a worker dies before acquiring fully insured status, survivor benefits may be paid to his or her children and to his or her widow(er) caring for such children under age 16 (commonly referred to as mother's or father's benefits), if the worker was "currently insured" at the time of death. An individual is currently insured with six credits in the 13-calendar-quarter period ending with the quarter in which death occurred.

To be insured for disability benefits, a worker must be fully insured and meet a test of substantial recent covered work—that is, he or she must have credit for work in covered employment for at least 20 quarters of the 40 quarters ending with the quarter of disability or, in the case of workers who are disabled before age 31, one-half the quarters after age 21, with a minimum of 6 such quarters. A blind worker needs only to be fully insured to qualify for benefits. The insured status requirements for each of the various benefits paid under the program are summarized in table 1.

Annual earnings test.—The law provides that a beneficiary who has substantial earnings from work will have some or all benefits withheld, depending on the amount of his or her annual earnings. Benefits will also generally be withheld from a person receiving benefits as a family member if the worker on whose account he or she is eligible for benefits has substantial income from work. This provision, which is generally called the earnings test, is included in the law to assure that monthly benefits will be paid to a worker and to his or her family members and survivors only when they do not have substantial earnings from work. The amount a beneficiary can earn without having benefits reduced is increased automatically—in proportion to the rise in average earnings—whenever OASDI cash benefits are increased automatically. In 1989, the benefits of a beneficiary under age 65 are reduced $1 for each $2 in annual earnings in excess of $6,480; a beneficiary aged 65-69 may earn $8,880 before his or her benefits are reduced. (Beginning in 1990, beneficiaries who have reached normal retirement age (currently age 65) will have their benefits reduced $1 for each $3 in earnings exceeding the exempt amount.) Beginning with the month in which they attain age 70, beneficiaries are eligible to receive full benefit payments regardless of their earnings. In the absence of this provision, some persons who work and pay Social Security contributions significantly beyond normal retirement age might never receive any monthly benefit.

Under the "special earnings test" that applies to beneficiaries who work outside the United States in noncovered employment, a beneficiary receives no benefits for any month in which he or she works more than 45 hours or, in the case of family members, in which the worker works more than 45 hours.

Disability requirement.—For purposes of entitlement to monthly benefits, disability is defined as the "inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which 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 he or she lives, or if a specific job vacancy exists for that person, or if he or she would be hired on application for the work. The amount of earnings that ordinarily demonstrates SGA is set forth in regulations. At present, earnings averaging more than $300 a month are presumed to represent SGA, and earnings below $190 generally indicate the absence of SGA. If the determination of disability cannot be made on the basis of the medical evidence only, consideration is given to the person's age, education, and work experience. A less strict rule is provided for blind workers aged 55 or older. Such blind workers are considered disabled if, because of their blindness, they are unable to engage in substantial gainful activity requiring skills and abilities comparable to those required in their past occupation.

Monthly benefits at a permanently reduced rate are payable to

Table 1.—Benefits payable and insured-status requirements under the OASDI program, January 1989[1]

Retirement insurance benefits	
Monthly payments, equal to 100 percent of the primary insurance amount, are payable to:	**If worker is:**
A retired worker aged 65 or older[2]	Fully insured
And monthly payments, equal to 50 percent of the primary insurance amount, are payable to a worker's:	
Spouse or divorced spouse aged 65 or older[3]	*Fully insured*
Child or grandchild under age 18, or age 19 if in school	Fully insured
Child or grandchild aged 18 or older who has been disabled since before age 22	Fully insured
Wife of any age if caring for an entitled child under age 16 or disabled	Fully insured
Monthly payments of $151.90 are payable at age 72 to:	
A worker who attained age 72 before 1964 (1967 for women)	Transitionally insured
And monthly payments of $76.10 are payable at age 72 to a worker's:	
Spouse who attained age 72 before 1969	Transitionally insured
Survivor insurance benefits	
Monthly payments equal to 100 percent[4] of the primary insurance amount are payable to a worker's:	**If at death the worker is:**
Widow(er) or surviving divorced spouse aged 65 or older[5]	Fully insured
Monthly payments equal to 82-1/2 percent of the primary insurance amount are payable to a worker's:	
One dependent parent aged 62 or older	Fully insured
Monthly payments equal to 75 percent of the primary insurance amount are payable to a worker's:	
Widow(er) or surviving divorced spouse under age 62 if caring for an entitled child under age 16 or disabled	*Either fully or currently insured*
Child or grandchild under age 18, or age 19 if in school	Either fully or currently insured
Child or grandchild aged 18 or older who has been disabled since before age 22	Either fully or currently insured
Dependent parent aged 62 or older, when both parents are entitled	Fully insured
Lump-sum payment of $255 may be paid to a worker's:	
Widow(er) who was living with the worker at time of death; or, if none, to a person who was (or could have been) entitled to widow(er)'s, mother's or father's benefits for month of death; or, if none, to a person (or in equal shares to persons) who was (or could have been) entitled to a child's benefit for month of death	Either fully or currently insured
Monthly payments of $151.90 are payable at age 72 to a worker's:	
Widow(er) who attained age 72 before 1969	Transitionally insured
Disability insurance benefits	
Monthly payments equal to the amounts payable in retirement cases[6] are payable to:	**If worker is:**
A disabled worker under age 65 and his or her spouse and children[7]	Fully insured and has 20 quarters of coverage in the 40 calendar quarters ending with the quarter of disability onset[8]
A blind worker under age 65 and his or her spouse children[7]	Fully insured
Special age-72 benefits	
Monthly payments $151.90 are payable to:	**If the person meets:**
Certain persons who attained age 72 before 1972	Reduced requirements for insured status that apply only to this type of repayment

[1] This table reflects the currently applicable normal retirement age (NRA) of 65. As explained in the text below, the NRA—the age at which unreduced retirement benefits are payable—will be increased gradually from age 65 to 67 beginning in the year 2003. Benefits will still be available at age 62 for retired workers and their spouses and at age 60 for widow(er)s, but the maximum reduction for worker's and spouse's benefits will be greater.

[2] Reduced benefits are payable at age 62; benefit amount is permanently reduced by 5/9 of 1 percent for each month the benefit is paid before age 65 (or 20 percent over the full 3-year period). Benefit amount is increased by a delayed retirement credit (DRC) of 1/4 of 1 percent for each month (3 percent for each full year) that no benefits are payable to a fully insured person between the normal retirement age (currently 65) and age 70. The DRC will be raised to 3-1/2 percent per year for workers who attained age 62 in 1987-88, to 4 percent for workers attaining age 62 in 1989-90, and so on, until it reaches 8 percent per year for workers attaining age 62 after 2004.

[3] Reduced benefits are payable at age 62; benefit amount is permanently reduced by 25/36 of 1 percent for each month the benefit is paid before age 65 (or 25 percent over the full 3-year period).

[4] Where a worker was already receiving reduced retirement benefits at time of death, the benefit payable to the widow(er) or surviving divorced spouse cannot be more than the worker would be getting if still alive, except that the benefit amount cannot be reduced to less than 82-1/2 percent of the primary insurance amount for a widow(er) or surviving divorced spouse aged 62 or older.

[5] Reduced benefits are payable at age 60; benefit amount is permanently reduced by 19/40 of 1 percent for each month the benefit is paid before age 65 (or 28.5 percent over the full 5-year period). Benefits equal to 71.5 percent of the full amount are payable to a disabled widow(er) or disabled surviving divorced spouse aged 50-59.

[6] Except that benefits for a disabled worker before age 65 are not reduced unless he or she previously received a reduced retirement benefit.

[7] Same categories as in retirement cases.

[8] The special alternative insured status retirement for young workers disabled before age 31 is one-half the calendar quarters after age 21 up to date of disability, or, if disabled before age 24, one-half the quarters in the 3 years ending with the quarter of disability.

disabled widows and disabled widowers beginning at age 50. The widow or widower must have become totally disabled within 7 years after the spouse's death or within 7 years after the end of a previous entitlement to benefits as a mother or father or as a disabled widow or widower (previously entitled and whose benefits were terminated because of SGA or medical recovery). The test of disability for disabled widows and widowers is more restrictive than that for disabled workers. Disability determinations for a widow or widower are made solely on the level of severity of the impairment (without regard to such factors as age, education, and work experience, which are considered in disabled-worker benefit cases). The disabling impairment must be severe enough to prevent an individual from engaging in "any gainful activity" (as distinguished from substantial gainful activity). Benefits are also payable to a worker's adult children who have been disabled since before age 22, based on the same definition of disability that applies to workers.

Initial determinations of disability are generally made by Disability Determination Service (DDS) units in a State agency under regulations established by the Secretary of Health and Human Services. These DDS units are usually a division of a State's Department of Vocational and Rehabilitation Services. The costs are reimbursed by the Federal Government. If the initial application is denied, the applicant may request reconsideration. If the reconsideration results in a denial, the applicant may appeal for a hearing before an Administrative Law Judge (ALJ). A sample of decisions made by the State agencies is reviewed by the Social Security Administration to assure consistency and conformity with national policies.

Applicants are referred to State vocational rehabilitation agencies for possible vocational rehabilitation services. Disability benefits are not payable to anyone who, without good cause, refuses vocational rehabilitation services made available to him or her. Payment may be made from the Social Security trust funds for the cost of providing vocational rehabilitation services to Disability Insurance beneficiaries who are successfully rehabilitated.

To further encourage a return to work, a disabled person who has not recovered, but who returns to work, is allowed a trial work period during which his or her benefits are continued. As a general rule, when a disabled person is in a trial work period, only the month in which earnings from employment exceed $75 will count as one of the months of the trial work period. At the end of 9 months of trial work (not necessarily consecutive months) the case is reviewed to see if the person is able to engage in substantial gainful activity. If he or she is not able to do so and has not medically improved, the benefits are continued. If he or she is able to engage in SGA, the benefits are continued for a 3-month period of adjustment. The person thus receives a total of 12 benefit payments for months in which he or she works (9 months of trial work and 3 months of readjustment). In addition, as long as the beneficiary does not recover medically during the 36-month period following the trial work period, the benefits will be reinstated for any month in which earnings fall below the SGA level. Beneficiaries who recover from their disabilities before they work 9 months, as well as beneficiaries who recover before testing their ability to work, continue to receive benefits for an additional 3 months, including the month in which they recover.

The law includes numerous other provisions designed to encourage disability beneficiaries to return to work. These include the deduction of impairment-related work expenses from a person's earnings when determining if he or she is engaging in substantial gainful activity and the continuation of Medicare coverage for at least 39 months after the trial work period ends. A cap, lower than the one that prevails for other types of benefits, is set on the maximum family benefits payable in disability cases because of concern that some disabled workers might be discouraged from returning to work because their benefits could exceed their predisability net earnings.

Payment of cash benefits abroad and totalization agreements.—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 quarters of coverage 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 auxiliary or survivor 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 Treasury Department has suspended payments.

Through international totalization agreements, the U.S. Social Security system is coordinated with the systems of certain other countries. Authorized under the 1977 amendments, these agreements benefit both workers and employers by eliminating dual coverage and contributions for the same work under the social security systems of the countries that are parties to the agreement. Such agreements also prevent the impairment of social security protection that results when a person works under the systems of two countries but is not eligible for benefits in one or both countries when he or she retires, becomes disabled, or dies. The United States currently has social security agreements in effect with 11 countries—Italy (1978), the Federal Republic of Germany (1979), Switzerland (1980), Belgium, Norway, and Canada (1984), the United Kingdom (1985), Sweden (1987), Spain and France (1988), and Portugal (August 1989).

Types of Benefits

Monthly retirement benefits are payable at age 62 to a retired insured person and to the spouse of a retired insured person. These benefits are permanently reduced if claimed before the normal retirement age (currently age 65). Unreduced benefits are payable to the wife or husband of a retired worker at any age if he or she is caring for a child, under age 16 or disabled, who is entitled to benefits on the earnings record of the worker. Child's benefits are paid to the retired worker's unmarried child under age 18 or aged 18-19, if he or she is a full-time student in elementary or secondary school. They are also paid regardless of age if the child has been disabled since before age 22.

Monthly survivor benefits are payable to a widow or widower at age 60, or, if disabled, at age 50; to a widow or widower at any age if he or she is caring for a child, under age 16 or disabled, who is entitled to benefits on the earnings record of the worker; to unmarried children under age 18, or aged 18-19 if they are in elementary or secondary school, and at any age if the child has been disabled since before age 22; and to a dependent parent at age 62. A lump-sum death payment of $255 is also payable to the spouse who is living with the insured worker at the time of the worker's death or is eligible to receive benefits at that time based on the worker's earnings record, or, if there is no qualified spouse, to the child or children of the worker eligible for monthly survivor benefits.

Monthly disability benefits are payable to a disabled worker under age 65 after a waiting period of 5 full calendar months. These benefits terminate if he or she recovers or returns to substantial gainful work despite the impairment. When the worker attains age 65, he or she is transferred to the retirement rolls. Benefits for family members of a disabled worker are payable under the same conditions as for family members of retired workers.

Under certain circumstances, benefits may also be paid to the divorced spouse of a retired, deceased, or disabled worker and to the remarried widow or widower of a deceased worker.

Benefit Amounts

A worker's Social Security benefit amount is based on his or her average covered earnings computed over a period of time equal to the number of years he or she reasonably could have been expected to work in covered employment. Specifically, the number of years in the averaging period equals the number of 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—generally minus 5 years. 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. The averaging period may include years before age 22 and after age 61 in lieu of years with lower earnings between ages 21 and 62.

For persons who were first eligible (attained age 62, became disabled, or died) before 1979, the actual dollar amount of covered earnings is used in the computation. For persons first eligible after 1978, the actual earnings are indexed—updated to reflect increases in average wage levels in the economy. After a worker's average monthly earnings (AME) or average indexed monthly earnings (AIME) 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 in favor of low earners since they have less margin for reduction in income than high earners.

The primary insurance amount (PIA) is $899.60 for workers whose earnings were at or above the maximum amount counted for contribution and benefit purposes each year and who retire at age 65 in 1989. Since 1981, newly eligible retired workers have not been subject to a statutory minimum benefit amount. The law does, however, provide to long-term, low-paid workers a special minimum benefit that is higher than that permitted by the regular benefit formula.

For persons first eligible in 1989, the benefit formula provides that the PIA at first eligibility is equal to:

- 90 percent of the first $339 of AIME, plus
- 32 percent of AIME between $339 and $2,044, plus
- 15 percent of AIME above $2,044.

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 levels generally keep pace with increases in wages. For example, in the future, initial Social Security retirement benefits are expected to replace a constant proportion (about 41 percent) of past covered earnings for persons who had a full worklife with earnings equal to the average wage in the economy and retired at the normal retirement age. For persons who worked a full worklife and earned the Federal minimum wage, the replacement rate is expected to be around 60 percent, the exact rate depending on future levels of the minimum wage. And for persons who always earned the maximum amount subject to Social Security taxes, the replacement rate is expected to be about 27 percent.

In general, after a worker's Social Security benefit level has been determined for the year of first eligibility—the year he or she attains age 62, becomes disabled, or dies—the amount is increased automatically each December (payable in the January checks) to reflect any increase in the Consumer Price Index (CPI). (If Social Security trust fund reserves were to fall below certain levels, a different rule would apply. The amount of any increase would be based on the lesser of the rise in the cost of living or in average wages, with provision for a "catch up" when reserves have been built up.)

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 the normal retirement age is equal to the PIA rounded to the next lower multiple of $1. For workers retiring before the normal retirement age, the benefit is actuarially reduced to take into account the longer period over which they will receive benefits. Currently, a worker who retires at age 62 receives 80 percent of the full benefit amount; a spouse who begins to receive benefits at age 62 receives 75 percent of the amount that would have been payable at age 65; a widow(er) who first receives benefits at age 60 will be paid 71-1/2 percent of the deceased spouse's basic benefit amount, as will a disabled widow(er) aged 50-59.

As described earlier, the normal retirement age (the age of eligibility for unreduced retirement benefits) will be increased gradually from age 65 to age 67 beginning in the year 2003. Benefits will continue to be available at age 62 for retired workers and their spouses and at age 60 for widow(er)s, but the maximum reduction in worker's and spouse's benefits will be greater.

A worker who delays retirement past normal retirement age has his or her benefits increased based on the delayed retirement credit. This credit, currently 3 percent of the PIA per year, takes into account benefits foregone by persons who continue to work past age 65 and have earnings in excess of the earnings test. The delayed retirement credit will gradually rise from the current 3 percent per year to 8 percent per year during the period 1990-2009.

Benefits for eligible family members are based on a percentage of the worker's PIA. In the case of a retired worker, a wife's or husband's benefit at the normal retirement age and a child's benefit are equal to 50 percent of the worker's PIA. A surviving widow's or widower's benefit is equal to as much as 100 percent of the amount of the deceased worker's PIA. The benefit of a surviving child is 75 percent of the worker's PIA.

The law sets a limit on the total monthly benefit amounts that may be paid either to a worker and his or her eligible family members or to the worker's survivors. This limitation assures that the family is not considerably better off financially after a worker retires, becomes disabled, or dies than it was while he or she was working.

A person who is eligible for a benefit based on his or her own earnings and also for a benefit as an eligible family member or survivor (generally as a wife or widow) will receive the full amount of his or her own benefit, plus an amount equal to any excess of the other benefit over his or her own—in effect, the larger of the two.

In addition, benefits may be reduced if a person's annual

earnings from work or self-employment (or the earnings of the worker on whose record that person receives benefits) exceed a specified exempt amount. In 1989, beneficiaries aged 65-69 may earn up to $8,880 without a benefit reduction; those under age 65 may earn up to $6,480. (The exempt amount increases automatically as wage levels rise.) A person's benefits are reduced $1 for each $2 in earnings over the annual exempt amount. Beginning in 1990, this rate of reduction will become $1 for each $3 for persons who have reached the normal retirement age. Persons aged 70 or older may earn any amount without having their benefits reduced.

Benefits for disabled workers are computed in much the same way as are benefits for retired workers. Benefits to the family members of a Disability Insurance beneficiary are paid on the same basis as those to the family of a retired worker. The limitation on family benefits is, however, somewhat more stringent for disabled-worker families than for retired-worker or survivior families. Table 2 shows the number of individuals receiving benefits and the average payment amounts for various benefit categories.

Program Financing

The financing plan of the OASI and DI programs requires workers and their employers and self-employed persons to pay taxes on earnings in covered jobs up to the annual taxable maximum ($48,000 in 1989; automatically adjusted as wages rise). These taxes (which constitute more than 95 percent of program revenues) are automatically deposited in two separate trust funds—the OASI Trust Fund and the DI Trust Fund. (The hospital insurance or HI portion of the Medicare program is also financed in this way, as described on page 45.)

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. A Board of Trustees, which by law is composed of the Secretary of the Treasury as Managing Trustee, the Secretary of Labor, the Secretary of Health and Human Services, and two public members, is responsible for managing the trust funds and for making periodic reports to Congress.

In addition to the Social Security taxes paid by employees, employers, and the self-employed, trust fund revenues include relatively small amounts transferred to the Social Security trust funds from the general fund: The Federal Government's employer Social Security taxes for those Federal employees who are covered under Social Security (including payments for military service wage credits); interest on Social Security trust fund investments; an amount equal to the revenue lost from the tax credit against the Social Security tax liability of the self-employed; [2]

[2] In 1986-89, the law provides for a tax credit against OASDI and HI tax liability equal to 2.0 percent of covered self-employment income.

Table 2.—Number of persons receiving monthly benefits under OASDI, December, selected years 1940-88, and average monthly amount, December 1988

Type of beneficiary	1940	1950	1960	1970	1975	1980	1985	1988	Average amount, December 1988
All beneficiaries	222,488	3,477,243	14,844,589	26,228,629	32,084,511	35,618,840	37,058,353	38,613,372	$464.88
Retired workers	112,331	1,770,984	8,061,469	13,349,175	16,588,001	19,582,625	22,432,103	23,838,645	515.92
Disabled workers	. . .	. . .	455,371	1,492,948	2,488,774	2,861,253	2,656,500	2,822,156	508.87
Wives and husbands [1] of retired or disabled workers	29,749	508,350	2,345,983	2,951,552	3,320,310	3,480,212	3,374,602	3,376,243	255.03
Widows and widowers [2]	4,437	314,189	1,543,843	3,177,879	3,779,194	4,287,930	4,756,872	4,921,035	472.78
Widowed mothers and fathers [2]	20,499	169,438	401,358	523,136	581,845	562,798	371,658	321,928	353.57
Disabled widows and widowers [2]	. . .	. . .	. . .	49,281	109,511	126,659	105,945	103,534	334.72
Children [3]	56,648	699,703	2,000,451	4,122,305	4,972,008	4,609,813	3,319,477	3,207,829	272.58
Of retired workers	6,410	46,241	268,168	545,708	642,564	642,445	457,408	433,726	218.39
Of deceased workers	48,238	633,462	1,576,802	2,687,997	2,918,940	2,608,653	1,916,928	1,810,835	353.39
Of disabled workers	. . .	. . .	155,481	888,600	1,410,504	1,358,715	945,141	963,268	145.07
Parents	824	14,579	36,114	28,729	21,444	14,796	9,541	7,270	411.50
Special age-72 beneficiaries [4]	. . .	. . .	. . .	533,624	223,424	92,754	31,655	14,732	145.28

[1] Includes divorced spouses.
[2] Includes surviving divorced spouses.
[3] Includes disabled adult children aged 18 or older whose disability began before age 22.
[4] Represents benefits for certain persons who attained age 72 before 1972 and who became eligible only under special insured provisions of the Social Security Act.

and funds to pay for limited benefits to certain very old persons who qualify under special insured-status requirements. In addition, the revenues from the income tax on up to one-half of the Social Security benefits of beneficiaries with substantial amounts of other income are appropriated to the OASI and DI Trust Funds. [3]

Legislation enacted in 1981 and 1983 authorized certain borrowing of assets among the trust funds, with interest paid by the borrowing fund to the lending fund. The borrowing authority, which permitted borrowing among the OASI, DI, and HI Trust Funds under certain conditions, expired at the end of 1987. Repayments were completed by May 1, 1986.

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 that are financed by payroll taxes. In 1989, OASDI tax rates are 6.06 percent each for the employee and employer and 12.12 percent for the self-employed. The self-employed rate is subject to a credit at present (see footnote 2 in table 3). The Federal Disability Insurance Trust Fund is allocated a portion of these contributions: 0.53 percent each for the employee and employer and 1.06 percent for the self-employed. Current and future scheduled tax rates are shown in table 3. Table 4 summarizes the status of the OASI and DI Trust Funds during selected years.

Administration

The Secretary of Health and Human Services has the overall responsibility for administering all aspects of the OASDI program except (1) collection of Social Security contributions, which is performed by the Internal Revenue Service of the Department of the Treasury; (2) the preparation and mailing of benefit checks (or the payment of benefits through direct deposit into beneficiary bank accounts), which is also performed by the Department of the Treasury; and (3) the management and investment of the trust funds, which is supervised by the Secretary of the Treasury as Managing Trustee. The Social Security Administration, a constituent unit of the Department of Health and Human Services, headed by the Commissioner of Social Security, administers the OASDI program.

The law provides for the appointment of an Advisory Council on Social Security every 4 years. The Council reviews the status of the OASDI and Medicare trust funds and makes recommendations on the scope of coverage, adequacy of benefits, and all other aspects of these programs, including their impact on the public assistance programs authorized under the Social Security Act. Each Advisory Council must include equal representation of employee and employer organizations, the self-employed, and the public. In 1986, legislation required the appointment of a Disability Advisory Council to replace the regular statutory Council that would otherwise have been appointed.

Each person working in covered employment or self-employment is required to obtain a Social Security number, which is used to identify the lifetime earnings record on

[3] For income tax purposes, a portion of Social Security benefits is included in gross income for beneficiaries whose incomes exceed certain base amounts—$32,000 for married couples filing jointly, $0 for married taxpayers filing separately who lived with their spouses at any time during the year, and $25,000 for all other taxpayers, including single individuals and heads of household. Income for this purpose is defined as the sum of adjusted gross income (before Social Security benefits are considered), plus certain nontaxable income, such as tax-exempt interest income, and one-half of Social Security benefits. Beneficiaries whose incomes exceed the base amount that applies to them must include as part of gross income for tax purposes one-half of their benefits or one-half the difference between their income as computed above and the base amount, whichever is less.

Table 3.—Tax rate schedule for OASDI and HI programs [1]

Period	Total	OASDI	HI
	Percent of covered earnings for employee and employer each		
1988-89	7.51	6.06	1.45
1990 and after	7.65	6.2	1.45
	Percent of covered earnings for the self-employed [2]		
1988-89	15.02	12.12	2.9
1990 and after	15.3	12.4	2.9

[1] Tax rates apply to annual earnings up to $48,000 in 1989; this maximum taxable amount is subject to automatic adjustment as earnings levels rise.

[2] For 1988-89, credits (financed from general revenues) are provided to the self-employed against their Social Security tax liability; the amounts of these credits are equal to 2.0 percent of the annual self-employment income. After 1989, the tax credits will be replaced with special provisions designed to treat the self-employed in much the same manner as employees and employers are treated for Social Security and income-tax purposes.

which his or her benefits are based. The same number is used for life and is recorded by each new employer. To date, more then 330 million Social Security numbers have been issued; about 121 million persons had earnings credited to their records in 1987.

Employers withhold Social Security taxes from their employees' paychecks and forward these amounts, along with an equal employer tax, to the Internal Revenue Service 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 Internal Revenue Service. Self-employed persons report their earnings for Social Security purposes and pay their Social Security contributions in connection with their income tax return. Information from self-employment income reports is sent by the Internal Revenue Service to the Social Security Administration.

Table 4.—Status of the Old-Age and Survivors Insurance and Disability Insurance Trust Funds, by selected years, 1940-87

[Amounts in millions]

Year	Total receipts [1]	Expenditures				Total assets, end of year
		Total	Benefit payments	Net administrative expenses	Other expenditures [2]	
	Old-Age and Survivors Insurance Trust Fund					
1940	$368	$62	$35	$26	. . .	$2,031
1950	2,928	1,022	961	61	. . .	13,721
1955	6,167	5,079	4,968	119	-$7	21,663
1960	11,382	11,198	10,677	203	318	20,324
1965	16,610	17,501	16,737	328	436	18,235
1970	32,220	29,848	28,798	471	579	32,454
1975	59,605	60,395	58,517	896	982	36,987
1980	105,841	107,678	105,083	1,154	1,442	22,823
1981	125,361	126,695	123,803	1,307	1,585	21,490
1982	125,198	142,119	138,806	1,519	1,793	[3] 22,088
1983	150,584	152,999	149,221	1,528	2,251	[3] 19,672
1984	169,328	161,883	157,841	1,638	2,404	[3] 27,117
1985	184,239	171,150	167,248	1,592	2,310	[3] 35,842
1986	197,393	181,000	176,813	1,601	2,585	39,081
1987	210,736	187,668	183,587	1,524	2,557	62,149
	Disability Insurance Trust Fund					
1957	$709	$59	$57	$3	. . .	$649
1960	1,063	600	568	36	-$5	2,289
1965	1,247	1,687	1,573	90	24	1,606
1970	4,774	3,259	3,085	164	10	5,614
1975	8,035	8,790	8,505	256	29	7,354
1980	13,871	15,872	15,515	368	-12	3,629
1981	17,078	17,658	17,192	436	29	3,049
1982	22,715	17,992	17,376	590	26	[4] 2,691
1983	20,682	18,177	17,524	625	28	[4] 5,195
1984	17,309	18,546	17,898	626	22	[4] 3,959
1985	19,301	19,478	18,827	608	43	[4] 6,321
1986	19,439	20,522	19,853	600	68	7,780
1987	20,303	21,425	20,519	849	57	6,658

[1] Includes transfers from general revenues—for military service wage credits and special age-72 benefit payments—net interest on trust funds, income taxes paid on Social Security benefits under 1983 legislation, as well as contributions from employees, employers, and self-employed persons based on earnings up to the maximum taxable amount.

[2] Includes transfers to (or from) the Railroad Retirement program and expenditures for vocational rehabilitation services to disabled workers, childhood disability beneficiaries, and disabled widows and widowers.

[3] Includes amounts borrowed from the Disability Insurance and Hospital Insurance Trust Funds under the interfund borrowing provisions of Public Law 97-123.

[4] Excludes amounts lent to the Old-Age and Survivors Insurance Trust Fund under the interfund borrowing provisions of Public Law 97-123.

Reported earnings are posted to the worker's earnings record in the central office of the Social Security Administration in Baltimore, Maryland. When a worker or worker's 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 benefit payable. (The earnings credited to the worker's record are also used to determine entitlement to Hospital Insurance benefits.) 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 beneficiaries' accounts through electronic fund transfer or other means.

The Social Security Administration operates one of the largest recordkeeping systems in the world. Automated techniques are used to perform the huge job of posting earnings to individual records and computing benefits from these records. The use of electronic data processing and telecommunications has been extended to practically all areas of program operations. Under the Systems Modernization Plan, begun in 1982, SSA's computer systems are being updated, improved, and put to new uses. The Claims Modernization Project/Field Office Systems Enhancement, for

example, uses a claims process in which field office staff are able to enter information directly into the system, to request from agency records any information needed to process the claim, and to produce a paper copy of the completed application for the claimant to sign.

The Baltimore headquarters complex houses staff offices, a national computer center, disability operations, central records maintenance, and foreign claims operations. Data operations centers are located in Wilkes-Barre, Pennsylvania; Albuquerque, New Mexico; and Salinas, California. At these centers, data are converted from source documents for electronic data processing. 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 field network of more than 1,300 offices and 34 teleservice centers. Field operations are directed by the 10 Regional Commissioners and their staffs. The field installations are the main points of contact by the public with SSA. They issue Social Security numbers, help workers and employers correct records of earnings, help claimants file applications for benefits and assemble the evidence necessary to prove their eligibility, adjudicate retirement and survivor insurance claims and help determine the amounts of benefits payable, forward disability insurance claims to cooperating State agencies (generally State vocational rehabilitation agencies) for a determination of disability, and provide to workers and their families the information necessary for them to understand their rights and obligations under the program.

Everyone has the right to appeal a decision on benefit entitlement. The appeals process consists of several levels of review. At each level, a review must be requested in writing within certain time periods. First, the claimant may request reconsideration of the initial determination. If the claimant is dissatisfied with the reconsideration determination, he or she may request a hearing and appear in person before an administrative law judge from the Social Security Administration's Office of Hearings and Appeals. If the administrative law judge's decision does not satisfy the claimant, a review by the Appeals Council may be requested. And, finally, the claimant may take his or her case to the Federal courts. The SSA hearings and appeals process is administered through 135 hearing offices aligned under 10 regional chief administrative law judges. The central office of the Office of Hearings and Appeals is located in Arlington, Virginia.

In calendar year 1988, the administrative expenses of the cash benefit program amounted to about 1.1 percent of benefit payments.

Unemployment Insurance*

Unemployment insurance programs are designed to provide benefits to regularly employed members of the labor force who become involuntarily unemployed and who are able and willing to accept suitable employment. The first unemployment insurance law in the United States was established by the State of Wisconsin in 1932 and served as a forerunner to the unemployment insurance provisions of the Social Security Act of 1935. Unlike the old-age insurance benefit provisions of the Social Security legislation, which are administered by the Federal Government alone, the unemployment insurance system was made Federal-State in character. The existence of the Wisconsin law, concern regarding the constitutionality of an exclusively Federal system, and various untried aspects of administration were among the factors that influenced the adoption of this kind of system.

By means of a tax offset, the Social Security Act provided an inducement to the States to enact unemployment insurance laws. A uniform national tax was imposed on the payrolls of industrial and commercial employers who in 20 or more weeks in a calendar year had eight or more workers. Employers who paid a tax to a State with an approved unemployment insurance law could credit (offset) up to 90 percent of the State tax against the national tax. Thus, employers in

*Statutory provisions as of September 4, 1988.

States without an unemployment insurance law would not have an advantage in competing with similar businesses in States with such a law because they would still be subject to the Federal payroll tax. Furthermore, their employees would not be eligible for benefits.

In addition, the Social Security Act authorized grants to States to meet the costs of administering the State 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 adopted its own unemployment insurance program, which was incorporated into the Federal-State system in 1961. In a similar fashion, the 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 be eligible for the offset against the Federal tax and if the State is to receive Federal grants for administration. These requirements are intended to assure that a State participating in the program has an unemployment insurance system that is fairly administered and financially secure.

One requirement is that all contributions collected under the State laws be deposited in the unemployment trust fund in the U.S. 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 in the trust fund at any time, but only to pay benefits. [4] Thus, unlike the situation in the majority of States having workers' compensation and temporary disability insurance laws, unemployment insurance benefits are paid exclusively through a public fund. No private plans can be substituted for the State plan.

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

Coverage

Approximately 100 million workers—or 97 percent of all wage and salary workers—were in jobs covered by unemployment insurance in 1988. Coverage originally was limited to employment covered by the Federal Unemployment Tax Act (FUTA), which relates primarily to industrial and commercial workers in private industry. Two Federal laws passed during the 1970's—the Employment Security Amendments of 1970 and the Unemployment Compensation Amendments of 1976—added substantially to the number and types of workers protected under the State programs.

Private employers in industry and commerce are subject to the law if they have one or more individuals employed at least 20 weeks during the current or preceding year or if they paid 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 and 10 or more employees in 20 weeks of the year. Domestic employees in private households are subject to FUTA if their employer pays wages of $1,000 or more in a calendar quarter. Excluded from coverage are workers employed by their families and the self-employed.

State and local government employees and employees of most nonprofit organizations are also exempt from FUTA. However, as a result of Federal legislation enacted in 1976, most employees in these groups now must be covered by State law as a condition for securing Federal approval of the State law. Under this form of coverage, local government 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.

Many States have extended coverage beyond that provided by Federal legislation. For example, 21 jurisdictions have covered nonprofit organizations employing one or more workers (rather than four or more).

Federal civilian employees and ex-servicemen have been brought under the unemployment insurance system through special Federal legislation. Benefits for these persons are financed through Federal funds but are administered

[4] A 1946 amendment provided that employee contributions to the unemployment trust fund could be withdrawn to finance temporary disability insurance benefits, but not to administer such a system.

by the States and paid in accordance with the provisions of the State laws. However, Federal law prescribes certain eligibility requirements and a 13-week maximum duration for ex-servicemen's benefits. Railroad workers are covered by a separate unemployment insurance law enacted by Congress. This law is described in connection with the other benefit programs for persons employed in the railroad industry (see page 58).

Eligibility for Benefits

Unemployment benefits are available as a matter of right (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.[5] To be eligible for benefits, the worker must be ready, able, and willing to work and must be registered for work at a State public employment office. Workers who meet these eligibility conditions may still be denied benefits if they are found to be responsible for their own unemployment.

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 unemployment benefits. As of September 1988, the base period used in six States is 52 weeks closely preceding the claim. In one State, a uniform calendar-year base period established by law is used for all workers.

Seven States specify a flat minimum amount of earnings, ranging from $1,000 to $2,800, in the base period to qualify. Twelve States and Puerto Rico 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 a calendar quarter other than that in which the claimant had the most wages. Eighteen States, the District of Columbia, and the Virgin Islands simply require base period wages totaling a specified multiple—commonly 1-1/2—of the claimant's high-quarter wages. Ten 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 has enough wages or weeks of work in his or her base period and is therefore eligible for benefits, his or her eligibility extends throughout a benefit year, which is 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, in order to qualify for benefits, the unemployed worker make a job-seeking effort independent of the agency's effort.

Eleven States have added a proviso that claimants who become disabled after filing a claim and registering for work shall be eligible for benefits as long as no offer of work suitable but for the disability is refused (limited to 3 weeks in Massachusetts and 6 weeks in Alaska). In addition, most States have special disqualification provisions that specifically restrict the benefit rights of students who are considered not available for work while attending school and of individuals who quit their jobs for family reasons. Federal law also restricts the benefit eligibility of some groups of workers under specified conditions: School personnel between academic years, professional athletes between sports seasons, and aliens not legally in the United States.

The major reasons for disqualification from benefit eligibility 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 a worker's receipt of benefits. The disqualification may

[5] Although the benefits are not means tested, they are subject to Federal income taxes under the Tax Reform Act of 1986 (Public Law 99-514). As described later in the text, the benefit may be reduced if the worker is receiving certain types of income—pension, back pay, or workers' compensation for temporary partial disability.

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 the claimant in a given period of unemployment. However, benefit rights cannot be eliminated completely for the whole benefit year because of a disqualifying act other than discharge for misconduct or fraud, or because of disqualifying income. Also, no State can 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 to a claimant if he or she refuses to accept a new job under substandard labor conditions, or where he or she would be 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 a postponement of benefits, generally for an indefinite period, depending on how long the unemployment lasts because of the dispute. State laws vary as to how the disqualification applies to workers not directly involved in the disputes, but in nine States all workers who are unemployed because of a labor dispute are subject to disqualification.

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 less than a dollar-for-dollar basis to take into account contributions made by the worker to the pension plan.

In 21 States, a worker also is disqualified for any benefits for a week in which he or she receives certain other forms of remuneration—such as wages in lieu of notice or dismissal payments, workers' compensation for temporary partial disability, back pay, or holiday pay. In 21 other States, such remuneration serves to reduce the weekly benefit; the claimant may receive as a benefit only the amount by which the benefit exceeds the other payment. All but four jurisdictions (three States and Puerto Rico) permit simultaneous payment of unemployment benefits and supplemental unemployment benefits under collective-bargaining agreements. These four jurisdictions have not taken action on the issue.

Types and Amounts of Benefits

In December 1988, an average of 1.8 million unemployed workers were receiving benefits each week under the State unemployment insurance programs. Their average weekly benefit was $145 and the average duration of benefits (regular program) for the 12 months ending December 1988 was 13.9 weeks. [6]

Under all State laws, the weekly benefit amount—that is, the amount payable for a week of total unemployment—varies with the worker's past wages within certain 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 percent, subject to specified dollar maximums. The benefit provisions under State unemployment laws are shown in table 5.

Forty laws use a formula that computes weekly benefits as a fraction of wages in one or more quarters of the base period. Most commonly, the fraction is taken of wages in the quarter during which wages were highest, as this quarter most nearly reflects full-time work. In 32 of these States and the District of Columbia, the same fraction is used at all benefit levels. The other laws use a weighted schedule, that gives a greater proportion of the high-quarter wages to lower-paid workers than to those earning more; in these areas, the minimum fraction varies from 1/19 (1/11 in Puerto Rico) to 1/25 and the maximum from 1/23 to 1/33.

Five States compute the weekly benefit amount as a percentage of annual wages. Eight States base the weekly benefit directly on average weekly wages during a recent period.

Each State establishes a ceiling on the weekly benefit amount and no worker may receive an amount larger than this ceiling. The maximum may be either a fixed dollar amount or a flexible amount. Under the latter arrangement, which has been adopted in 36 jurisdictions, the maximum is adjusted automatically in accordance with the weekly wages of covered employees. The maximum in these jurisdictions is expressed as a percentage of the Statewide average weekly wage—from 49 percent to 70 percent. Such provisions remove the need for constantly amending the flat maximum statutory dollar amount as wage levels change.

The maximum weekly benefit for all States varies from $96 to $268 (excluding allowances for dependents provided by 14 jurisdictions); the median basic

[6] As is explained later in the text, the duration of benefits under the regular program varies by jurisdiction, and there is a program of extended benefits during periods of high unemployment.

Table 5.—Selected benefit provisions under State unemployment insurance laws, September 4, 1988

State	Weekly benefit amount for total unemployment			Duration of benefits (weeks) [1]	
	Computation (fraction of high-quarter wages unless otherwise indicated) [2]	Minimum [3]	Maximum [3]	Minimum [4]	Maximum
Alabama	1/24	$22	$120	11+	26
Alaska	3.8-0.95% of annual wages, plus dependents' allowance	38-62	188-260	[1]16	[1]26
Arizona	1/25	40	145	12+	26
Arkansas	1/52 of wage in two highest quarters, up to 66 2/3% of State average weekly wage	37	207	10	26
California	1/24-1/33	30	166	[1]12+	[1]26
Colorado	55% of 1/26 of wage in two highest quarters, up to 50% of State average weekly wage	25	214	13+	26
Connecticut	1/26 up to 60% of State average weekly wage, plus dependents' allowance	15-22	216-266	[1]26	[1]26
Delaware	1/46-1/52 of wage in two highest quarters, depending on trust fund balance	20	205	24	26
District of Columbia	1/23 up to 55% of State average weekly wages, plus dependents' allowance	13	[2]268	26	26
Florida	1/2 of claimant's average weekly wage	10	200	10	26
Georgia	1/50 of wage in two highest quarters	37	[5]165	9+	26
Hawaii	1/25 up to 66 2/3% of State average weekly wage	5	223	[1]26	[1]26
Idaho	1/26 up to 60% of State average weekly wage	44	193	10	26
Illinois	49% of claimant's average weekly wage, up to 49% of State average weekly wage, plus dependents' allowance	51	176-230	[6]26	[6]26
Indiana	4.3%, plus dependents' allowance	40	96-161	9+	26
Iowa	1/19-1/23 up to 65% of State average weekly wage, plus dependents' allowance	26-31	174-214	11+	26
Kansas	4.25% up to 60% of State average weekly wage	52	210	10	26
Kentucky	1.185% of base period wages, up to 55% of State average weekly wage	22	166	15	26
Louisiana	1/25 of 4 quarters of base period wages, up to 66 2/3% of State average weekly wage [7]	10	191	8	26
Maine	1/22 up to 52% of State average weekly wage, plus dependents' allowance	29-43	171-256	15+-22	26
Maryland	1/24, plus dependents' allowance	25-33	[2]205	26	26
Massachusetts	1/52 of wage in two highest quarters, up to 57.5% of State average weekly wage, plus dependents' allowance	14-21	236-354	10+-30	30
Michigan	70% of claimant's after-tax earnings, up to 55% of State average weekly wage (up to 58% in January 1989), plus dependents' allowance	58	242	15	26
Minnesota	[8]	38	254	10+	26
Mississippi	1/26	30	145	13+	26
Missouri	4.5%	22	140	11+	26
Montana	49% of claimant's average weekly wage, up to 60% of State average weekly wage	46	185	8	26
Nebraska	1/17-1/24	20	134	20	26
Nevada	1/25 up to 50% of State average weekly wage	16	184	12+	26
New Hampshire	0.7-1.4% of annual wages	39	156	26	26
New Jersey	60% of claimant's average weekly wage, up to 56 2/3% of State average weekly wage, plus dependents' allowance	51	[2]241	15	26
New Mexico	1/26 up to 50% of State average weekly wage	31	159	19+	26
New York	50% of claimant's average weekly wage	40	180	26	26
North Carolina	1/52 of wage in two highest quarters, up to 66 2/3% of State average weekly wage	16	228	13-26	26
North Dakota	1/65 of wage in two highest quarters and 1/2 wage in third quarter, up to 60% of State average weekly wage	43	183	12	26

See footnotes at end of table.

Table 5.—Selected benefit provisions under State unemployment insurance laws, September 4, 1988—**Continued**

State	Weekly benefit amount for total unemployment			Duration of benefits (weeks) [1]	
	Computation (fraction of high-quarter wages unless otherwise indicated) [2]	Minimum [3]	Maximum [3]	Minimum [4]	Maximum
Ohio	1/2 claimant's average weekly wage, plus dependents' allowance [9]	$42	$157-248	20	26
Oklahoma	1/25 up to 50-60% of State average weekly wage [10]	16	197	[11] 20+	[11] 26
Oregon	1.25% of base period wage, up to 64% of State average weekly wage	53	229	[1] 6+	[1] 26
Pennsylvania	1/23-1/25 up to 66 2/3% of State average weekly wage, plus dependents' allowance	35-40	252-260	16	26
Puerto Rico	1/11-1/26 up to 50% of State average weekly wage	7	110	[1] 20	[1] 20
Rhode Island	60% of claimant's average weekly wage, up to 67% of State average weekly wage, plus dependents' allowance	48-58	240-300	12	26
South Carolina	1/26 up to 66 2/3% of State average weekly wage	20	147	15	26
South Dakota	1/26 up to 62% of State average weekly wage [7]	28	140	18+	26
Tennessee	1/25-1/33 of average wage in two highest quarters	30	155	12+	26
Texas	1/25 [7] [12]	34	210	13+	26
Utah	1/26 up to 60% of State insured average fiscal year weekly wage	14	202	10	26
Vermont	1/45 of wages in two higest quarters	31	169	26	26
Virgin Islands	1/26 up to 50% of State average weekly wage	32	146	13+	26
Virginia	1/50 of wage in two highest quarters	56	176	12	26
Washington	1/25 of average of wage in two highest quarters, up to 55% of State average weekly wage	57	209	16+-30	30
West Virginia	1.0% of annual wage up to 70% of State average weekly wage [7]	24	225	26	26
Wisconsin	50% of claimant's average weekly wage, up to 66 2/3% of State average weekly wage [7]	38	200	1-14+	26
Wyoming	1/25 up to 55% of State average weekly wage [13]	36	200	12-26	26

[1] Benefits extended under exclusively State funded program when unemployment in State reaches specified levels: Alaska and California by 50%; Oregon by 25% (until July 1, 1989); Connecticut and Hawaii by 13 weeks. 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 percent for up to 13 weeks under the Federal-State Extended Unemployment Compensation Program.

[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 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 benefit. In the District of Columbia, Maryland, and New Jersey the maximum is the same with or without dependents' allowances.

[3] When two amounts are given, the higher includes dependents' allowances.

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

[5] Maximum will be $115 if trust fund falls below $175 million.

[6] Eligible for lesser of 26 weeks of benefits or their total base period wages.

[7] The minimum and maximum weekly benefit amounts are frozen indefinitely in Louisiana and Wisconsin. The maximum weekly benefit is frozen until July 1989 in West Virginia, until October 1989 in Texas, and indefinitely in South Dakota.

[8] Depending on balance in the fund, 60% to 66 2/3% of State average weekly wage.

[9] Maximum amount adjusted annually by same percentage increase as occurs in State average weekly wage.

[10] Maximum weekly benefit amount may be frozen or be a variable percent of State average weekly wage depending on condition of State fund.

[11] Duration can be as low as 10 weeks for individuals with only one employer in a base period.

[12] Maximum amount adjusted annually by $7 for each $10 increase in average weekly wage of manufacturing production workers.

[13] When revenues in the fund are inadequate to pay benefits, weekly benefit amounts over $90 will be reduced to 85% of the computed amount.

Source: **Comparison of Unemployment Insurance Laws**, Department of Labor, Washington, DC, September 4, 1988.

weekly maximum in September 1988 was $188. Because statutory increases in the maximum tend to lag behind the increase in wage levels, the maximums in States with fixed amounts often curtail the benefit amounts to below the 50-percent level. Minimum limits on benefits—ranging from $5 to $58 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. All States also provide for the payment of reduced weekly benefits—partial payments—when earnings exceed the specified amount. In a majority of the States, this amount is defined as a wage that is earned for a week of less than full-time work and that is less than the claimant's regular weekly benefit amount.

In recent years, considerable attention has been given to worksharing plans. By means of worksharing, an employer might spread the hours of work among employees to avoid the need for layoffs because of reduced workload. Under a worksharing plan approved by the State employment security agency, unemployment benefits would be payable on a prorated basis for hours of work lost through implementation of this plan. (Such lost hours might be insufficient to be compensable under the State's regular partial benefits formula.) As of September 1988, 14 States—including 5 of the 6 with the largest employment nationally—have worksharing plans in effect.

Thirteen States and the District of Columbia provide additional allowances for certain dependents. They all include children under ages 16, 18, or 19 (and, generally, older if incapacitated), 10 include a nonworking spouse, and 3 consider other dependent relatives. The amount allowed per dependent varies considerably by State but generally is $10 or less per week, and, in the majority of States, the amount is the same for each dependent.

All but 11 States require a waiting period of 1 week of total unemployment before the benefits can begin. Four States pay benefits retroactively for the waiting period if unemployment lasts a certain period or the employee returns to work within a specified period.

All but three jurisdictions provide a statutory maximum duration 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 various 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. The minimum in these 44 jurisdictions ranges from as little as 1 week to as many as 24 weeks. Four States and Puerto Rico have their own State-financed programs for payment of extended benefits whenever unemployment reaches a specified level.

In 1970, 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. Employment conditions in an individual State trigger extended benefits. This happens when the unemployment rate among insured workers in a State averages 5 percent or more over a 13-week period and is at least 20 percent higher than the rate for the same period in the 2 preceding years. If the insured unemployment rate reaches 6 percent, a State may by law disregard the 20-percent requirement in initiating extended benefits. Once triggered, extended benefit provisions remain in effect for at least 13 weeks. When a State 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 benefit period ends, another Statewide period cannot begin for at least 13 weeks.

Most eligibility conditions for extended benefits and the weekly benefit payable are determined by State law. 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 his or her regular benefits is eligible for a 50-percent increase in the duration of benefits for a maximum of 13 weeks. There is, however, an overall maximum of 39 weeks of regular and extended benefits. Extended benefits are payable at the same rate as the weekly amount under the regular State program.

Since 1958, several temporary Federal programs have been created to supplement the permanent program during economic downturns. The 1982 Federal supplemental compensation program, modified in 1983, was the most recent of these supplemental programs. This program, which ended in March 1985, paid extra weeks of benefits, varying in duration up to 14 weeks.

Financing

All employers who are covered by the Federal Unemployment Tax Act are charged a tax of 6.2 percent on

the first $7,000 annually of each worker's covered wages, effective January 1985. However, employers do not pay the full amount because they may credit toward the Federal tax the payroll tax contributions that they pay toward a State unemployment insurance program established by an approved law. The 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 obtained such loans when their reserves for paying benefits were depleted during periods of high unemployment. As of November 1988, only one State had an outstanding loan balance.

Effective January 1985, the total credit may not exceed 5.4 percent of taxable wages. The remaining 0.8 percent, including a 0.2 percent temporary surcharge, is collected by the Federal Government. The permanent 0.6 percent portion is used for the expenses of administering the unemployment insurance program, for the 50-percent share of the costs of extended benefits, and for loans to States with depleted benefit reserves. Any excess is distributed among the States in proportion to their taxable payrolls. Such distribution has occurred in only 3 years—all during the 1950's. Loans to States had been interest-free but, beginning April 1982, interest is payable except on certain short-term "cash flow" loans. The temporary 0.2 percent share is being used to repay general revenue advances made to help pay the Federal share of extended benefit payments. This surcharge, enacted in 1976, will end when the repayment is complete.

All States finance unemployment benefits almost completely through employer contributions. There is no Federal tax on employees, and only five States collect employee contributions. In September 1988, 37 jurisdictions had adopted tax bases higher than the $7,000 Federal base.

Most States have a standard tax rate of 5.4 percent of taxable payroll. However, the actual tax paid by an employer generally depends on the employer's record of employment stability. All jurisdictions except Puerto Rico use this system, called experience rating. Under experience rating, an employer's State contribution rate is varied on the basis of his or her record of employment stability, measured generally by benefit costs attributable to former employees. Employers with favorable benefit cost experience are assigned lower rates than the standard 5.4 percent, and those with less favorable experience are assigned higher rates.

The provisions of experience rating systems vary widely among the States. In 47 States, the amount of benefits paid to an employer's former workers is the basic factor in measuring his or her experience. The other States rely on the number of separations from an employer's service, or the amount of decline in his or her covered payrolls. Benefits are commonly charged against all employers who paid the claimant's 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 States, benefits paid after a disqualification are not charged to any employer's account.

Contribution rates may also be modified according to the current balance of each State's unemployment insurance trust fund. When the balance falls below a specified level, the 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 zero percent; the maximum in one State is 10.5 percent.

In 1988, the estimated national average employer contribution rate actually paid was 2.4 percent of taxable payroll, or 1.0 percent of total wages in covered work. The average contribution rate varied widely by State, however. The percent of taxable payroll ranged from 0.7 to 5.4. The percent of total wages ranged from 0.3 to 3.0. Nonprofit organizations and State and local governments have the option of reimbursing the State fund for unemployment insurance benefits attributable to service for them or of paying the regular State unemployment taxes on the same basis as other employers.

The States do not collect any tax for the administration of the unemployment insurance laws because funds are appropriated each year by Congress out of the proceeds of the earmarked Federal unemployment tax for the "proper and efficient administration" of the Federal-State program.

Administration

There are no Federal regulations concerning the form of the organization administering unemployment insurance or its place in the State government. Twenty-seven States have placed their employment security agencies in the Department of Labor or under some other State agency. The others have independent departments, boards, or commissions to administer the

program. Advisory councils have been established in all but three jurisdiction; 46 of them were mandated by law. The councils assist the employment security agencies in formulating policy and addressing any problems related to the administration of the Employment Security Act. In most States, the councils 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. These offices process claims for unemployment insurance and 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.

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

Most States collect from employers quarterly wage reports that provide the basis for the calculation and award of benefits. Other States obtain the data needed to determine benefit rights only after a claim has been filed.

Claims must be filed within 7 days after the week for which the claim is made, unless there is a good cause for late filing. Claims must continue to be filed throughout the period of unemployment, usually weekly and in person. Benefits are paid weekly.

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

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

Workers' Compensation

Workers' compensation, designed to provide cash benefits and medical care when workers are injured in connection with their jobs and survivor benefits to the dependents of workers whose death results from a work-related accident, was the first form of social insurance to develop widely in the United States. The Federal Government led the way, covering its civilian employees with an act that was passed in 1908 and reenacted in 1916. Similar laws were enacted by 9 States in 1911; and, by 1920, all but 6 States had such laws.

Today, 55 workers' compensation programs are in operation. Each of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands has its own workers' compensation program. In addition, two Federal workers' compensation programs cover Federal Government employees and longshore and harbor workers throughout the country. A Federal program also protects coal miners with pneumoconiosis, or "black lung" disease. Under this program, which was enacted into law in 1969, monthly cash benefits are payable to miners disabled by black lung disease and to their dependents or survivors. Medical benefits are also

payable on the basis of a diagnosis of pneumoconiosis.

Before the passage of workers' compensation laws, to recover damages for a work-related injury, employees ordinarily had to file suit against their employers and prove that the injury was caused by the employer's negligence. The employer, however, could block recovery by using any of three common-law defenses: Assumption of risk—the injured worker could not be compensated if it were proved that the injury was due to an ordinary hazard of employment; fellow-worker rule—the injured worker could not be compensated if it were proved that a fellow worker caused the injury by his negligence; and contributory negligence—the injured worker could not be compensated if it were proved that the worker contributed to the accident by his or her own negligence, regardless of any fault of the employer.

Many employees believed that these defenses made recovery too difficult. Legislation was sought to ensure that a worker incurring an occupational injury would be compensated regardless of fault or blame in the accident and with a minimum of delay and legal formality. In turn, the employer's liability was limited because workers' compensation benefits became the exclusive remedy for work-related injuries.

As a result of this workers' compensation legislation, the usual condition for entitlement to benefits is that the injury or death "arise out of and in the course of employment." Cash compensation and medical benefits are generally not payable if injuries are due to the employee's intoxication, willful misconduct, or gross negligence.

Coverage

In 1987, State and Federal workers' compensation laws covered about 88.4 million employees, or 87 percent of the Nation's employed wage and salary labor force. Only in New Hampshire does the State law cover all jobs. Among the most usual exemptions are domestic service, agricultural employment, and casual labor. However, 38 programs now have some coverage for agricultural workers and 25 programs have some coverage for domestic workers.

Many programs exempt employees of nonprofit, charitable, or religious institutions; some limit coverage to workers in hazardous occupations. Under 14 programs, employers having fewer than a specified number of employees are exempt from coverage (fewer than three employees in 9 States, fewer than four in 2 States, and fewer than five in 3 States).

The coverage of State and local public employees differs widely from one State program to another. Thirty programs 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 entirely 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 U.S. 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 risk assumption, fellow worker, and contributory negligence.

The programs are compulsory for most private employments covered 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 it, they lose the customary common-law defenses against suits by employees in private industry.

The programs also vary regarding the methods used 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 are permitted to carry insurance against work accidents with commercial insurance companies or to qualify as self-insurers by giving proof of financial ability to carry their own risk. In eight jurisdictions, however, commercial insurance is not allowed. In four of these areas, employers must insure with an exclusive State insurance fund, and in four others, they must either insure with an exclusive State insurance fund or self-insure. In 14 jurisdictions, a State fund is "competitive" with private insurance carriers. Federal employees are provided protection through a federally financed and operated system. Table 6 shows total workers' compensation benefits paid, including Federal black lung payments, by type of insurer for selected years. Also shown are the amounts for medical care and cash benefits and benefits and employer costs related to covered payroll.

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 rehabilitative 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 breadwinner are usually calculated as a percentage of weekly earnings at the time of injury or death—most commonly 66-2/3 percent. 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. Four out of five programs have adopted flexible provisions for

Table 6.—Benefits and costs under State and Federal workers' compensation programs, selected years, 1940-86[1]

Year	Benefits paid during year (in millions)				Type of of benefit		Percent of covered payroll[2]	
		Type of insurance						
	Total	Insurance losses paid by carriers[3]	State fund disburse-ments[4]	Employers' self-insurance payments[5]	Medical and hospital	Cash compensation	Cost[6]	Benefits
1940	$256	$135	$73	$48	$95	$161	1.19	0.72
1950	615	381	149	85	200	415	.89	.54
1955	916	563	238	115	325	591	.91	.55
1960	1,295	810	325	160	435	860	.93	.59
1965	1,814	1,124	445	244	600	1,214	1.00	.61
1970	3,031	1,843	755	432	1,050	1,981	1.11	.66
1975	6,598	3,422	2,324	852	2,030	4,568	1.32	.83
1980	13,562	7,023	4,333	2,206	3,930	9,632	1.96	1.06
1985	22,472	12,341	5,874	4,257	7,485	14,987	1.81	1.31
1986	25,019	13,840	6,408	4,771	8,558	16,461	1.98	1.39

[1] Beginning in 1959, includes Alaska and Hawaii.

[2] Excludes programs financed from general revenus—most Federal black lung benefits and supplemental pensions in a few States.

[3] Net cash and medical benefits paid during calendar year by private insurance companies under standard workers' compensation policies.

[4] Net cash and medical benefits paid by competitive and exclusive State funds, the Federal system for Government employees, and, beginning in 1970, by the Federal Black Lung benefit program.

[5] Cash and medical benefits paid by self-insurers, plus value of medical benefits paid by employers carrying workers' compensation policies that exclude standard medical coverage.

[6] Premiums written by private carriers and State funds and benefits paid by self-insurers increased to allow for administrative costs. Also includes benefits paid and administrative costs of Federal system for Government employees.

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, as well as waiting-period requirements. These provisions also operate to reduce the specified percentage.

Compensation is payable in all jurisdictions, except in the Virgin Islands, after a waiting period ranging from 3 days to 7 days, with a 3-day waiting period being most common. However, for workers whose disabilities continue for a specified period of time—ranging 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 disability—that is, the employee is unable to work at all while he or she is recovering from the injury, but the worker is expected to recover fully. When the worker has been determined to be 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. Table 7 shows the maximum percentage of benefits and the maximum period for which benefits are payable. It also shows the minimum and maximum payments per week, as well as the total maximum amounts when these are expressly stated in the laws. For temporary disability, maximum weekly benefits (excluding dependents' allowances) range from $175 to $1,094 ($45 in Puerto Rico). The median State maximum in July 1988 was $340.50.

Most programs provide temporary total disability benefits for the duration of the disability and 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.

If the total injury appears to be permanent, 44 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 8 programs where permanent total disability benefits are limited in duration, amount, or both, the payment periods range from 260 weeks to 700 weeks. Some programs provide additional payments for an attendant if one is required.

In 10 States and under the Federal civilian employee program, 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 amount that is payable whether or not there are dependents. Under some programs, the term "dependents" is defined to include the spouse as well as children.

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 earnings 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 it is subject to different (generally lower) dollar maximums under 22 programs.

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 38 programs, there are limitations on the maximum amounts and/or periods of payment ranging from 200 weeks to 1,000 weeks, and $10,000 to $494,520.

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

Table 7.—Minimum and maximum benefits for temporary total disability under workers' compensation laws, July 1, 1988

State	Maximum percentage of wages	Payments per week		Percentage of State average weekly wage	Maximum duration of benefit[1]
		Minimum	Maximum		
Alabama	66 2/3	$95 or worker's average weekly wage, if less[2]	$344.00	100	. . .
Alaska	80% of spendable earnings	$110 or worker's spendable weekly wage, if less	$1,094.00	200	. . .
Arizona	66 2/3	. . .	[3] $253.19	. . .	. . .
Arkansas	66 2/3	$20	$189.00	(4)	450 weeks
California	66 2/3	$112.00	$224.00	. . .	. . .
Colorado	66 2/3	. . .	$354.69	80	. . .
Connecticut	66 2/3	$128.60 or 80% of worker's average weekly wages, if less[2]	$643.00	150	. . .
Delaware	66 2/3	$88.38 or actual wage, if less[2]	$265.14	66 2/3	. . .
District of Columbia	The lesser of 66 2/3 or 80% of spendable earnings	[2] $120.48	$481.92	100	. . .
Florida	66 2/3	$20.00 or actual wage, if less	$344.00	100	350 weeks
Georgia	66 2/3	$25.00 or average wage, if less	$175.00	. . .	. . .
Hawaii	66 2/3	$83.50 or workers's average wage if less, but not lower than $38[2]	$334.00	100	. . .
Idaho	[5] 60-90	[2] $141.30	$282.60 to $392.50	90	After 52 weeks, maximum weekly benefit is 60% of State average weekly wage
Illinois	66 2/3	$100.90 to $124.30 or worker's average wage, if less	$566 .97	133 1/3	. . .
Indiana	66 2/3	$50 or worker's average wage, if less	$256.00	. . .	500 weeks or $95.00
Iowa	80% of worker's spendable earnings	$116.00 or actual wage, if less[2]	$660.00	200	. . .
Kansas	66 2/3	$25	$263.00	75	$100,000
Kentucky	66 2/3	[2] $66.11	$330.53	100	. . .
Louisiana	66 2/3	$70 or actual wage, if less[2]	$262.00	75	. . .
Maine	66 2/3	$25	$447.92	166 2/3	. . .
Maryland	66 2/3	$50 or actual wage, if less	$382.00	100	. . .
Massachusetts	66 2/3	$82.20 or worker's average wage, if less[2]	[3] $411.00	100	260 weeks or 250 multiplied by State average weekly wage
Michigan	80% of spendable worker's earnings	. . .	$397.00	90	. . .
Minnesota	66 2/3	$188 or actual wage, if less, but not less than $68.40[2]	$376.00	100	. . .
Mississippi	66 2/3	$25	$198.00	. . .	450 weeks or $89,100
Missouri	66 2/3	$40	$279.64	75	400 weeks
Montana	66 2/3	. . .	$299.00	100	. . .
Nebraska	66 2/3	$49 or actual wage, if less	$245.00	. . .	. . .
Nevada	66 2/3	. . .	$354.46	100	. . .

See footnotes at end of table.

Table 7.—Minimum and maximum benefits for temporary total disability under workers' compensation laws, July 1, 1988—**Continued**

State	Maximum percentage of wages	Payments per week		Percentage of State average weekly wage	Maximum duration of benefit [1]
		Minimum	Maximum		
New Hampshire	66 2/3	$149 or actual wage, if less [2]	$560.00	150	. . .
New Jersey	70	[2] $85	$320.00	75	400 weeks
New Mexico	66 2/3	$36 or actual wage, if less	$275.99	85	700 weeks
New York	66 2/3	$30 or actual wage, if less	$300.00	. . .	. . .
North Carolina	66 2/3	$30	$356.00	110	. . .
North Dakota	66 2/3	$184 or actual wage, if less [2]	[3] $306.00	100	. . .
Ohio	72% for first 12 weeks; thereafter 66 2/3	$128.33 or actual wage, if less [2]	$385.00	100	. . .
Oklahoma	66 2/3	$30 or actual wage, if less	$231.00	66 2/3	300 weeks
Oregon	66 2/3	$50 or 90% of actual wage, if less	$370.96	100	. . .
Pennsylvania	66 2/3	[2] $125.67	$377.00	100	. . .
Puerto Rico	66 2/3	$10	$45.00	. . .	312 weeks
Rhode Island	66 2/3	. . .	[3] $337.00	100	. . .
South Carolina	66 2/3	$75 or actual wage, if less	$319.20	100	500 weeks
South Dakota	66 2/3	$141 or worker's average wage, if less [2]	$281.00	100	. . .
Tennessee	66 2/3	$35	$231.00	. . .	$92,400
Texas	66 2/3	$39	$231.00	(6)	401 weeks
Utah	66 2/3	$45	[3] $344.00	100	312 weeks
Vermont	66 2/3	$172 or worker's average wage, if less [2]	[3] $514.00	150	. . .
Virgin Island	66 2/3	$60 or actual wage, if less	$193.00	66 2/3	. . .
Virginia	66 2/3	$90.50 or actual wage, if less [2]	$362.00	100	500 weeks
Washington	[5] 60-75	$44.05 to $83.81	$385.49	100% of State's monthly wage	. . .
West Virginia	70	[2] $119.51	$358.52	100	208 weeks
Wisconsin	66 2/3	$20	$348.00	100	. . .
Wyoming	66 2/3	. . .	$346.40	100% of State's monthly wage	. . .
United States:					
Federal employees	66 2/3	$159.12 or actual wage, if less	$1,029.48	(7)	. . .
Longshore workers	66 2/3	$154.24 or worker's wage, if less [2]	$616.96	200% of national average weekly wage	. . .

[1] Benefits payable for duration of disability without any dollar limit unless otherwise stated.

[2] Adjusted automatically as State's average weekly wage increases (with respect to the Longshore program as national average weekly wage rises).

[3] Plus dependents' allowance: Arizona, $10 monthly per dependent residing in United States; Connecticut, $10 weekly per dependent child under age 18, not to exceed 75 percent of workers' wage; Massachusetts, $6 per dependent if weekly benefits are below $150 and 100 percent of wages; North Dakota, $5 per dependent child, not to exceed worker's net wage; Rhode Island, $9 per dependent (maximum 4), not to exceed 80 percent of worker's average wage; Utah, $5 per dependent (maximum 4) not to exceed State average wage; Vermont, $10 per dependent under age 21.

[4] Under current law, the maximum weekly benefit will be set as a percentage of the State average weekly wage at a specified future date.

[5] According to number of dependents (and in Washington, marital status). Idaho, 7 percent ($21.98) of State average weekly wage for each dependent child (maximum 5).

[6] Maximum increased by $7 for each $10 increase in average weekly wage for manufacturing.

[7] Based on 75 percent of the pay of specific grade level in the Federal civil service.

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 provide weekly or monthly death payments to the spouse for life or until remarriage (regardless of the spouse's age at the death of the worker). All programs provide payments to children until age 18 or later if they are incapacitated or are students. Under 11 programs, however, the maximum amounts payable to a surviving family are limited, ranging from $65,000 to $250,000 ($16,500 in the Virgin Islands). Under 16 programs, payments are limited to a specific period, ranging from 6 years to 20 years (sometimes reduced by benefits paid to the deceased worker before his or her death). In a few others, dollar and duration limits apply. Many laws contain special provisions for lump sums payable to widows who remarry and thereby become disqualified for periodic payments.

In all the compensation acts, provision is made for payment of burial expenses, subject to a specified maximum amount that ranges from $400 to $5,000 ($300 in Puerto Rico). The median maximum payment is $2,000. States pay these amounts regardless of the availability of monthly survivor benefits except in Oklahoma where $1,000 is paid to the decedent's estate when there are no dependents.

Medical benefits.—All compensation acts 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, medical drugs and supplies, appliances, and prosthetic devices.

Medical aid is also furnished without a limitation on time or amount for accidental injuries (except that the Virgin Islands limits medical care to $16,000 per injury). A few programs provide for only limited medical benefits when occupational disease, dental care, or prostheses and appliances are involved.

Under 23 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 aid is usually 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. Provisions requiring review and approval of medical bills by the administering agency are also common.

Offset provisions.—Certain disabled workers may be eligible for cash benefits under both workers' compensation and the Social Security Disability Insurance (DI) program. The 1965 Amendments to the Social Security Act provide for a reduction in Social Security payments so that total benefits under both programs do not exceed the higher of 80 percent of a worker's former earnings or the total family benefit under Social Security before offset. The offset also applies where the worker receives both DI benefits and Federal Black Lung program benefits (Part C, financed by employer funds).

Under Federal law, the Social Security offset is not applied if State law provides a workers' compensation offset—that is, if the workers' compensation benefit is reduced to offset concurrent payment of a DI benefit to the disabled worker. Presently, 13 States have such provisions. However, the Omnibus Reconciliation Act of 1981 eliminated the preference to any new State offset provisions. Thus, no additional State offset provisions are expected to be enacted with respect to DI benefits. The Federal offset is relinquished only where

State workers' compensation offset provisions were in effect by February 18, 1981.

Under several programs, 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. In addition, benefits under the Federal Black Lung benefit program are reduced to the extent that workers' compensation benefits attributable to the same disease are being paid.

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. A few State laws contain provisions for nominal contributions by the covered employee for hospital and medical benefits.

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 experience rating. In industries characterized primarily by clerical operations, premium or "manual" rates may be less than 0.1 percent of payroll; in very hazardous occupations the rates may be as high as 20 percent or more.

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-insurance—and the proportion of the employer premium assigned to acquisition costs and costs for services and general administration. Nationally, it is estimated that in 1986 the cost to employers for obtaining insurance or for self-insuring the risk of employment injury averaged 2.0 percent of payroll.

State costs of administering the workers' compensation laws and supervising the operations of the insurance medium—the private carrier, the self-insurer, and/or the State fund—may be provided through legislative appropriations or through special assessments on insurance carriers and self-insurers. In 1986, the programs were about evenly divided in the method used to defray administrative costs.

Administration

State workers' compensation laws in 26 jurisdictions are administered in the State's labor department or other agencies that administer general labor laws. In another 23 areas, the law is administered by an independent workers' compensation agency. Court administration exists in the remaining four States (with some 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 that part of the Black Lung benefit program administered by the Social Security Administration.

Generally, State administrative agencies are expected to exercise supervisory, adjudicative, and enforcement powers to ensure prompt and continued payment of obligations and to secure compliance with the laws. This activity is often carried out through boards or commissions. However, in those States that maintain exclusive State funds, these tasks of administration are merged with those of providing the insurance protection—that is, the functions of setting rates, collecting premiums, and paying benefits.

About half the programs require reports by employers of all work-related accidents or injuries. The others require such reports only if medical care beyond first aid is required, time is lost after the day of the accident, or for cases with a compensable claim. A claim for compensation must be filed with the administering agency for due notice (most often 30 days) to the employer or insurer. The deadline is commonly not longer than 1 year or 2 years after the injury, onset of disability, or death. Time limits 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 take the initiative 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 provide for adjudication through hearings before the administrative body, which usually has exclusive jurisdiction over the determination of facts; appeals to the courts usually are limited to questions of law. Under the four programs where the laws are administered through court procedure rather than a special agency, contested cases are adjudicated in the first instance by the courts.

Rehabilitation

All workers' compensation programs provide for physical rehabilitation when needed. In addition, all but eight of the workers' compensation laws contain special provisions for rehabilitation in the form of retraining, education, and job placement and guidance to help injured workers find suitable work. A few programs provide for the direct operation of rehabilitation facilities to make available to injured workers the full services necessary to restore their ability to perform a job.

In most of the acts, payments for items such as food, lodging, and travel are provided to facilitate the vocational rehabilitation of the worker. Under some laws, these payments are provided through the extension of the period for which regular compensation is payable; under others, they are in addition to the payment of indemnity benefits, with time limitations in some cases.

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 the right 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 handicapped workers, all States have some form of subsequent-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.

In 27 programs, the second-injury fund legislation is broad enough to apply to any preexisting impairment. Under the remaining programs, legislation is limited to workers who have certain specified impairments or whose combined injuries result in permanent total disability.

The method of financing the subsequent-injury fund differs among the various programs. Usually an assessment is made against an employer or insurance carrier in death cases without surviving dependents (or sometimes in disability cases as well), or an annual assessment is made against insurance carriers and self-insurers.

The Black Lung Benefit Program

The Black Lung benefit program was established in 1970 by the Federal Coal Mine Health and Safety Act of 1969. Generally regarded as a specialized workers' compensation program, it provides monthly cash benefits to coal miners who are totally disabled because of pneumoconiosis (black lung disease), and to survivors of miners who die from this disease. Medical benefits are also payable for the diagnosis of the disease and treatment for conditions resulting from the disease.

History.—Originally, the Black Lung benefit program was established with the expectation that the States eventually would provide protection against this occupational disease to coal mine workers through their workers' compensation programs. The original program, Part B, was established under the administration of the Social Security Administration (SSA).

Beginning in July 1973, the Department of Labor was given responsibility for all new claims. The Department was to administer a program, Part C, under which black lung benefits would be paid by the coal mine operator deemed responsible for the worker's disability when benefits were not provided under the State workers' compensation law. Where there was no black lung coverage under workers' compensation laws and when no responsible mine operator could be established, the Department of Labor was to pay claims from general revenues. Claims initiated before July 1973 (and, in certain survivor cases, before December 1973) continued to be paid by SSA from general funds.

In addition to the cash benefits authorized under the original 1969 law, the Black Lung benefit program was expanded to include benefits for medical diagnosis and treatment for conditions resulting from pneumoconiosis. Later, this provision was broadened to include

beneficiaries under the original legislation as well.

When it became evident that the States were not going to change their laws sufficiently to meet Federal standards, Congress in 1977 amended the Act to provide an industry trust fund that, starting in 1978, began paying benefits for cases in which no responsible coal mine operator could be identified. The Government-administered trust fund was financed by an excise tax on coal taken from mines.

At the same time, coverage and eligibility under the program were expanded, providing benefits to new categories of workers and liberalizing rules for medical eligibility. The 1981 program termination date previously in the law was eliminated, making the program permanent.

Benefits.—At the end of 1987, about 412,000 disabled workers, dependents, and survivors were receiving black lung cash benefits under the combined programs administered by SSA and the Department of Labor. In addition to those who actually mine the coal on the surface or underground, individuals disabled by black lung may be eligible for benefits if they processed or transported coal, constructed coal mines, or were owners or managers who had worked in the extraction of coal. Evidence of the existence of pneumoconiosis can be established by several means including definitive X-ray readings and presumptions based on the number of years of mining employment and the extent of disability.

The monthly benefit payable to a disabled miner is a flat amount equal to 37-1/2 percent of the monthly pay rate for a Federal Government employee in the first step of General Schedule grade 2. As of January 1989, this monthly benefit amount was $358.90. For one dependent of a disabled miner, an additional 50 percent of the basic benefit is payable; for two dependents, the additional amount is 75 percent of the benefit; and for three or more, it is 100 percent or a total of $717.80. A widow, widower, or other surviving dependent (child, parent, brother, or sister) of a disabled miner who died also receives the basic benefit of $358.90. If there is more than one survivor, additional amounts are paid in accordance with the above benefit schedule (divided equally among the survivors), except that a surviving widow or child precludes a parent from succeeding to benefits; a surviving widow, child, or parent precludes brothers and sisters from succeeding to benefits.

Benefits are paid regardless of the age of the miner or dependent (other than child) or how long ago the miner's disability began or death occurred. Benefit payments are reduced on a dollar-for-dollar basis if the beneficiary is also receiving payments for disability (due to black lung) under a State workers' compensation program or is receiving benefits under a State unemployment insurance or disability insurance program based on the miner's disability. Benefits paid to miners and dependents (except widows, wives, and children) are also subject to reduction due to excess earnings computed as under the Social Security program's annual retirement test (a 50-cent reduction for each $1 of excess earnings). Black lung benefits are not considered workers' compensation payments for purposes of applying the workers' compensation offset provisions contained in the Social Security DI provisions and thus, are not reduced due to receipt of DI benefits.

During calendar year 1987, total black lung benefit payments amounted to $1.5 billion, of which $0.9 billion was made through the part of the program administered by the SSA and $0.5 billion was made through the Department of Labor. Almost three-fifths of the payments were made to miners and their dependents; the remainder was paid to survivors. These payments include $118 million in medical benefits.

Financing and administration.—The original part of the Black Lung benefit program, Part B, administered by SSA, has been funded from the beginning through general revenues. The later part of the program, Part C, administered by the Department of Labor, is currently intended to be self-supporting. Where a coal mine operator can be assigned responsibility for a worker's disability, benefits are paid by insurance (or self-insurance) arranged for by the employer. However, most of the benefits paid through Department of Labor auspices, as well as administrative costs, are financed by a trust fund established in the 1977 amendments.

The Government-administered trust fund is financed by an excise tax on coal taken from the mines. Currently, this tax remains as enacted in 1981: The lesser of $1 per ton of coal from underground mines (50 cents from surface mines) or 4 percent of the coal's selling price. These rates represent a doubling of the originally enacted rates, which had proved to be insufficient to pay claims.

Because of the growing interest charges on the debt that the trust fund has already incurred, it is anticipated that further corrective legislation will be needed to make the program fully funded. Under current law, rates will revert back to previous levels by the earlier of January 1, 1996, or after all the principal and interest owed to the U.S. Treasury have been paid.

Temporary Disability Insurance or Cash Sickness Insurance

Five States, Puerto Rico, and the railroad industry have social insurance programs that partially compensate for the loss of wages caused by nonoccupational disability or maternity. These programs are known as temporary disability insurance because payments have a durational limit. Private arrangements for similar kinds of insurance are more widespread.

Federal law does not provide for a Federal-State system of disability insurance comparable to the Federal-State system of unemployment insurance. However, the Federal Unemployment Tax Act (FUTA) was amended in 1946 to permit States where employees made contributions under the unemployment insurance program to use some or all of these contributions for the payment of disability benefits (but not for administration). Three of the nine States that could have benefited by this provision for initial funding for temporary disability insurance took advantage of it: California, New Jersey, and Rhode Island. Four other jurisdictions enacted temporary disability insurance laws without any supplemental funds from the unemployment insurance system.

In addition, workers in States that do not have compulsory temporary disability insurance laws are often protected by their employer or union through group disability insurance or formal paid sick-leave plans established through collective bargaining or the employer's initiative. Workers in States that have temporary disability insurance provisions may also have similar coverage. Some workers also secure a measure of protection by purchasing individual accident and sickness insurance from private insurance companies.

It is estimated that through these various voluntary and governmental group arrangements, in 1986 about two-thirds of the Nation's wage-and-salary workers in private employment had some protection against loss of earnings caused by short-term nonoccupational disability. These workers received about $20.0 billion in wage-replacement benefits (including formal sick leave), of which $2.0 billion was paid under temporary disability insurance laws.

Coverage

Some 21 million employees, or about one-fourth of the country's wage-and-salary labor force in private industry, were covered in 1986 by temporary disability insurance laws. The first State law was enacted by Rhode Island in 1942, followed by legislation in California and the railroad industry 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 five State temporary disability insurance laws and the Puerto Rico law cover most commercial and industrial wage-and-salary workers in private employment if the employer has at least one worker. Principal occupational groups excluded are domestic workers, family workers (parent, child, or spouse of the employer), government employees, and the self-employed. State and local government employees are included in Hawaii and hospital employees in Rhode Island; a similar program under another law covers State government employees in California. Agricultural workers are covered to varying degrees in California, Hawaii, New Jersey, and Puerto Rico but are not covered in other jurisdictions. The California law permits self-employed individuals to elect coverage on a voluntary basis. Workers employed by railroads, railroad associations, and railroad unions are covered by temporary disability insurance under the national system included in the Railroad Unemployment Insurance Act.

The laws generally permit individuals who depend only on prayer or spiritual means for healing to elect not to be covered by the contribution and benefit provisions of the law. Other than for this type of minor execption, the laws make coverage against the risk of wage loss due to short-term nonoccupational disability mandatory for all employees subject to the law. However, the methods used for providing this protection vary. In Rhode Island, the coverage is provided through an exclusive, State-operated fund into which all contributions are paid and from which all benefits are disbursed. In addition, a covered employer may provide supplemental benefits in any manner he or she chooses. The State system does not take account of private cash sickness plans. The railroad program is also exclusively publicly operated in conjunction with its unemployment insurance provisions.

In California, New Jersey, and

Puerto Rico, coverage is provided through a State-operated fund, but employers are permitted to "contract out" of the State fund by purchasing group insurance from commercial insurance companies, by self-insuring, or by negotiating an agreement with a union or employees' association. Coverage by the State fund is automatic unless or until an employer or the employees take positive action by substituting a private plan that meets the standards prescribed in the law and is approved by the administering agency. Premiums (in lieu of contributions) are then paid directly to the private plan and benefits are paid to the workers affected.

The Hawaii and New York laws are similar to an employer-liability law because they require employers to provide their own disability insurance plan for their workers—by setting up an approved self-insurance plan, by an agreement with employees or a union establishing a labor-management benefit plan, or by purchasing group insurance from a commercial carrier. In New York, the employer may also provide protection through the State Insurance Fund, which is a quasi-public competitive carrier that writes insurance on a premium-paying basis. Both Hawaii and New York operate special funds to pay benefits to workers who become disabled while unemployed or whose employers have failed to provide the required protection. In other jurisdictions, benefit payments for the disabled unemployed are made from the regular State-operated funds.

In 1986, private plans accounted for more than 25 percent of the covered workers in New Jersey and about 6 percent in California. In contrast, private plans cover all workers in Hawaii, almost all in New York (95 percent), and 66 percent in Puerto Rico.

Eligibility for Benefits

To qualify for benefits, a worker must fulfill certain requirements regarding past earnings or employment and must be disabled as defined in the law. In addition, claimants may be disqualified if they receive certain types of income during the period of disability.

Earnings or employment requirements.—A claimant must have a specified amount of past employment or earnings to qualify for benefits. These requirements limit benefits to individuals with a substantial attachment to the covered labor force. These stipulations are similar to those under unemployment insurance but are less stringent in some cases. However, in most jurisdictions with private plans, the plans either insure workers immediately upon their employment or, in some cases, require a short probationary period of employment, usually 1-3 months. Upon cessation of employment after a specified period, a worker generally loses his or her private plan coverage and must look to a State-created fund for such protection.

Disability requirements.—The laws generally define disability as inability to perform regular or customary work because of a physical or mental condition. Stricter requirements are imposed for disability during unemployment in New Jersey and New York. The laws in Hawaii, New Jersey, New York, and Puerto Rico also deny payments for periods of disability because of willfully self-inflicted injuries or injuries sustained in the performance of illegal acts. Puerto Rico also denies payments to victims of automobile accidents who are covered under other laws. All the laws pay full benefits for disability due to pregnancy. (In Puerto Rico, benefits are not payable for disability caused by or related to abortion except when the abortion was performed for medical reasons or in cases where complications have resulted from an abortion.)

Disqualifying income.—All the laws restrict payment of disability benefits when the claimant is also receiving workers'compensation payments. Further, New York does not pay benefits for employment-related disability, even if workers' compensation is not payable. The other jurisdictions do not pay for disabilities for which workers' compensation is payable. 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 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 disability laws provide that a claimant cannot receive disability benefits for a 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 disability 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 a claimant's previous earnings in covered employment. In general, the benefit amount for a week is intended to replace at least half the weekly wage loss for a limited time. All the laws, however, specify minimum and maximum amounts payable for a week. As of September 1988, the maximum weekly amount ranged from $104 in Puerto Rico to $252 in Rhode Island. In three States, the maximum is recomputed annually so that it will equal a specified percentage of the State's average weekly wage in covered employment: 66-2/3 percent in Hawaii, 53 percent in New Jersey, and 70 percent in Rhode Island, which also pays benefits to dependents.

The maximum duration of benefits payable per disability or per year is 26 weeks to 39 weeks. Hawaii, New York, Puerto Rico, and the railroad program provide for benefits of a uniform duration for all claimants who qualify. In the other States, the length of time that benefits will be paid varies, depending on the total amount of base period earnings (as under the unemployment insurance program) or length of covered 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, these provisions 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 other States, where private plans may deviate sharply from statutory specifications.

In California, before a private 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 private plans must be "actuarially equivalent" to the statutory formula and must meet certain minimum standards. Some features of a 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 up to 40 percent of the statutory benefits.

Private plans may also deviate from the statute with respect to conditions under which benefits are not denied in any case in which they would have been paid under the statute. In fact, however, where there are State-operated plans, financial considerations tend to operate as a restrictive force on the liberalization of private plans because the laws forbid requiring employees to pay higher premiums for private plan coverage.

In 1986, the average payment for a week of disability ranged from $74 in Puerto Rico (publicly operated fund and private plans combined) to $177 in Hawaii (private plans). The average duration per period of disability was only 3.8 weeks in Hawaii, but it was 10.4 weeks in California.

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 allowing private pension plans, 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 benefit. In five of the jurisdictions (all but California and Rhode Island), employers are also required to contribute. In general, the government does not contribute. The State-operated plan in Rhode Island is financed through an employee payroll tax of 1.0 percent on a worker's wage up to 70 percent of the State average annual wage in covered employment. Railroad employers pay a joint unemployment insurance-temporary disability insurance contribution on wages of up to $600 a month per employee. The contribution is the same for all employers but can vary each year from 0.5 percent to 8.0 percent, depending on the level of financial reserves in the system for the previous year.

Under the California State plan, employees pay no more than 1.2 percent and no less than 0.1 percent of payroll tax. Self-employed persons who have elected coverage contribute at a rate of 1.25 percent of wages, deemed to be $5,475 a quarter, without regard to actual self-employment earnings. In New Jersey, the State plan for employed workers is financed by a tax of 0.5 percent of covered wages up to $10,700 a year paid by employees and a corresponding tax of 0.5 percent for employers. However, the 0.5 percent employer tax rate may be modified to vary between 0.1 percent and 1.1 percent of covered payroll, depending on the experience of the employer with the disability risk and the level of reserves.

For benefits not exceeding the statutory benefits, New York employees may be required to contribute 0.5 percent of their wages up to a maximum of 60 cents per week; employers bear any additional costs that may arise. There is no ceiling on the employer's liability. In Puerto Rico, employees and employers each contribute 0.5 percent of the worker's wages, up to $9,000. The cost of benefits for agricultural workers is paid from public funds. In Hawaii, employees pay one-half the cost of benefits, not to exceed 0.5 percent of taxable weekly wages; the balance is paid by the employer. The taxable wage base is computed annually as 121 percent of the State average weekly wage.

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 cost 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, the 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 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, to setting standards of performance, and to 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 in the care of an authorized religious practicioner 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.

Section II: Health Care Programs

Health and medical care expenditures in the United States, including expenditures for medical research and medical facilities construction, were estimated at $500.3 billion for 1987. This amount constituted 11.1 percent of the gross national product. Fifty-nine percent of these expenditures originated in the private sector and 41 percent represented expenditures by Federal, State, and local governments.

Two-thirds of the public expenditures for health and medical care were for the Medicare and Medicaid programs—41 percent and 26 percent, respectively. Hospital and medical care costs for the Department of Defense and for veterans' account for 10 percent; workers' compensation payments for 4 percent; and various public health expenditures, medical research, and construction of medical facilities account for most of the remainder.

Through the Medicare and Medicaid programs, public health and medical care expenditures in the United States targets two broad population groups. The Medicare program covers persons aged 65 or older who are insured under the Social Security program and also persons who have been receiving Social Security disability benefits for 2 years or more. The Medicaid program covers persons with limited income and resources—for the most part, those individuals receiving assistance under the Aid to Families With Dependent Children (AFDC) or Supplemental Security Income (SSI) programs and those who would be eligible for such assistance if their income or resources were somewhat lower.

The first coordinated efforts to obtain government health insurance in the United States were mounted at the State level between 1915 and 1920. State health insurance programs were envisioned as a complement to the workers' compensation laws that had recently been enacted in the majority of States. However, these efforts came to naught, in part as a result of changed national priorities and public attitudes in the years following World War I.

Renewed interest in government health insurance surfaced during the 1930's at the Federal level. Again, nothing concrete resulted beyond the limited provisions in the Social Security Act that supported State activities relating to public health and health care services for mothers and children. Broader initiatives in health care were crowded out by the initiatives in public assistance, old-age insurance, and unemployment insurance included in the Social Security Act of 1935. One of the concerns was that the health care system would have to be expanded and strengthened before large-scale improvements in the provision of health and medical care could be undertaken.

From the late 1930's on, there was broad agreement on the need for some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs for middle-income Americans. The main issue that remained to be resolved was whether health insurance would be privately or publicly financed. Private health insurance, mostly group insurance financed through the employment relationship, ultimately prevailed.

Private health insurance coverage expanded rapidly beginning in World War II as employee fringe benefits were expanded because the Government limited direct wage increases. This trend continued after the war. Concurrently, numerous bills incorporating proposals for national health insurance, financed by payroll taxes, were introduced in the Congress during the 1940's.

Instead, Congress acted in 1950 to improve access to medical care for needy persons who were receiving public assistance, including those eligible under the newly enacted program of Aid to the Permanently and Totally Disabled. The resulting legislation, for the first time, permitted Federal participation in the financing of State payments made directly to the providers of medical care for costs incurred by public assistance recipients. Such cost-sharing initially remained subject to the maximum monthly individual payment amount for which Federal matching was available. Legislation in 1956 and 1958 significantly increased Federal sharing in the payment for medical costs of public assistance recipients. The increase resulted from liberalized reimbursement formulas under which the maximum payment amount subject to Federal matching was defined in terms of average State expenditures per recipient. As a result, high medical payments in a given month for some recipients became eligible for Federal cost-sharing as long as the payments were offset by zero or lower payments for other recipients within the State.

The aged population was also perceived as requiring special attention in order to improve their access to medical care. Studies showed that persons aged 65 or older had, on the average, higher medical costs, lower incomes, and less access to health insurance

than younger persons in the active workforce. Again, while general agreement on the need for Congressional action existed, views differed regarding the best method for accomplishing the desired objective. Pertinent legislative proposals during the 1950's and early 1960's reflected three widely divergent approaches. One approach sought hospital insurance for aged Social Security beneficiaries, financed through payroll taxes; the second called for Federal matching grants to the States for various medical services for aged persons with low to moderate incomes and resources; and the third proposed Federal matching grants to the States to subsidize the cost of private health insurance for the aged.

When a consensus on any of these three approaches proved elusive, Congress passed more limited legislation in 1960—including "Medical Assistance to the Aged" (MAA)—and increased Federal cost-sharing in medical vendor payments for aged public assistance recipients. The MAA legislation provided Federal matching grants to the States for medical services to persons aged 65 or older who would be eligible for assistance if their income and/or resources were somewhat lower—the "medically needy." Participation in MAA required States to introduce more liberal eligibility conditions for the medically needy with regard to factors besides income and resources. In 1962, the States were permitted to extend the increased Federal cost sharing in medical vendor payments to blind and disabled assistance recipients.

In 1965, following a lengthy national debate, Congress passed legislation establishing the Medicare program as title XVIII of the Social Security Act. As enacted, Medicare included not only Hospital Insurance (HI) benefits for the aged (Part A), but also Supplementary Medical Insurance (SMI) benefits for the aged (Part B). The HI program pays for part of the costs of inpatient hospital care and health care provided by skilled-nursing facilities and home health agencies. The program is financed by payroll taxes on employers, employees, and the self-employed. The SMI program covered services and supplies furnished by physicians, outpatient hospital services, and other specified expenses. Participation in the SMI program was voluntary for persons entitled under the HI program and was funded through premiums from participating persons and a matching Federal contribution from general revenues.

The 1965 legislation also created Medicaid (the Grants to States for Medical Assistance Program) as title XIX of the Social Security Act. The Medicaid program replaced both medical vendor payments to public assistance recipients and the MAA program for medically needy persons aged 65 or older. The new, unified program was designed to provide more effective medical care for needy persons through improved standards of care, increased Federal matching under a formula with no maximum, and liberalized eligibility rules.

Under Medicaid, the States were required to extend coverage to recipients of income-support payments—Aid to Families With Dependent Children, Old-Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled. The three adult assistance programs were subsequently replaced by the Supplemental Security Income (SSI) program. The States also were given the option of providing coverage to the medically needy—those persons who would have been eligible except that their income or resources were too high—under income-support programs. In addition, Federal participation under the Medicaid legislation required States to liberalize certain eligibility rules besides those regarding income and resources.

Medicare: Health Insurance for the Aged and Disabled

The Social Security Amendments of 1965 established two related contributory health insurance plans covering virtually all persons aged 65 or older: A basic compulsory program of Hospital Insurance (HI) and a voluntary program of Supplementary Medical Insurance (SMI). Benefits were first available in July 1966, although posthospital, extended-care services in skilled-nursing facilities were not covered until January 1967. The 1972 amendments extended Medicare coverage to certain severely disabled persons under age 65, including disabled workers, disabled widows and widowers, childhood disability beneficiaries, and persons suffering from terminal kidney

disease. Provisions enacted in 1988 provide for the program's first broad coverage of outpatient prescription drugs and protection for elderly and disabled beneficiaries from the costs of catastrophic medical bills.

Hospital Insurance Coverage

Individuals who are eligible for Social Security or Railroad Retirement benefits are eligible for Hospital Insurance (HI) benefits (Part A) when they attain age 65, whether they have claimed cash benefits or not. (If a person is covered by an employer-sponsored health insurance plan as an employee or spouse, that plan becomes the primary payer and Medicare is secondary payer.) Hospital insurance provides basic protection against the costs of inpatient hospital services and related posthospital extended care. In addition, HI protection (and, optionally, SMI) is provided to disabled individuals (but not to their dependents) who have been entitled to disability insurance benefits or railroad retirement disability benefits for at least 24 months. Fully or currently insured workers and their dependents who have end-stage renal disease are also entitled to HI benefits and can also enroll in the SMI program.

The 1972 amendments provided that persons who reach age 65 without qualifying for HI, under either the regular or a special transitional provision, may voluntarily enroll in the program by paying a monthly premium ($156 for 1989; the amount is recalculated annually). States and other public organizations may purchase hospital insurance protection on a group basis for their retired or active employees aged 65 or older at the same cost. Enrollment in the Supplementary Medical Insurance program (Part B) is required as a condition for "buying into" the HI program.

Approximately 28.8 million persons aged 65 or older and 3.0 million disabled beneficiaries under age 65 were protected by the HI program in 1987. During 1987, HI benefit payments amounted to $50.0 billion.

Benefits provided.—Under the HI plan, beneficiaries receive the following services.

- Inpatient hospital services covered by Medicare are unlimited with only an annual deductible as a result of provisions in the 1988 legislation. Once the patient has paid the annual deductible (set at $560 in 1989, but to be recalculated each year), all remaining costs of covered hospital services will be paid by Medicare. Covered hospital care includes all those services ordinarily furnished by a hospital to its inpatients: Semiprivate accommodations, operating room, laboratory procedures and X-rays, drugs and biologicals, nursing services (no payments are made for private duty nursing), therapy services, and services of interns and residents-in-training. Inpatient services in a psychiatric hospital are subject to a lifetime limit of 190 hospital days of care. Beginning January 1, 1989, beneficiaries who are furnished three pints of whole blood (or equivalent quantities of packed red blood cells) are subject to a single annual deductible equal to the cost of the blood. This deductible may be waived if the blood is replaced by the beneficiary or on the beneficiary's behalf or if the beneficiary has already met the deductible under Part B.
- Certain posthospital, extended-care services are provided. The 1988 provisions remove the earlier requirement for prior hospitalization, and beginning in 1989, if a patient requires a skilled level of nursing care but not hospital care, such services are covered in an institution or section of a hospital that qualifies as a skilled-nursing facility (SNF). Payment for up to 150 days of care in a year is covered, but for the first 8 days patients must pay a coinsurance amount equal to 20 percent of the national average daily cost of SNF care ($25.50 per day in 1989).
- Home health services—part-time or intermittent skilled-nursing care, physical therapy, or speech therapy—also are provided. Unlimited home visits are covered if the beneficiary is homebound and if a physician determines that the individual needs home health care and sets up a home health plan of care. Medicare pays the reasonable cost of all covered home health visits. Durable medical equipment furnished as part of the home health plan is subject to 20-percent coinsurance (that is, the beneficiary must pay the first 20 percent of the cost).
- Hospice care covers beneficiaries certified as terminally ill. The services are provided primarily in the beneficiary's home.

No service is covered as posthospital extended-care or posthospital home health services if such service would not be covered

when furnished to a patient in a hospital. Special provisions are included for Christian Science sanatoriums and for payment for emergency services provided by nonparticipating hospitals.

Financing and administration.—Hospital insurance is financed by a tax on earnings that is separate from the tax used to finance retirement, survivor, and disability benefits but which is applied to the same maximum earnings base. (In 1989, annual earnings up to $48,000 are subject to Social Security taxes.) This income is channeled into a separate Federal Hospital Insurance (HI) Trust Fund, established on a basis similar to that of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. All hospital insurance benefits and administrative costs are paid from this trust fund. The HI contribution rate of 1.45 percent applies equally to employers and employees. The tax rate for the self-employed equals the combined employer and employee rate of 2.9 percent.[7]

The catastrophic benefits in the 1988 Medicare Catastrophic Coverage Act (MCCA) are financed in part by an income-related supplemental premium that will be collected through the federal tax system beginning in 1989. The supplemental premium will be paid by individuals eligible for Medicare Part A with Federal income tax liability of at least $150 for that year. The premium rate for 1989 is $22.50 for each $150 of Federal income tax liability with a maximum premium of $800. The rates and maximum are fixed in the law until 1993, after which they will be adjusted annually. The legislation also creates a new Federal Hospital Insurance Catastrophic Coverage Reserve Fund for receipts from the supplemental catastrophic premium.

The Secretary of Health and Human Services has overall responsibility for administering the HI program. In 1965, a new component was created in the Social Security Administration (SSA) to manage the Medicare program. In March 1977, management was transferred from SSA to the newly formed Health Care Financing Administration (HCFA). The HCFA has responsibility for administering the Federal Medicare program and the combined Federal-State Medicaid programs.

As provided by law, the administrators of the HI program have entered into agreements with State agencies and private organizations to secure their assistance in administering the program. The HCFA develops regulations and guidelines for determining if hospitals, skilled-nursing facilities, home health agencies, hospices, and other suppliers of medical services meet the conditions for program participation. These standards include the requirements for medical and nursing staff, the physical environment in which care is provided, the maintenance of records, and the overall quality of care being provided. State agencies—usually health departments—apply the standards and also render consultative services to health care providers. Each participating provider must agree to limit beneficiary service charges to the applicable deductibles and coinsurance.

Hospitals and skilled-nursing facilities nominate a fiscal intermediary to process claims for HI benefits and to make payment settlements. The intermediaries are assigned by HCFA on a regional basis. Both Blue Cross/Blue Shield plans and commercial carriers serve as intermediaries.

Skilled-nursing facilities, home health agencies, and some hospitals are reimbursed on the basis of reasonable costs, subject to certain monetary limits. Most hospitals use a prospective payment system with rates set in advance and related to the patient's diagnosis. Hospices are paid prospectively set rates based on the level of care.

To improve the quality and effectiveness of Medicare services, the 1972 amendments authorized the establishment of medical review organizations called Professional Standards Review Organizations (PSRO's). The 1982 amendments replaced the PSRO's with Peer Review Organizations (PRO's). A PRO is composed of local practicing physicians organized for the purpose of conducting peer reviews. The PRO's are responsible for assuring that the care provided to Medicare beneficiaries is medically necessary and reasonable, is provided in the appropriate setting (hospital versus nonhospital), and meets professionally accepted standards. To receive Medicare payments, each hospital must have an agreement with a PRO.

Payments ordinarily are made only for services provided in the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Supplementary Medical Insurance Coverage

Medical benefits supplementing those provided under the HI program are available to aged and disabled persons who are eligible

[7] In 1986-89, the law provides a tax credit for the self-employed against OASDI and HI tax liability equal to 2.0 percent of covered self-employment income.

for HI protection and to other categories of aged individuals. In 1987, some 31.2 million persons were enrolled in the SMI program, and the program paid $29.9 billion in benefits. Enrolled individuals pay a monthly premium of $31.90 in 1989, which is deducted from their Social Security benefits, Railroad Retirement annuity, or Federal Civil Service Retirement annuity. [8] Enrollees who are not yet receiving their benefits are billed quarterly. The premium rate is adjusted each year. Supplementary Medical Insurance costs not covered by premiums are financed from general revenues.

In prior years, aged persons receiving public assistance—cash payments or medical assistance—could be enrolled in the SMI program by their State assistance agency paying the premium for the individual. The 1988 provisions make the Medicaid buy-in of Medicare coverage for the elderly and disabled mandatory rather than a State option. Coverage will be phased in beginning in 1989 for persons at or below 85 percent of the Federal poverty income guidelines in most States and is to cover all persons below the poverty guidelines in all States by 1993. The States have the option of offering coverage at higher income levels than the mandatory phase-in schedule (up to a maximum of 100 percent of the poverty guidelines) and will be eligible for Federal matching funds.

[8] This amount includes the standard monthly SMI premium rate of $27.90 and a $4.00 supplemental monthly flat premium under the Medicare Catastrophic Coverage Act of 1988, which affects most Part B beneficiaries. For residents of Puerto Rico, this monthly flat premium is $1.30; for residents of other territories and commonwealths it is $2.10; for Part B-only enrollees there is no flat premium.

Under the same phase-in schedule, individuals for whom the State buys in to Medicare will be covered under the Medicare prescription drug catastrophic benefit. A State may elect to provide prescription drug benefits under the Medicaid program up to the amount of the Medicare drug deductible.

Persons may terminate their enrollment in the SMI program at any time by filing a notice with SSA. If persons withdraw before coverage starts, there is no premium liability. However, the premium rate is increased by 10 percent for each full year they remain 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 health insurance plan.) Enrollment may also be terminated for failure to pay the premium.

Benefits provided.—The SMI program covers the following services and supplies:

- Physicians' and surgeons' services, including certain chiropractic care, except routine physical examinations and routine care of the eyes, ears, and feet, and most immunizations and cosmetic surgery.
- Outpatient hospital services for diagnosis or treatment.
- Outpatient laboratory tests, X-rays, and other diagnostic tests.
- X-ray, radium, and radioactive isotope therapy. (Effective January 1, 1990, routine mammography screenings to detect breast cancer will be covered.)
- Outpatient physical therapy services, including speech pathology, under a plan established by a physician, whether or not the patient is homebound.
- Ambulance services.
- Surgical dressings, splints, casts, and other devices for reduction of fractures and dislocations; rental or purchase of durable medical equipment such as oxygen equipment, hospital beds, and wheelchairs used in the patient's home; prosthetic lenses (including those ordered by an optometrist); and prosthetic devices other than dental.
- Home health services.
- Antigens, bloodclotting factors for hemophilia, pneumococcal vaccine, and hepatitis B vaccine.
- Rural health clinic services.
- Home and institutional dialysis services and supplies.
- Comprehensive outpatient rehabilitation services.
- Ambulatory surgical center services.
- Effective January 1, 1990, outpatient prescription drugs used in immunosuppressive therapy and certain intravenous (IV) drugs that can be administered in a home setting. Effective January 1, 1991, coverage will be provided for all outpatient prescription drugs.

For most covered services, the beneficiary is liable for a $75 annual deductible and the first 20 percent of costs in addition to that deductible. Effective January 1, 1990, once any enrollee's covered out-of-pocket expenses for coinsurance on Medicare-approved

charges and deductibles exceed the limit (set at $1,370 in 1990), Medicare will pay 100 percent of the approved charges for the remainder of the year. The cap on out-of-pocket expenses will be adjusted annually. Counted as expenses toward the out-of-pocket cap are the Part B annual deductible, the Part B blood deductible, and all Part B coinsurance. Not included in out-of-pocket expenses are the Part B premium and balance bill amounts (the difference between Medicare-approved amounts and the physician's actual charge). Beneficiaries will be required to continue to pay the 20-percent coinsurance for in-home services (that is, respite care) even after the catastrophic cap is met.

A special limitation is placed on outpatient treatment by physicians of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year is limited to $250 or 50 percent of allowed charges, whichever is smaller. (The actual payment may be lower if charges for these services are used to meet part or all of the $75 annual deductible.) For services of physical and occupational therapists in independent practice, no more than $500 of charges per year can be reimbursed.

Under MCCA, effective January 1, 1990, coverage of a beneficiary's prescription drugs requires the beneficiary to first meet a deductible of $550 and to pay a coinsurance amount of 20-50 percent, depending on the drug. The coinsurance schedule is set at 50 percent for 1991 after beneficiaries meet a deductible of $600. When fully implemented in 1993, Medicare will pay 80 percent of the prescription drug costs above a deductible that assumes that 16.8 percent of Part B enrollees will have bills that exceed the deductible. This drug deductible may not be included in the basic catastrophic out-of-pocket limit.

Payments for SMI covered services are made on either a cost or a charge basis. If payments are on a cost basis (to some providers of services), the intermediary must ascertain that the cost is reasonable. If the payments are on a charge basis (to physicians or others furnishing individual services), the carrier must verify that such charges meet the existing reasonable charge guidelines. Outpatient clinical laboratory services are reimbursed on the basis of fee schedules, and limitations are placed on certain other services.

Payment for physicians' services and other services reimbursed on a charge basis is made in one of two ways. A beneficiary may file a claim for reimbursement based on an itemized bill, whether paid or unpaid, and receive payment for 80 percent of what have been determined to be reasonable charges above the deductible. In this case, the beneficiary is responsible for the total bill. Similarly, the physician may submit the bill for the beneficiary without accepting assignment and the patient remains responsible for the total bill. Alternatively, the physician or supplier may accept an assignment and submit a claim directly for payment, agreeing to accept the carrier's determination for reasonable charges as the full fee for the services involved. The patient then pays no more than the deductible and 20 percent of the balance of the reasonable charge.

Physicians and suppliers may also voluntarily "participate" in Medicare and always accept assignment instead of making the decision each time a service is provided. A beneficiary who uses a participating physician or supplier is assured that he or she will not be responsible for more than the initial deductible and the coinsurance applicable to the reasonable charge.

The Medicare reasonable charge is the lowest of (1) the customary charge (generally the charge most frequently made) by each physician and supplier for each separate service or supply furnished to patients in the previous calendar year, (2) the prevailing charge (the amount that is high enough to cover the customary charges in 3 out of 4 bills submitted in the previous year for each service and supply) for each covered service and supply, or (3) the actual charge. Increases in prevailing charges for physicians' services are ordinarily limited from year to year by an economic index formula that relates physicians' fee increases to the actual increases in the cost of maintaining a practice and to rises in general earnings levels.

Medicare has been authorized to make payments on a per capita basis to prepayment plans. Some plans receive payment for services covered by both the HI and SMI programs. Special reimbursement provisions apply to provide an incentive to health maintenance organizations and competitive medical plans to furnish Medicare services at less cost. Those organizations that operate more efficiently may encourage beneficiaries to join them by offering reductions in cost-sharing or providing coverage of additional services.

Financing and administration.—The SMI program is financed through the Federal Supplementary Medical Insurance Trust Fund, into which are placed the premiums paid by enrollees and the amount paid by the Federal Government

from general revenues. Responsibility for administration of the SMI program, like the HI program, was transferred from SSA to HCFA in March 1977. As provided by law, HCFA enters into contracts with carriers to serve as administrative agents for claims processing. The Federal Government reimburses the carrier for administrative expenses. Blue Cross/Blue Shield plans and commercial carriers operate as carriers to process SMI claims for services furnished by physicians and other health care providers. Carriers perform specific functions such as determining allowable payments; holding, disbursing, and accounting for funds; assisting in the application of safeguards against unnecessary utilization of services; and granting hearings to individuals with contested claims. Some institutional providers of services, such as home health agencies, hospital outpatient departments, and comprehensive outpatient rehabilitation centers, are served by HI intermediaries.

The MCCA establishes a separate Federal Catastrophic Drug Insurance Trust Fund into which the drug portion of the supplemental and flat premium under Part B will be paid. The HCFA will contract with qualified entities to assist in the implementation and operation of the "point of sale" electronic claims system that is required in administering the outpatient prescription drug benefit. These new "limited carriers" will be responsible for receiving electronic information and responding to requests from pharmacies and individuals regarding their deductible status.

Medicaid

Title XIX of the Social Security Act provides for a program of medical assistance for certain persons with low incomes and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments. [9] Although medical assistance was not specifically provided for in the original Social Security Act in 1935, the Federal Government did share with the States the cost of providing maintenance assistance, including some medical care, to categorically needy persons.

Subsequent amendments to the act (in 1950, 1956, 1960, and 1962) expanded the Federal involvement and monies available to assist the States in providing for medical care to their federally assisted welfare recipients. The establishment of the Medicaid program in 1965 provided Federal grants and guidance (with federally imposed restrictions and requirements) to assist States in the provision of more adequate medical care to eligible needy persons.

Within broad Federal guidelines, each State determines its own eligibility requirements; the amount, duration, and scope of services; the rate of reimbursement for services; and administers its own program. The Medicaid programs vary considerably from State to State.

Eligibility

States have wide discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, a State must provide Medicaid coverage for all persons who are receiving (or would be receiving, under specified conditions) payments under the Aid to Families With Dependent Children (AFDC) program and for most persons who are receiving Supplemental Security Income (SSI) payments. (The coverage of SSI recipients may be restricted to those who have undergone a separate State determination for Medicaid eligibility or to those who meet SSI eligibility standards that are somewhat more restrictive than Federal standards.)

As a result of legislation in recent years, States must also cover several other related groups not eligible for AFDC or SSI payments. These "mandatory" Medicaid groups include:

- Children aged 1 through 6 (born after September 1983) and pregnant women who meet the State's AFDC financial requirements;

[9] All States participate in Medicaid. The District of Columbia, Guam, Puerto Rico, the Virgin Islands, American Samoa, and the Northern Mariana Islands also provide Medicaid coverage. Arizona provides medical assistance through a title XIX authorized demonstration program.

- Recipients of adoption assistance and foster care under title IV-E of the Social Security Act;
- Effective July 1, 1989, pregnant women and infants up to age 1 whose family income is at or below 75 percent of the the Federal poverty level (phased in to 100 percent of the poverty level by July 1, 1990);
- Certain Medicare beneficiaries (limited benefits, described later) beginning January 1, 1989; and
- Special protected groups (usually individuals who lose cash assistance because of the cash program's rules, but who keep Medicaid for a period of time; for example, persons who lose AFDC or SSI due to earnings from work or increased Social Security benefits).

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share the characteristics of the mandatory groups, but have somewhat more liberally defined eligibility criteria. These include, primarily, certain categories of young children, pregnant women, and persons needing long-term care who are not otherwise covered by Medicaid.

The States may further elect to have a "medically needy" program to provide Medicaid eligibility to certain additional individuals and families with high medical costs who meet the eligibility requirements except that they have more income and/or countable resources than are otherwise allowed. Within this program, such otherwise eligible persons may "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses that reduce their excess finances. If a State elects to have a medically needy program, it is required to provide coverage to certain children under age 18 and to pregnant women. A State may choose to include aged, blind, and disabled persons; caretaker relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. In 1987, 36 States provided a program for the medically needy.

Medicaid does not provide medical assistance to all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for a few specified persons), eligibility for Medicaid is limited to the groups described above.

Once entitlement to Medicaid is determined, coverage generally is retroactive to the third month prior to application. Coverage usually stops at the end of the month in which a person's circumstances change.

In all, 23.2 million persons received Medicaid benefits in fiscal year 1987. Table 8 shows the distribution of these recipients and the amounts paid for their care.

Amount, Duration, and Scope of Medical Services

Within broad Federal guidelines, States determine the amount and duration of all services offered under their Medicaid programs. They may limit, for example, the days of hospital care or the number of physician visits covered. These State-discretion features assure even greater variety between States' Medicaid programs.

Federal regulations for title XIX require that, in order to receive Federal matching funds, certain basic services must be offered in any State Medicaid program:

Table 8.—Number of Medicaid recipients and total and average payment amounts, by eligibility category and services in specified facilities, fiscal year 1987

Eligibility category and type of service	Nmber of recipients [1] (in thousands)	Total payment amount (in millions)	Average payment amount
	Eligibility category		
All recipients	23,183	$45,098	$1,945
Dependent children under age 21	10,225	5,536	541
Adults in families with dependent children	5,623	5,603	996
Persons aged 65 or older	3,260	16,133	4,949
Blind or totally and permanently disabled persons	3,385	16,759	4,951
Other	1,412	1,070	758
	Type of service		
Inpatient hospital	3,838	$12,703	$3,310
Intermediate-care facility	991	12,916	13,033
Mentally retarded	149	5,606	37,624
All other	842	7,310	8,682
Skilled-nursing facility	574	5,971	10,402

[1] Categories do not add to total because of the small number of recipients that are in more than one category during the year.

- Inpatient hospital services;
- Outpatient hospital services;
- Laboratory and X-ray services;
- Physician services;
- Rural health clinic services;
- Nurse-midwife services;
- Prenatal care;
- Skilled-nursing facility services for individuals aged 21 or older;
- Home health care for persons eligible for skilled-nursing services;
- Family planning services and supplies (at a 90-percent matching rate for all States); and
- Early and periodic screening, diagnosis, and treatment services for individuals under age 21.

In addition, States may elect to provide other optional Medicaid services (currently 32 options) with Federal matching funds. Examples of optional services include clinic services, intermediate-care facility (ICF) services for the aged and disabled, ICF services for the mentally retarded, optometrist services and eyeglasses, prescribed drugs, and dental services. For the medically needy, however, a State may choose the services that it will provide; it need not include all the services listed above.

Service Providers and Reimbursement

With certain exceptions, a State's Medicaid plan must allow recipients their freedom of choice among participating providers of health care. States may provide Medicaid services through various prepayment arrangements such as health maintenance organizations (HMO's). They may also request Federal administrative "waivers" under which they offer an alternative (but no more costly) health care package for persons who would otherwise be institutionalized under Medicaid. Certain restrictions and requirements apply for waiver approval and Federal matching funds.

Reimbursements for Medicaid services generally are made directly to the providers of services for care rendered to eligible individuals. Providers must accept the Medicaid reimbursement level as payment in full. States have broad discretion in determining the reimbursement methodology and resulting rate for services, subject to Federal upper limits and a few exceptions.

Reimbursement rates, however, must be reasonable and adequate to assure that services are available for the Medicaid population and to maintain the quality and supply of providers who agree to participate in the Medicaid program. States may impose some nominal deductibles, coinsurance and/or copayments on some Medicaid recipients (with certain exclusions) for certain services.

Medicaid-Medicare Relationship

Persons who are eligible for Medicare as well as for Medicaid are called "dual eligibles." States' Medicaid programs "buy" their dual-eligible persons in to the Medicare program by paying their Medicare premiums. For these persons, Medicaid supplements the Medicare coverage and provides many Medicaid services that are not provided under Medicare. These include such services as hearing aids, eyeglasses, and long-term nursing home care.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) requires State Medicaid programs to cover the premiums, deductibles, and coinsurance for certain qualified Medicare beneficiaries with incomes and resources below poverty. (This provision is being phased in over several years.) These persons will not become newly eligible for full Medicaid benefits because of the new law; they benefit because their Medicare cost-sharing expenses are covered.

Effective September 30, 1989, MCCA also accelerates Medicaid eligibility for some nursing home patients by protecting more income and assets for the institutionalized persons' spouses living at home. The MCCA limits the amount of assets and income of a married couple that must be "spent down" before Medicaid will pay for nursing home care. Before an institutionalized person's monthly income is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted for bringing the spouse's income to a moderate level.

Financing and Administration

Each State develops and administers its own Medicaid program under guidelines set by Federal law and regulations. The Health Care Financing Adminstration (HCFA), Department of Health and Human Services, administers Federal participation in the Medicaid program. Total 1987 expenditures were $47.6 billion, of which $26.6 billion were derived from Federal general revenues and $21.0 billion from State funds.

In 1987, States were reimbursed for their Medicaid costs at a rate between the prescribed minimum of 50 percent and 78.5 percent of actual expenditures. On average, States received reimbursement for 56 percent of their Medicaid costs from the Federal Government. The percentage of Medicaid expenses to be paid by the Federal Government is determined annually for each State by a formula that compares

the State's average per capita income level with the national average. The wealthier States have a smaller share of their costs reimbursed.

Expenditures for State administration of the Medicaid program are shared by the Federal Government. Most administrative costs are matched at 50 percent for all States. Depending on the complexity and need for incentives for a particular service, higher matching rates (75, 90, and 100 percent) are used for other costs.

Since 1972, Medicaid institutions have been required to implement the utilization review practices that govern Medicare institutions. The same State agency must certify facilities for participation under both programs. The agency must also establish a plan for statewide review of the quality and appropriateness of the services offered.

The Medicaid program must function within the constraints of Federal and State budgetary limitations as well as other social, economic, and political factors. Thus, the Medicaid program varies from State to State and is continually changing.

Section III: Programs for Special Groups

Veterans of the Armed Forces who served during military conflicts, many public employees, and railroad workers are eligible for special benefits not available to other persons.

The tradition of veterans' benefits stretches back to the days of the colonies. In the 17th century, some colonies provided benefits for disabled veterans, and the Continental Congress provided disability pensions for veterans of the Revolutionary War. The first Congress of the United States passed a veterans' pension program in 1789. At first, these veterans' benefits 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.

Retirement programs for certain groups of government employees—mainly teachers, policemen, and firemen—date back to the 19th century. The teachers' pension plan of New Jersey, which was established in 1896, is probably the oldest Statewide contributory retirement plan for government employees. By the early 1900's, a number of local governments had set up retirement plans for policemen and firemen, followed by plans for general municipal employees. 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 initiated for Federal employees.

Before the Federal old-age insurance system was enacted for commercial and industrial workers, attempts were made to establish a uniform, industrywide pension system for railroad workers. The vast majority of railroad employees had been covered under the railroads' private pension plans, some of which dated back to the 19th century. During the depression of the 1930's, these plans were financially weakened and Federal action was sought. Congress responded with the Railroad Retirement Act of 1934, which was subsequently declared unconstitutional. The tax provisions of a second law, in 1935, also were declared invalid by a lower court. Finally, amendments in 1937 provided a compromise acceptable to both employers and employees in the railroad industry. The major item of agreement was that the Federal system should assume the payment of pensions to those on the private benefit rolls of the railroads.

Veterans' Benefits

A variety of programs and benefits are available to veterans of military service. Included in these programs are disability payments, educational assistance, hospitalization and medical care, survivor and dependents benefits, special loan programs, and hiring preference for certain jobs. Most of the veterans' programs are administered by the newly created Cabinet-level Department of Veterans Affairs, which replaced the Veterans' Administration in March 1989.

During fiscal year 1987, total benefits to veterans and their dependents, exclusive of career retirement and Social Security benefits, reached $25.8 billion. This amount included $14.3 billion for disabled veterans, their dependents, and survivors; $10.6 billion for medical programs; and $0.9 billion for educational programs. As of March 1, 1989, 593,468 veterans were receiving pensions and 539,703 widows were receiving survivor benefits.

History

Benefit programs for military veterans had their origins in the earliest days of the Nation's history. As early as the 17th century, some of the Colonies had enacted laws to provide care for disabled veterans, and the Continental Congress provided disability pensions for veterans of the Revolutionary War.

In 1789, the first Congress of the United States enacted a pension program for veterans that was actually administered by the Congress. As the number of military pensioners grew, administrative responsibility for the pension program was shifted from Congress to a succession of agencies.

The initial scope of the veterans' program consisted of pensions to disabled veterans and to the widows and dependents of those who died while on active duty. Coverage was broadened early in the 19th century with the introduction of programs for domiciliary care and incidental medical and hospital care.

America's involvement in World War I triggered the establishment of several new veterans' programs. They provided disability compensation, insurance for service persons and veterans, and vocational rehabilitation for disabled veterans. In 1930, the Veterans' Administration was established to consolidate the administrative responsibility for all veterans' programs under a single agency.

Significant features of the veterans' benefit system were added in 1944 as a result of the World War II GI Bill of Rights. Major new features under this law included extensive educational benefits and a home loan program. Legislation in 1988 replaced the Veteran's Administration with the Cabinet-level Department of Veterans Affairs. This change reflects the importance accorded to veteran's programs and an effort to streamline their administration.

Cash Benefits

Two major cash benefit programs are available for veterans. The first program provides benefits to veterans with service-connected disabilities and, on the veteran's death, benefits are paid to the eligible spouse, parents, and children. These benefits are not means-tested—that is, they are payable regardless of other income or resources. The second program provides benefits to needy veterans who have non-service-connected disabilities. These benefits, however, are means-tested.

Compensation for service-connected disabilities.—The disability compensation program pays monthly cash benefits to veterans whose disability resulted from an injury or disease incurred or aggravated by active military duty, whether in wartime or peacetime. Individuals discharged or separated from military service under dishonorable conditions are not eligible for compensation payments. The amount of monthly compensation depends on the degree of disability, rated as the percentage of normal function lost. Payments range from $73 a month for a 10-percent disability to $1,468 a month for total disability. In addition, specific rates of up to $4,195 a month are paid when eligible veterans suffer certain specific severe disabilities. Such cases are decided on an individual basis. Veterans who have at least a 30-percent service-connected disability are entitled to an additional dependants' allowance. The amount is based on the number of dependents and degree of disability.

Pensions for non-service-connected disabilities.—Monthly benefits are provided to wartime veterans with limited income and who are totally and permanently disabled (or to those aged 65 or older and not working) because of a condition not 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, or the Vietnam era. Generally, the period of service must have lasted at least 90 days and the discharge or separation cannot have been dishonorable.

Effective December 1, 1988, maximum benefit amounts for non-service-connected disabilities range from $538 per month for a single veteran without a dependent spouse or child to $1,028 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 $91 per month. Benefits to veterans without dependents are reduced to $60 per month if they are receiving long-term domiciliary or medical care from the Department of Veterans Affairs. 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 the surviving spouse, children (younger than age 18, disabled, or students), and certain parents of service persons or veterans who die as the result of an injury or disease incurred or aggravated by active duty or training or from a disability otherwise compensable under laws administered by the Department of Veterans Affairs.

Dependency and indemnity compensation payments are also made if the veteran was receiving or was entitled to receive compensation for a service-connected disability at the time of death. The disability had to be continuously rated totally disabling for a period of 10 years or more or had to have lasted continuously for at least 5 years after the veteran's date of discharge. To qualify for benefits, a surviving spouse must have been married to the veteran for at least 1 year before the veteran's death or for any period of time if a child was born of or before the marriage to the veteran.

Eligibility for survivor benefits based on a non-service-connected

death of a veteran with a service-connected disability requires a marriage of at least 2 years' duration before the veteran's death. No marriage duration requirement exists for the surviving spouse of a Vietnam era veteran. A surviving spouse is generally required to have lived continuously with the veteran from marriage until his or her death. Eligibility for benefits ends with the spouse's remarriage but may be regained upon dissolution of the new marriage.

The monthly benefit amount payable to a spouse depends on the last pay rate of the deceased service person or veteran. The benefit amount ranges from $539 to $1,480 a month. The amounts payable to eligible parents are lower, ranging from $5 to $303 a month, depending on (1) the number of parents eligible, (2) their income and (3) their marital status.

Special allowances, in addition to the regular monthly benefit, are payable to both surviving spouses and parents if their physical condition requires the regular aid and attendance of another person. This special allowance is $161 a month. Spouses whose condition does not require the regular aid and attendance of another person, but whose physical condition confines them to the house, are entitled to an allowance of $79 a month in addition to their regular benefit. Death pensions under prior provisions are payable for service-connected deaths before 1957.

Pensions for non-service-connected death.—Pensions are paid based on need to surviving spouses and dependent children (under age 18, students, or disabled) of deceased veterans of the wartime periods specified in the disability pension program. For a pension to be payable, the veteran generally must have met the same service requirements established for the non-service-connected disability pension program, and the surviving spouse must meet the same marriage requirements as under the dependency and indemnity compensation program.

The pension amount depends on the composition of the surviving family and the physical condition of the surviving spouse. Pensions range from $360 a month for a surviving spouse without dependent children to $688 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 $91 a month for each additional dependent child.

Hospitalization and Other Medical Care

The Department of Veterans Affairs provides a nationwide system of hospital and other medical care for veterans. Eligibility for any particular medical program is based on a variety of factors. Care is furnished to eligible veterans at these facilities according to priority groups. The highest priority is for care given to veterans who need treatment for a service-connected disability.

Hospital care.—Eligible veterans are provided free hospital care and medical services if they are:

- Disabled because of an injury or disease incurred or aggravated during active military duty.
- Retired from active military service for a disability incurred in the line of duty.
- A former prisoner of war.
- Aged 65 or older.
- Receiving a pension from the Department of Veterans Affairs.
- Eligible for Medicaid.
- In need of treatment for a condition related to exposure to Agent Orange or to radiation from nuclear testing while on active duty.

Veterans who cannot meet these requirements must certify that they are unable to defray the cost of medical care elsewhere. The need for hospital care will be determined by a Department of Veterans Affairs physician. Admission to a facility is made according to the veteran's priority for care.

Care for dependents and survivors.—The dependents and survivors of certain veterans may be eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) if not eligible for medical care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or for Medicare. CHAMPUS is the health program administered by the Department of Defense for dependents of active duty personnel, and military retirees and their dependents.

Those eligible for care under the CHAMPVA program include:

- The spouse or child of a veteran with a total, permanent service-connected disability.
- The surviving spouse of a veteran who died as a result of a service-connected disability or who had a total, permanent service-connected disability at the time of death.
- The surviving spouse or child of a person who died while on active duty.

Beneficiaries covered by CHAMPVA may be treated at Department facilities when space is available. Usually, however, the person with CHAMPVA coverage is treated at a community hospital of his or her choice: The Department of Veterans Affairs pays for a part of the bill and the beneficiary is responsible for a copayment under the CHAMPVA program.

Nursing home care.—Eligibility for admission to a Department of Veterans Affairs nursing home is the same as for hospitalization in a Department facility. Admission is based on a priority system—with the highest priority given to veterans requiring nursing home care for a service-connected condition. The Department of Veterans Affairs also contracts with community nursing homes to provide care at Department expense to certain veterans. Community nursing home care is usually limited to 6 months and is available to veterans with a service-connected disability or to veterans discharged from a Department hospital to the nursing home.

Outpatient medical treatment.—Extensive outpatient medical treatment is available to veterans. It includes rehabilitation, consultation, training, and mental health services in connection with the treatment of physical and mental disabilities. Veterans who are at least 50 percent disabled by a service-connected disability, receiving veterans' aid and attendance or housebound benefits, former prisoners of war, or veterans of World War I may receive outpatient care for any condition. Other veterans may receive outpatient care for their service-connected disabilities or may complete an episode of outpatient care in a Department facility to prevent a need for hospitalization in the immediate future. Outpatient care is furnished according to priority groups within the resources available to the facility.

Other medical benefits.—Other Department of Veterans Affairs programs and medical benefits are available to certain eligible veterans and include: Domiciliary care for veterans with limited income who have permanent disabilities but who are ambulatory and able to care for themselves; alcohol and drug dependence treatment; prosthetic appliances; modifications in the veteran's home required by his or her physical condition, subject to prescribed cost limitations; and, for Vietnam-era veterans, readjustment counseling services. Under limited circumstances, the Department may authorize hospital care or other medical services in the community at Department expense.

Educational Assistance

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 1977. The veterans' educational assistance program assists 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.

Public Employee Programs

The Federal Government, the 50 States, and many localities maintain programs that provide retirement, disability, and survivor benefits for their employees. These jurisdictions may also provide health insurance, group life insurance, paid sick leave, workers' compensation benefits, and unemployment insurance.

Federal Civilian Employment

Civilian employees of the Federal Government receive various types of protection through employee benefit programs. Federal employees are covered by retirement, life insurance, health insurance, and workers' compensation programs. They also receive paid sick leave and severance pay and are covered under the Federal-State unemployment insurance system.

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. By September 1987, 2.8 million Federal workers were covered. This figure includes the 2.2 million workers covered by the Civil Service Retirement System (CSRS) and the 600,000 who are 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 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. The principal provisions of the two largest retirement systems are summarized below.

The CSRS allows optional retirement with full annuity at age 55 with 30 years of service, at age 60 with 20 years of service, or at age 62 with 5 years of service. In addition, workers with 20 years of service at age 50 or 25 years of service at any age are eligible for full retirement benefits if they are involuntarily separated from Federal employment. Workers with at least 5 years of service may retire because of disability at any age if they meet the criteria used to determine the existence of a disability.

Regular CSRS benefits are based on the average of a worker's three highest-salaried years. The formula used is 1.5 percent of that average for each of the first 5 years of service, 1.75 percent for each of the next 5 years, and 2 percent for each additional year. This formula provides long-term-service employees with retirement benefits equal to approximately two-thirds of their "high-three" earnings average. Those who retire because of disability are guaranteed a benefit of 40 percent of their high-three average or an annuity based on the projection of their service to age 60, whichever is less. If a disabled annuitant's regular retirement benefit is larger than this guaranteed amount, he or she receives the larger amount—although no annuity may exceed 80 percent of the high-three average salary.

The spouse of an employee who dies before retiring receives a survivor benefit equal to 55 percent of the disability guarantee. At the time of retirement, a married worker's annuity is actuarially reduced in order to provide survivor benefits to his or her spouse after the worker's death. Such annuities are equal to 55 percent of the worker's unreduced benefit amount. Child survivors usually receive flat monthly payments.

The CSRS is financed in part by joint employer-employee contributions and in part from general revenues. Federal workers and their employing agencies each contribute 7 percent of the employee's salary and the Government assumes the balance of the cost, including unfunded liabilities. The CSRS benefits are usually adjusted each year to keep pace with increases in the cost of living as measured by the Consumer Price Index.

Full-time, permanent Federal employment was not covered by the Social Security program before January 1, 1984. Those workers—primarily part-time or temporary employees—who were not covered by the Federal retirement system have had Social Security coverage since 1950. All Federal civilian workers have been covered under the Hospital Insurance program (Part A of Medicare) since January 1, 1983. They pay 1.45 percent of their salaries as taxes to that system.

The FERS program was established by legislation enacted in June 1986 to cover all employees hired after December 31, 1983, and any who chose to transfer from CSRS. The benefits provided by the new system are analogous to those provided under CSRS, but the structure of FERS is quite different.[10]

The FERS structure is three-tiered, and the first tier is the Social Security program. All workers enrolled in FERS are covered by Social Security. They contribute to the program at the current tax rate and are eligible for the same benefits as all other workers covered by Social Security. The second tier of FERS is a Federal pension. For workers who retire at age 62 with at least 20 years of service, this annuity is based on the average of a worker's three highest-salaried years and calculated at the rate of 1.1 percent per year of service. For workers who retire before age 62, or after age 62 with fewer than 20 years of service, the multiplier is 1 percent per year of service. The FERS-covered workers contribute toward this pension; in 1989, their combined contribution rate for Social Security, Medicare, and the Federal pension is 8.45 percent of salary.

The disability provisions of FERS are integrated with those of the Social Security program. In general, the benefit provided is 40 percent of high-three average pay plus 40 percent of the regular Social Security disability payment. Survivor benefits under FERS are paid in addition to benefits paid under Social Security. The survivor benefit formula varies according to the employment status of the worker at the time of death—that is, whether the decedent was currently employed, formerly employed, or an annuitant.

A worker who meets the full age and service requirements for an

[10] For a detailed examinaton of the provisions of FERS, see Wilmer L. Kerns, "Federal Employees Retirement System Act of 1986," Social Security Bulletin, November 1986, pages 5-10.

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 Plan. Under this plan workers may contribute up to 10 percent of their salaries to the plan, with the Government matching contributions up to 5 percent of the salary. Interest earnings are not deductible 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.

The Federal pension segment of FERS is administered by the Civil Service Retirement and Disability Trust Fund, as is the CSRS. In 1987, the Fund paid $20.8 billion to 1.5 million retired and disabled annuitants and $3.5 billion to 530,000 survivor annuitants.

The group life and health insurance programs available to Federal employees are optional and are financed by joint contributions from the worker and his employing agency. The Government pays one-third of the cost of basic life insurance and an average of 60 percent 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 percent of a service member'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 percent of preretirement 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 percent) of the retired service member's unreduced benefit at the time of death. During 1988, 1.6 million retired service members and their survivors received $19 billion in military retirement benefits.

The Department of Defense provides medical care for active duty personnel, retirees, and 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-service members 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 and firefighters, to be eligible for retirement based only on length of service—regardless of their age. Other workers normally must meet age and service requirements. In 1986, State and local governments paid $24.4 billion in retirement benefits to 3.5 million persons; 3.0 million of those received benefits based on age and years of service.

Benefits under State and local retirement systems are usually calculated on a 3- to 5-year average salary and a 1.5 percent or 2.0 percent 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.

When the Social Security program was enacted in 1935, State and local government employees were not included. However, legislation enacted in 1950 and later provided coverage to these workers at the employer's option and under certain conditions. In 1954, 3.4 million State and local employees came under the Social Security system when the option of coverage was extended to all workers (except police and firefighters) even if they were already covered by a pension plan. By 1986, an estimated 10.2 million State and local workers were covered by the program—about 72 percent of all whose major job was in State and local government at that time.

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 States' 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 percent 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. Like the Social Security program, the Railroad Retirement program provides monthly benefits to retired and disabled workers and their dependents and to survivors of insured 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 1988 that number was 303,000. By the end of fiscal year 1988, 915,000 beneficiaries were on the rolls—407,600 were employee annuitants and 220,000 were spouse 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, 1983, 1986, and 1987. Continuing financing problems led to legislation in December 1987 to establish a Commission on Railroad Retirement Reform. The Commission's mandate is to conduct a comprehensive study of the issues pertaining to the long-term financing of the system and to submit recommendations to the Congress for revisions in, or alternatives to, the current payroll tax method of financing. Its purpose is to assure the provision of retirement benefits to current and future retirees on an actuarially sound basis. The seven-member Commission will represent railroads, labor, and the public, and is expected to submit its report to the President and both Houses of Congress by October 1, 1989.

The basic requirement for a regular employee retirement annuity under the Railroad Retirement Act is 120 months (10 years) of creditable railroad service. For employees with less than 10 years of service, time with the railroad industry is counted as covered employment under the Social Security program.

Annuities are calculated under a two-tier formula. The first tier is

*Adapted from the **Informational Conference Handbook, January 1989**, Railroad Retirement Board, 1989.

calculated generally the same as for a Social Security benefit and is based on railroad credits and any nonrailroad 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 industrial pensions paid over and above Social Security benefits to workers in other industries.

Persons covered by the Railroad Retirement program participate in Medicare on the same basis as those covered by Social Security.

Types of Benefits

Employee annuities.—At age 62, employees with 10-29 years of creditable service are eligible for regular annuities based on age and service. Early retirement reductions are applied to annuities awarded before age 65.

Employees with 30 years or more of service are eligible for regular annuities at age 60, with early retirement reductions applied to annuities awarded before age 62. An annuity based on age cannot be paid until the employee stops working for a railroad.

Annuities based on total disability are payable at any age, if an employee is permanently disabled for all regular work and has at least 10 years of creditable railroad service. Annuities based on occupational disability are payable at age 60 with at least 10 years of service or at any age with at least 20 years of service, when the employee is permanently disabled for his or her regular railroad occupation. A current connection with the railroad industry is also required for an annuity based on occupational, rather than total, disability. An employee who worked for a railroad in at least 12 of the 30 months immediately preceeding retirement will meet the current connection requirement. An annuity based on disability cannot be paid until the employee stops working, and a 5-month waiting period is required after the onset of disability before payment of the annuity can begin.

Vested dual benefits.—An employee who qualified for both Railroad Retirement and Social Security benefits before 1975, and who meets certain vesting requirements, can receive an additional annuity amount. Generally, the employee must have been fully qualified for both pensions as of December 31, 1974, and must have had a current connection with the railroad industry.

Supplemental annuities.—In addition to these regular annuities, a supplemental annuity may be paid at age 65 to an employee who has both 25-29 years of creditable service (or age 60 with 30 years or more) and a current connection with the railroad industry. Neither a regular annuity nor a supplemental annuity is payable for any month in which a retired employee works for a railroad or for the last nonrailroad employer he or she worked for before retirement.

Spouse and survivor annuities.—The age requirements for a spouse annuity depend on the employee's age at retirement and his or her years of service. If a retired employee is aged 62 with 10-29 years of service, that employee's spouse is eligible for an annuity at age 62. However, reductions for early retirement are applied to the spousal annuity if the spouse retires before age 65.

If a retired employee is aged 60 and credited with 30 years of service, his or her spouse is eligible for an annuity at age 60. For those who met the 60/30 requirement after July 1, 1984, an early retirement reduction is applied to the spouse annuity if the employee retires before age 62.

The spouse of an employee who is qualified to receive an age and service annuity may receive a spouse annuity at any age if he or she is caring for a child of the employee and that child is under age 16 or became disabled before age 22. A wife in this situation receives a regular spouse annuity and may continue to receive partial (tier II only) benefits while the child is aged 16-18 . If the husband of a railroad worker is caring for such a child, he will receive an annuity equal to what Social Security would pay in the same situation. This amount is generally less than the amount of the regular spouse annuity.

A spouse annuity cannot be paid while the spouse is working for a railroad. It is not payable in any month in which the employee's annuity is not payable nor for any month in which the spouse returns to work.

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. This guarantee covers situations in which some family members would be eligible for a Social Security benefit that does not exist under the Railroad Retirement Act. For example, the Social Security program provides benefits for the children of workers who are retired, disabled, or deceased. Under the Railroad Retirement program, only the children of deceased workers receive such benefits. Therefore, when a retired railroad worker has children who would be eligible to

receive benefits under Social Security, his or her annuity is increased to reflect the Social Security payment level.

Survivor annuities are payable to widows and widowers, children, and certain other dependents. Eligibility for survivor benefits depends on whether or not the employee was "insured" under the act at the time of death. "Insured" means that the worker must have had at least 10 years of railroad service and have had a current connection with the industry. When a deceased employee is uninsured, his work credits are transferred to the Social Security system and the jurisdiction of survivor benefits passes to the Social Security Administration. The tier I annuity portion of a widow's or widower's annuity may be reduced for receipt of any Federal, State, or local government pension based on his or her own earnings.

A lump-sum death benefit is payable to survivors of an employee with 10 years or more of service and a current connection with the industry if there is no survivor immediately eligible for an annuity upon the employee's death.

Amount of Benefits

When the employee's annuity begins, the total amount of Railroad Retirement benefits payable to an employee and his or her spouse is limited to the larger of $1,200 a month or an individual family maximum. The family maximum is based on the 2 years of highest taxable earnings in the 10-year period ending with the year the employee's annuity begins. This maximum applies only at the time of the initial award, and benefits are subsequently increased for the cost of living whether or not a maximum limitation was applied. 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. The reduction is being phased in over a 5-year period with a guarantee that the tier I amount cannot be reduced by more than 50 percent 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 1989, annual earnings of up to $8,880 for those aged 65-69 and $6,480 for those under age 65 were 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. Work restrictions can also affect payment, depending on the amount of earnings. The annuity is not payable for any month in which the annuitant earns more than $400 from employment or self-employment. Withheld payments will be restored if earnings for the year are less than $4,800.

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 percent 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 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 law, 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—7.51 percent in 1989. In addition, both employers and employees pay tier II taxes to finance the industry pension segment of the annuities. In 1989, the employer tax rate will is 16.1 percent, and the employee tax rate is 4.9 percent. The earnings base for tier I taxes is the same as for Social Security—$48,000 in 1989. The tier II earnings base for the same year is $35,700. 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.

The Committee on Economic Security, which had reported to President Roosevelt on the nationwide State plans for unemployment insurance, recommended that railworkers be covered by a separate plan because of the complications their coverage had caused the State plans. Congress subsequently enacted the Railroad Unemployment Insurance Act in June 1938. The Act established a system of benefits for unemployed railroad workers. The program was financed entirely 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. This program is financed by the contributions of railroad employers only, based on the taxable earnings of their employees. The taxable earnings base is the first $600 of each employee's salary.

The economic recession of the early 1980's caused large scale railroad layoffs that, in turn, increased payments under the unemployment insurance program to levels that were beyond the ability of the system to finance. By the end of December 1987, the Railroad Retirement Unemployment Insurance Account was $745 million in debt. To balance this account, a special repayment tax of 4 percent of the taxable earnings base is being levied on rail employers from 1989 to 1999.

Section IV: Income Support Programs

Income support programs are designed to provide benefits for persons in need. To be eligible for such programs, a person must have income and assets below a certain level and often must meet other eligibility criteria.

In the 19th century, relief or charity was viewed largely in the context of the English Poor Law and was given as sparingly as possible. Such relief, provided by cities, towns, and counties, typically took the form of food and/or shelter rather than cash assistance.

During the 1920's, the idea that certain categories of the poor, such as the aged or the blind, could not reasonably be expected to provide for themselves on the same basis as the young and able-bodied received growing acceptance. Programs of direct cash assistance for such persons gradually gained ground in the United States, and by 1929 nearly half the States had some kind of cash assistance program.

In 1932, the Congress passed the Emergency Relief and Construction Act. This law provided money for State and Federal public works projects. It made available $300 million to be loaned to the States for relief purposes. These loans were never repaid and, in fact, they constituted the first Federal grants-in-aid for public assistance.

By the beginning of 1933, 12-14 million Americans were unemployed and 19 million—nearly 16 percent of the population—were on State relief rolls. In that year, the Federal Emergency Relief Act was passed to help alleviate this burden on the States. This Act authorized $500 million in grants to the States for relief purposes. During the next 2 years, the Federal Government channeled $2.5 billion to State relief administrations, which distributed the monies to local government authorities. By 1934, old-age assistance was provided in 28 States and aid to the blind in 24.

The Social Security Act of 1935 established two categorical Federal-State grant programs:

- **Old-Age Assistance and Aid to the Blind.**—The 1935 act specified that the Federal Government would pay half the cost of State benefits to the needy aged and blind, up to $15 per month per person. This amount was increased on an ad hoc basis over the years. In 1950, eligibility was extended to the permanently and totally disabled. In 1972, the programs of Old-Age Assistance, Aid to the Permanently and Totally Disabled, and Aid to the Blind were replaced by the Supplemental Security Income (SSI) program. This program guarantees a minimum monthly benefit to needy aged, blind, and disabled persons who meet federally established eligibility criteria. Most States supplement the Federal benefits.
- **Aid to Dependent Children.**—This program, with modifications over the years, has become the program of Aid to Families With Dependent Children (AFDC).

Today, SSI and AFDC are the major cash assistance programs for those in financial need. In addition, a number of programs provide cash or in-kind benefits for special needs or purposes. Several programs offer food and nutritional services. The largest in terms of expenditures is the Food Stamp program, which provides coupons to be used to purchase food. In addition, various Federal-State programs provide energy assistance, public housing, and subsidized housing to individuals and families with low incomes. General assistance may also be available at the State or local level.

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, effective in January 1974. The establishment of this unified program ended the multiplicity of eligibility requirements and benefit levels that had characterized the assistance programs formerly administered at the State and local levels.

Under the SSI program, eligibility requirements were made uniform for both income and resources required to qualify for benefits and

with respect to the definitional requirements such as age of eligibility and medical conditions of disability and blindness.

Federal benefit payments under SSI were also made uniform so that qualified individuals are guaranteed the same minimum amount regardless of where they live. The SSI program also established uniform amounts of income to be excluded when determining the eligibility of an individual or couple.

Eligibility for SSI

The SSI program provides monthly cash payments to any aged, blind, or disabled person whose countable income is less than $4,416 per year, as of January 1, 1989. To qualify as an aged person, an individual must be at least 65 years old.

The qualifying standards for payments based on disability under SSI are 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 (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 12 months. Those who received assistance under their State program of Aid to the Permanently and Totally Disabled in December 1973 and for at least 1 month before July 1973 were eligible for SSI as long as they continued to meet that definition of disability. For a child under age 18, the disability must be of comparable severity to that of an adult.

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 with tunnel vision of 20 degrees or less. Blind recipients who were transferred to the SSI rolls may continue to meet the less strict State standards in effect in October 1972. Such persons are considered blind for purposes of the SSI program so long as they continue to meet that State definition.

Benefit Amounts

For the year beginning January 1, 1989, a maximum Federal monthly SSI payment of $368 is payable to eligible individuals living in their own households. To receive this maximum amount, individuals generally must have no more than $20 in other income. Eligible couples, in which both husband and wife are eligible for SSI by reason of age, disability, or blindness, may receive a maximum Federal monthly payment of $553. In addition, as discussed subsequently, the Federal payments are supplemented in all but two States.

Federal payments are adjusted automatically to reflect Social Security cost-of-living increases. Under the SSI program, States may not reduce their supplemental payments to offset any increase in the Federal amount. This assures that recipients will receive the full amount of the automatic increases. In December 1988, nearly 4.1 million persons were receiving Federal SSI payments averaging $227 per month (table 9).

Factors Affecting Benefits

The basic SSI payment is reduced by the amount of other income and support available to the recipient. Recipients who live in another person's household and receive support and maintenance there receive only two-thirds of the

Table 9.—Number of persons receiving federally and State-administered SSI payments and average monthly benefit amount, by reason for eligibility and type of payment, December 1988

Type of payment	Total [1]	Aged	Blind	Disabled
	Number of persons (in thousands)			
Total	4,541	1,464	83	2,993
Federally administered:				
Federal SSI payments	4,089	1,245	74	2,770
Federal SSI payments only	2,579	825	43	1,711
Federal SSI and federally administered State supplements	1,510	420	31	1,059
State supplement:				
Federally administered supplements only	375	188	9	178
State-administered supplements only	78	31	[2]	45
	Average monthly benefit amount			
Total	$263	$193	$309	$296
Federal SSI payments	227	156	250	259
Federally administered State supplements	123	124	172	120
State-administered State supplements	124	118	129	125

[1] Includes persons for whom reason for eligiblity was not available.
[2] 452 persons.

basic SSI payment. Recipients who are in public or private institutions and who have more than one-half the cost of their care paid for by the Medicaid program receive a maximum SSI payment of $30 per month while they are in the institution. However, those in public institutions not covered by Medicaid are generally ineligible for SSI. An individual may be eligible if the institution is a publicly operated community residence with no more than 16 residents. In addition, payments may be made to persons who are residents of public emergency shelters for the homeless for a period of up to 6 months in a 9-month period.

For individuals whose expected institutional stay on admission is not likely to exceed 3 months and for whom the receipt of benefits is necessary to maintain living arrangements to which they may return, continued payment of SSI benefits for up to 3 months is permitted at the rate that was applicable in the month prior to the first full month of institutionalization. Continued payments may also be made for up to 2 months for individuals who were eligible under section 1619 of the Social Security Act (related to work incentives).

If the recipients have other income, SSI payments generally are reduced. However, the first $20 per month of most unearned income is not counted. (If the $20 exclusion is not exhausted by unearned income, the remaining exclusion amount is applied to earned income, if any.) Any additional unearned income received by recipients during the month (most often a Social Security benefit) reduces SSI payments dollar for dollar. Under 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.

In order to encourage SSI recipients to work, earned income is treated differently. In addition to the initial $20 a month exclusion, $65 of earned income in any month is also excluded from countable income. Thereafter, SSI payments are reduced by $1 for every $2 earned.

Income from a number of other sources is excluded when determining payment amounts. These sources include income from scholarships, certain amounts of earnings of students, work expenses of blind persons, impairment-related work expenses of the disabled, and payments for providing foster care to an ineligible child. Income necessary for an approved plan of 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 provides additional work incentives—special SSI benefits and Medicaid coverage—to blind and disabled individuals eligible for SSI payments but who work despite severe impairments. This legislation made permanent and improved section 1619 of the Social Security Act, which was enacted as a temporary demonstration project in 1980.

Under section 1619, a disabled recipient who loses Federal SSI eligibility because of earnings over the substantial gainful activity level may continue to receive a special benefit 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. States have the option of supplementing this special benefit.

In addition, blind or disabled recipients who are no longer eligible for either regular or special SSI payments because of their earnings may retain Medicaid eligibility under the following conditions: (1) They continue to have the disabling impairment; (2) they meet all nondisability eligibility criteria except for earned income; (3) they would be seriously inhibited from continuing employment without Medicaid services; and (4) their earnings are insufficient to provide a reasonable equivalent of SSI payments and Medicaid.

The amount of assets a person may hold and be eligible for SSI is limited. In most cases, the limits are $2,000 for an individual and $3,000 for a couple. However, certain resources are excluded from the total. The most important of these exclusions is a house 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's household uses it for essential transportation (for example, to go to work or to obtain medical treatment) or if it is modified to be operated by or for transportation of a handicapped person.

If an automobile cannot be excluded based on the nature of its use, it may be excluded up to a current-market value of $4,500.

A recipient's life insurance policies are not countable if the face values do not exceed $1,500 per insured. Finally, 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. The value of burial spaces for a recipient, spouse, and immediate family member is excluded. There also is a provision for the exclusion of funds set aside for burial.

State Supplementation

The SSI legislation provided that anyone who received assistance under the former State assistance programs before January 1, 1974 (the date of SSI's implementation), 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 the Federal payment in order to maintain that assistance level. In addition, States have the option of supplementing the payments of their SSI recipients, whether they initially were awarded SSI or transferred from the prior State assistance programs.

A State may administer its supplemental payments or choose to have them administered by the Federal Government. When a State chooses Federal administration, the Social Security Administration (SSA) maintains that State's payment records and issues the Federal payment and the State supplement in one check. SSA assumes the cost of administering these supplements and is reimbursed by the State only for the amount of the supplementary payments. However, if a State chooses to administer its own supplementary payments, it processes applications and makes eligibility determinations separately from the Federal Government. As of January 1989, about half the States were administering their own supplementary payments.

The States are permitted a great deal of discretion in their optional supplementation levels. 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 a State. States may also differentiate among geographic regions, although not more than three may be recognized in a State.

States that administer their own supplementary programs have even greater discretion over their supplementation criteria. Some States rely on individual determination of need; others provide a supplement to all persons who qualify for SSI. In December 1988, 2.2 million persons were receiving State supplements; the average payment was $123. Of the 2.2 million recipients, 1.9 million were receiving federally administered supplements, and 270,000 were receiving State-administered supplements.

Administration

Federal SSI payments and the administrative costs of federally administered State supplements are financed from Federal Government general revenues. Total payments for calendar year 1988 were $13.8 billion, of which $10.7 billion was for Federal SSI benefit payments. Federally administered State supplements totaled $2.7 billion and State-administered supplements totaled $380 million.

Applications for SSI payments are taken at SSA district offices where the supporting documentation is examined, and the district office staff determines if the applicant meets the program criteria on age, income, and assets. When disability or blindness is involved, medical determinations of eligibility are made by the State disability determination agencies. The SSA district offices may also make emergency payments of up to $368 to an eligible individual and $553 to a couple (plus the federally administered State supplementary payments if any), if severe financial difficulty is evident.

Computation of benefit amounts is made through SSA's central computer operations. Certification is then made to the Treasury Department for the issuance of monthly checks.

Aid to Families With Dependent Children

The Social Security Act of 1935 included a provision that authorized matching grants to the States for financial assistance to dependent children. The 50 States, the District of Columbia, the Virgin Islands, Guam, Puerto Rico, and American Samoa now operate a program known as Aid to Families With Dependent Children (AFDC). The program aids children in families where need is brought about by

incapacity, death, continued absence, or unemployment of a parent.

Basic Program Principles

The AFDC program authorizes Federal matching grants to assist States in providing cash and certain noncash services to needy families with dependent children. The program is financed by Federal and State funds. Through formula grants to the States, the Federal Government matches State expenditures for assistance payments at a rate that varies by State. The Federal share of AFDC payments is determined in a way that provides a higher percentage of Federal matching to States with lower per capita incomes and a lower percentage to States with higher per capita incomes. The Federal Government also pays a certain percentage of the costs related to program administration and training and the costs for acquiring and implementing Statewide management information systems. Federal administration is the responsibility of the Family Support Administration, Department of Health and Human Services (DHHS). To qualify for grants, the States must comply with the Federal guidelines set forth in title IV, part A of the Social Security Act. The most important of these are:

- —Anyone wishing to apply for AFDC will be given an opportunity to do so.
- —Assistance will be confined to those in need.
- —An applicant's income and resources must be considered in determining eligibility and payment levels.
- —The AFDC program must be Statewide and either administered by a single State agency or, if locally administered, supervised by a single State agency.
- —Assistance must be provided promptly and an opportunity for a fair hearing must be given to anyone whose application is denied or whose payment is reduced or terminated.

In addition, the State must participate financially in its AFDC program, based on the grant formula for the State's share, and must submit for the Federal Government's approval a plan for administering the program. States may not exclude eligible individuals from participating in the program on the basis of citizenship or residency requirements. Within these broad guidelines, the States determine eligibility requirements and the amount of assistance. Among the States, choices on these matters vary greatly.

The factor with the greatest variability is the needs standard—the dollar amount that a State determines is essential to meet a minimum standard of living in that State for a family of specified size. On January 1, 1989, for example, the monthly needs standard for a family of three was $539 in New York, $421 in Colorado, and $368 in Mississippi.

In computing its needs standard, a State takes into account allowances for food, clothing, shelter, utilities, and other necessities. The family's need is theoretically equal to the difference between the determined needs standard for a family of given size and the actual income and resources available to the family. However, the States are not required to provide the full amount of this difference. States have statutory and administrative ceilings on the amount that may be paid, which may result in assistance payments below the needs standards. Payment standards are adjusted periodically by the States, based on their fiscal abilities. The Family Support Act of 1988 requires each State to evaluate its own need and payment standards at least once every 3 years, with special attention given to the adequacy of payments for shelter.

In January 1988, average monthly payments per family ranged from a low of $113.60 in Alabama to a high of $662.45 in Alaska. Average monthly payments per recipient ranged from $38.10 in Mississippi to $255.70 in Alaska. Nationwide, the average benefit per family was $366.60; per recipient it was $125.70.

Payments are usually made directly to AFDC recipients. However, individuals who are physically or mentally incapable of managing their own funds may have their payments go to a representative payee on their behalf. In some States, at a recipient's request, payments for rent and utilities may be made directly to a landlord or a utility company.

Eligibility

In January 1988, 3.7 million families—consisting of 10.9 million children and their parents—received $1.4 billion in AFDC payments in the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

The eligibility requirements for AFDC are set by the jurisdictions based on the provisions of the Social Security Act. In all jurisdictions, children to be assisted must be needy and deprived of parental support or care by reason of death, continued absence from the home, or physical or mental incapacity of a parent. The children

must be living in the home of a parent or other relative. Some 27 States, the District of Columbia, and Guam have unemployed parent programs that permit children to receive payments if the principal wage earner in the family is present but unemployed. To qualify, children must generally be under age 18. At a State's option, children aged 18 may also be eligible if they are full-time students in a secondary school or in the equivalent level of vocational or technical training and may reasonably be expected to complete the program before reaching age 19. Effective October 1, 1990, all States will be required to have an unemployed parent program with a work requirement. The same requirement will be effective in the territories on October 1, 1992.

A State may, at its option, provide assistance to a pregnant woman during the last 4 months of pregnancy if she has no other eligible children. Pregnant women are exempted from the work registration or training requirement beginning with the 6th month of a medically verified pregnancy.

To be eligible for AFDC, individuals must be either United States citizens or aliens lawfully admitted for permanent residence in the United States. In general, aliens who are refugees, conditional entrants, parolees, or asylees may be eligible for AFDC. However, aliens sponsored by private individuals are not usually eligible until 3 years after they enter into the United States because they are considered to have the income and resources of their private sponsors. Aliens who are sponsored by public or private agencies are also ineligible for a period of 3 years, unless the agency or organization ceases to exist or has become unable to meet the alien's needs.

When a stepparent lives with an AFDC family in a State that does not have a law of general applicability, for example, a law that holds the stepparent legally responsible to the same extent as a natural or adoptive parent, Federal law requires that a specified formula be used to count the amount of the stepparent's income available to the AFDC unit. In States with laws of general applicability, the same AFDC laws and regulations that apply to natural or adoptive parents apply to stepparents.

The needs, income, and resources of parents, legal guardians, and siblings (except Supplemental Security Income recipients or those who receive foster care) living in the same assistance unit as the dependent child must be taken into account. An assistance unit includes those persons in a household whose need and income are considered when determining the amount of assistance. Effective October 1984, the income of parents or legal guardians of a minor parent must also be counted if all parties are living in the same household. Other financial conditions for eligibility may be imposed on recipients, and they vary from State to State. Some States, for example, impose liens on the real property of recipients.

Eligibility is limited to families whose gross income is at or below 185 percent of the State standard of need. To encourage recipients toward self support, Federal law provides for disregarding some earned income in determining the amount of the AFDC payment. The first $90 of monthly earned income from full- or part-time employment is disregarded as a work expense deduction for both applicants and recipients. Further, $30 per month is disregarded for 12 months and, during the first 4 consecutive months of earnings, an additional one-third of earned income is disregarded. Finally, the actual per child monthly cost of child care—up to $175 for older children and up to $200 for infants—is deducted. Earned income is the amount of gross earnings rather than take-home pay. All other income is considered in determining the AFDC payment.

Assets held by AFDC applicants are considered when determining their eligibility. States must set a limit of $1,000 or less on the equity value of the resources that an assistance unit may own. Exceptions to the equity value limit include the value of a home owned and occupied by the assistance unit, the equity value of a car worth up to $1,500, a similarly valued burial plot or burial insurance policy, and, at State option, the value of basic essential items such as clothing and furniture of limited value.

Effective October 1, 1990, States must establish and have in operation a Job Opportunities and Basic Skills (JOBS) training program, which will replace the Work Incentive Program (WIN). By October 1, 1992, JOBS must be offered in all political subdivisions of a State, unless it is not feasible, because of the local economy and/or other factors. Essentially, the JOBS program must include educational activities, such as high school or equivalent education; basic and remedial education, including education for those whose English is less than proficient; and job skills training, job readiness, and job development and

placement. In addition, two of the following services are required:

—group and individual job search;

—on-the-job training;

—work supplementation; and

—community work experience programs (CWEP) or other work programs approved by the Secretary.

States must make an initial assessment of the education, child-care needs, work experience, skills, employability of each participant, and of the individual's family circumstances. Based on the assessment, the State in consultation with the participant must develop an employability plan. The participant will be notified of the services that the State agency will provide and of the activities (for example, child care and support services) that will support the employment goal. The need for supportive services, resource availability, employment opportunities and, to the maximum extent possible, participant preferences will be taken into consideration in developing the plan.

When a family receives AFDC payments because of continued absence of a parent, the local welfare agency must notify the local child support enforcement agency. As an eligibility requirement for AFDC, the custodial parent or caretaker relative must assign all rights to child support payments to the State, except for the first $50 collected per month per family.

Local child support enforcement agencies enforce the collection of obligations (child support payments). They provide services to welfare agencies, such as locating absent parents, establishing paternity, and obtaining support agreements. In addition to AFDC recipients, these agencies also assist other single parents regardless of their income level.

States use a number of methods to collect child support payments and past due amounts. These methods include: (1) direct payment to the agency by the individual who owes support, (2) withholding Federal and State tax refunds, (3) withholding unemployment compensation, (4) imposing liens on property, (5) establishing security and bonding conditions, (6) assignment of wages, and (7) notifying credit bureaus about overdue child support payments.

Administration and Financing

The cost of AFDC is shared by Federal, State, and local governments. Since 1958, the sharing formulae have been designed to provide higher Federal matching rates to States with more limited resources than to other States. The formula provides for varying, in relation to the annual per capita income of a State, the percentage of Federal participation in that part of the payment that is above a specified amount. A maximum percentage that varies, among the State programs, limits the amount of payments to be shared and the ratio of Federal sharing. The States may make higher payments by using State and/or local money.

Under the regular matching formula for AFDC, the Federal share is 5/6 of the first $18, with a maximum of $32 per recipient subject to Federal participation. The proportion applied to the average amount above the first $18 varies from 50 percent to 65 percent, depending on the State's fiscal capacity as measured by its annual per capita income. The same formula is applied to certain children in foster care, but the maximum payment is $100 per month for each child.

If it yields more Federal funds than the regular formula, States with an approved Medicaid plan may apply the Medicaid formula on a unified basis for both their AFDC and Medicaid reimbursements. This provides for Federal matching, again varying with the State's per capita income, of from 50 percent to 83 percent of the aggregate amount spent for cash payments and medical assistance to recipients. In 1989, all States use this more generous formula for calculating reimbursement, rather than the regular matching formula.

Generally, most service costs and other administrative expenses incurred under public assistance programs are shared equally by the Federal Government and the States. However, the Federal share can be increased to 75 percent of the cost of certain fraud prevention activities, and to 90 percent of the cost of implementing an approved Statewide management information system.

Under the JOBS program, 90 percent of approved program costs may be matched up to the amount of State expenditures under its allotment for the WIN program in fiscal year 1987. For additional amounts, the Medicaid matching rate is used for the Federal share, with a minimum Federal match of 60 percent, for nonadministrative costs and for personnel costs for full-time staff working on the JOBS program. A 50-percent matching rate has been authorized for other administrative costs and transportation and services.

Federal participation in the AFDC program is administered by the Family Support Administration under DHHS. The agency reviews and approves State plans and

grants, provides technical assistance, evaluates State operations, sets standards, and collects and analyzes statistics related to the program.

Each State has an agency that administers public assistance programs. Some States administer the program directly; others operate through local or county authorities supervised by the State agency. All of the federally aided programs must be administered by personnel selected through a merit system.

A person usually applies for assistance at a local public welfare office. The State must give an individual the opportunity to apply for assistance and to provide assistance with reasonable promptness to all eligible persons. Under the State plan, the local agency performs the investigatory and service functions.

Anyone whose claim is denied or delayed or whose grant is to be reduced or discontinued may request and is guaranteed a fair hearing with the State agency making such determinations.

Food Stamps

Initiated on a pilot basis in 1961, the Food Stamp program was formally established by the Food Stamp Act of 1964, with 22 States participating. Under this program, single persons and individuals living in households meeting nationwide standards for income and assets may receive coupons redeemable for food and accepted at most retail food stores. The value of the coupons that a unit receives each month is determined by the household size and income. Households without income receive an amount equal to the determined monthly cost of a nutritionally adequate diet for their household size. This amount is updated to account for food price increases. As of October 1988, an eligible four-person household with no income received $300 per month in food stamps. Households with income receive food stamps valued at the difference between the determined cost of a nutritionally adequate diet and 30 percent of their income, after certain allowable deductions have been made.

To qualify for the program, a household must have (1) less than $2,000 in disposable assets ($3,000 in assets if one member is aged 60 or older and the household has at least two persons), (2) gross income below 130 percent of the poverty income guidelines for the household size, and (3) net income lower than 100 percent of the poverty income guidelines after subtracting the five deductions listed below. Households with a person aged 60 or older or a disabled person receiving either Supplemental Security Income (SSI), Social Security (OASDI), or veterans' disability benefits may have gross income exceeding 130 percent of the poverty guidelines if, after subtracting the deductions listed below, the income is lower than 100 percent of the poverty income guidelines. All households, including those receiving other Federal assistance payments, must meet these requirements. One- and two-person households that meet the applicable standard receive at least $10 a month in food stamps.

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

(1) Twenty percent of earned income.
(2) A standard deduction of $106 (this amount is updated in October of each year).
(3) The amount paid for child care (up to $160 a month) while the child's caretaker is working or looking for work.
(4) Any medical expenses in excess of a $35 deductible for an aged or disabled person. If more than one person in the household is aged or disabled, $35 is subtracted for each person before deducting combined medical expenses.
(5) An excess shelter deduction—which is total shelter costs, including utilities, minus 50 percent of income after all the above deductions have been subtracted. Effective October 1, 1988, the

monthly limit is $170 for households without aged or disabled persons. Households with an aged or disabled person do not have a limit on this deduction.

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 payments or Social Security benefits are certified for a 1-year period. Households must report monthly income or expense changes of $25 or more or other changes in circumstances that would affect eligibility. Families with income or food loss resulting from natural disasters such as tornadoes or floods may be eligible for food stamps for up to 1 month if they meet the special disaster income and asset limits.

Special provisions allow drug addicts, alcoholics, or blind or disabled residents in certain group living arrangements, residents in shelters for battered spouses and children, and persons aged 60 or older to use their coupons for meals prepared at a nonprofit facility. Households whose members are aged 65 or older or are mentally or physically handicapped may be certified for food stamps through a telephone interview or a home visit.

The Food Stamp program is in effect in the 50 States, the District of Columbia, Guam, and the Virgin Islands. (Beginning in July 1982, Puerto Rico began receiving a block grant for nutrition assistance but the commonwealth does not participate in the Food Stamp program.) The Food Stamp program is administered nationally by the Food and Nutrition Service of the Department of Agriculture and operates through local welfare offices and the Nation's food marketing and banking systems. Since August 1, 1980, persons receiving or applying for SSI payments have been permitted to apply for food stamps through local Social Security district offices. The Federal Government, through general revenues, pays the entire cost of the food stamps, but Federal and State programs share administrative costs.

Originally, food stamp coupons were purchased by participants. The difference between the face value of the coupons and the amount the participant paid was known as the "bonus value." The amount paid for coupons varied according to household income. Legislation in 1971 required family allotments large enough to purchase a nutritionally adequate diet, established national eligibility standards, provided free food stamps to the poorest recipients, required automatic cost-of-living increases in food stamp allotments, and established work registration requirements for able-bodied adult household members up to age 65 (except students and those needed at home to care for children). Legislation in 1973 expanded the program (while phasing out the family food distribution program), provided for semiannual adjustments of coupon allotments, and broadened the categories of persons eligible to participate.

Major legislative changes in 1977 eliminated the purchase requirement and allowed households to receive only the bonus portion of their coupon allotments. Income deductions were limited to a standard deduction, a 20-percent earnings deduction, and a limited combined excess shelter and child-care deduction. The poverty income guidelines became the new eligibility limits and, for the first time, households receiving Aid to Families With Dependent Children (AFDC) or SSI payments were required to meet asset and income limits. The work registration exemption requirements were tightened for students and for caretakers, whose children now had to be under age 12. The age the registration exemption for older persons became effective was lowered from 65 to 60. Legislation in 1979 provided a medical deduction to aged and disabled persons, removed the limit on their shelter deduction, and tightened fraud provisions.

The 1980 legislation provided for an annual, rather than biennial, updating of the cost of an adequate diet and the amount of the standard deduction. This legislation also restricted student benefit eligibility.

The Omnibus Budget Reconciliation Act and the Food Stamp and Commodity Distribution Amendments of 1981 mandated further changes in the Food Stamp program. For the first time, a "gross income" eligibility standard was applied to all households not containing an aged or disabled person. The earnings deduction was lowered to 18 percent and the updates to deduction limits and to Thrifty Food Plan (TFP) cost increases to account for inflation, were postponed until July 1983 and October 1982, respectively. For new participants benefits from the first month were prorated to the day the application was filed. Boarders and persons who take part in strikes were excluded from the program and the definition of what constitutes a household was tightened. Provisions facilitating claims and overpayment collection and fraud recovery were also enacted. The program in Puerto Rico was replaced by a block grant and effective October 1983 monthly reporting/retrospective accounting

systems were made mandatory for all States. However, households composed solely of aged or disabled persons, as defined above, were exempted from the monthly reporting requirements, and migrant households were exempted from both requirements.

Further revisions were made by the Food Stamp Amendments of 1982. Among these changes, the scheduled adjustment to the TFP was reduced 1 percent and adjustments to the standard and shelter deductions were delayed until October 1, 1983. (Public Law 98-473 restored maximum food stamp allotments to the full cost of the TFP beginning November 1, 1984.) A new income limit for nonelderly and nondisabled households was added to the existing gross income limit. Benefit computations and adjustments were rounded down to the nearest dollar, and new restrictions were placed on the use of standard utility allowance. At the same time, the definition of disability for food stamp purposes was expanded to include certain veterans' payments, and annual cost-of-living adjustments to SSI payments and Social Security benefits were not counted in determining food stamp amounts for 3 months.

The Food Stamp program authorization was extended for 5 years by the Food Security Act of 1985 (Public Law 99-198). Among the revisions enacted, the definition of disability for food stamp eligibility purposes was again extended to include recipients of State supplementary SSI payments, government disability benefits, and Railroad Retirement disability payments. Households in which all members receive AFDC or SSI were made categorically eligible for food stamps. The earned income, child care, excess shelter cost deductions, and asset limits were increased as of May 1986. A portion of the income received under the Job Training Partnership Act was made countable income. Further, all States were required to implement an employment and training program for food stamp recipients by April 1987.

The Hunger Prevention Act of 1988 (Public Law 100-435) made several changes in the program. It raised the maximum food stamp allotments and established allotments as specified percents of the Thrifty Food Plan as of the preceding June. For fiscal year 1989, the allotments are 100.65 percent of the TFP as of June 1988; for fiscal year 1990, they are 102.05 percent of the TFP for June 1989; and for fiscal years 1990 and on, they are to be 103.00 percent of the TFP.

Other provisions of the 1988 legislation required States to institute prospective budgeting for households not required to report monthly and retrospective budgeting for households reporting monthly. It made permanent an amendment in the Homeless Eligibility Clarification Act that exempts residents of shelters from ineligibility as residents of institutions. Several provisions of the 1988 legislation also affect persons in farming. Households with farm income and expenses were given the option of averaging irregular farm-related expenses and farm income over 12 months and excluding as resources the value of farm land, equipment, and supplies for a period of 1 year after a household member ceases to be self-employed in farming.

An estimated 18.7 million persons received food stamps during fiscal year 1988. The average monthly value of food stamps per person was $50.04 and the total value of stamps issued during the year was $11.2 billion. Fiscal year 1989 issuances are expected to be about $11.4 billion.

Supplemental Food Program for Women, Infants, and Children

The Supplemental Food Program for Women, Infants, and Children (WIC) is a Federal nutrition and health assistance program designed to help pregnant and postpartum women, infants, and children up to 5 years of age, who are identified by health professionals as being at nutritional risk. Participants usually receive vouchers or checks that are redeemable for nutritious supplemental foods at participating retail grocery stores (worth about $33.4 dollars per person per month in fiscal year 1988), nutrition education, and access to health services.

Individual applicants must be residents of the State in which they receive benefits. The major eligibility criteria are divided into

three areas: (1) Category, (2) income, and (3) nutritional risk. They require that:

(1) An individual must be either a pregnant, breastfeeding, or postpartum woman; an infant under 1 year of age; or a child under 5 years of age.

(2) Household income must be below 185 percent of the poverty income guidelines, although States may set lower standards if the standards are consistent with those for State or local health programs. In no instance can the income criteria be below 100 percent of the poverty income guidelines. Currently, 14 States have set income eligibility criteria below 185 percent of the poverty income guidelines.

(3) An individual must have a medical, nutritional, or dietary disorder diagnosed by a health professional. The risks include anemia, underweight, history of poor pregnancy outcomes, or inadequate dietary pattern.

The WIC program is administered at the Federal level by the Food and Nutrition Service, Department of Agriculture. Grants are made to all 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and to 33 Indian tribes or associations. Local public or nonprofit private health or welfare agencies apply to the State to qualify to receive funds from this program. Individual participants apply to 1 of the approximately 7,600 approved local clinics that provide WIC services.

The WIC program is authorized under Section 17 of the Child Nutrition Act of 1966. Federal program costs in fiscal year 1988 were $1.80 billion, of which 80 percent was used to fund benefits. Average monthly participation was 3.6 million individuals—814,000 women, 1,096,000 infants, and 1,683,000 children. Estimated costs for fiscal year 1989 are $1.90 billion. Participation has grown steadily since the program's inception in 1974: More than 30 percent of the infants born in the United States participate in this program.

School Lunches

The national school lunch program is designed to help safeguard the health and well-being of the Nation's children by assisting the States in providing an adequate supply of food for all children at a moderate cost and to encourage the domestic consumption of nutritious agricultural commodities. All students eating lunches prepared at participating schools pay less than the total cost of the lunches. Children, in public and nonprofit private schools or residential child care institutions, who are determined by local school officials to be unable to pay the full established price for lunches receive their lunches free or at a reduced price.

Before January 1981, children were eligible for free school lunches if the income for their household was below 125 percent of the poverty income guidelines. They were eligible for a reduced-price lunch if the income in the household was 125-195 percent of the poverty guidelines. For these purposes, the term "income" excluded certain Federal benefits and specified hardship expenses. Effective January 1981, the hardship exclusion was replaced by a standard deduction. Beginning August 1981, the income definition was amended to a "gross income" concept and the standard deduction was eliminated. At the same time, the income eligibility criteria were changed to below 130 percent of the poverty income guidelines for free lunches and to between 130 percent and 185 percent of the poverty guidelines for reduced-price lunches. The Secretary of Agriculture revises income eligibility requirements each July 1 to reflect the latest Federal poverty income guidelines.

The national school lunch program is administered by the Food and Nutrition Service of the U.S. Department of Agriculture (USDA) through State educational agencies or through regional USDA nutrition services for some nonprofit private schools. All participating schools receive cash assistance.

Participating schools are reimbursed for every lunch they serve. Reimbursement is, in part, from funds made available under

Section 4 of the National School Lunch Act of 1946, as amended; reduced-price and free lunches receive additional funds under section 11 of the act. The amount of cash that schools are reimbursed (national average payment) is adjusted annually to reflect changes in the "food away from home" component of the Consumer Price Index for Urban Consumers.

Commodity schools are now eligible under section 11 for free and reduced price meal reimbursements in addition to the receipt of commodities.

During fiscal year 1989, Federal obligations under the school lunch program are approximately $3.2 billion. For the period July 1, 1988, through June 30, 1989, general cash assistance for lunches is 14.00 cents, plus an additional 92.25 cents for each reduced-price lunch and 132.25 cents for each free lunch. The national average value of donated commodities is 12.25 cents for each lunch.

Low-Income Home Energy Assistance Program

The Low Income Home Energy Assistance Program (LIHEAP) provides block grants to the 50 States, the District of Columbia, Puerto Rico, insular areas, and Indian tribal organizations to assist eligible households in meeting the costs of home energy. The program was established under title XXVI of the Omnibus Reconciliation Act of 1981 and has been in effect since fiscal year 1982. The LIHEAP is administered at the Federal level by the Department of Health and Human Services (HHS), which has administered energy assistance programs since fiscal year 1980.

Energy assistance programs in fiscal years 1977-79 were administered by the Community Services Administration. These earlier programs focused on crisis assistance to households facing immediate hardships. Annual funding for these programs was about $200 million.

For fiscal year 1989, a total of $1.4 billion was appropriated by the Congress for low-income home energy assistance. For fiscal year 1988, the appropriation was $1.5 billion.

The estimated number of households receiving home energy assistance in fiscal year 1988, by type of assistance, is shown below.

[In thousands]

Heating	5,907
Cooling	338
Energy crisis intervention:	
Winter	979
Summer	60
Low-cost energy weatherization/ energy related repair	202

These estimates were obtained from the HHS fiscal year 1988 LIHEAP Summer Telephone Survey. 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.

Eligible households may receive funds for heating and cooling costs and for weather-related and supply-shortage emergencies. The States must submit an application consisting of assurances by its chief executive officer and a plan describing how the State will carry out those assurances. In the assurances, the State agrees to:

- Use funds only for the purpose of the statute.
- Make payment only to eligible low-income households.
- Conduct outreach activities.
- Coordinate activities with similar and related programs.
- Provide, in a timely manner, the highest level of assistance to households with the lowest incomes and the highest energy costs in relation to income, taking into account family size.
- Give consideration to agencies that have managed the program before when designating local agencies to carry out the purposes of the program.
- Ensure that energy suppliers receiving benefits directly on behalf of eligible households will not treat assisted households differently from nonassisted households.
- Treat owners and renters equitably.
- Use not more than 10 percent of its allotment for planning and administration.
- Establish fiscal control and accounting procedures for proper disbursal of and accounting for Federal funds,

establish procedures for monitoring assistance provided, and prepare an annual audit.
- Permit and cooperate with Federal investigations.
- Provide for public participation in the development of its plan.
- Provide an opportunity for a fair administrative hearing to individuals whose claims for assistance are denied or not acted on with reasonable promptness.
- Cooperate with the Secretary of HHS with respect to data collection and reporting under section 2610 of the statute.

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. The act limits payments to households with income under 150 percent of the poverty income guidelines or 60 percent of the State's median income, whichever is greater, or to those households with members receiving Aid to Families With Dependent Children, Supplemental Security Income, food stamps, or means-tested veterans' benefits. States are permitted to set more restrictive criteria as well.

States make payments directly to eligible households or to home energy suppliers on behalf of eligible households. Payments may be provided in cash, fuel, or prepaid utility bills, or as vouchers, stamps, or coupons that may be used in exchange for energy supplies.

General Assistance

General assistance is a term used to describe assistance provided by State and local governments not financed in whole or in part by Federal Government funds. General assistance, in the form of direct cash assistance to eligible persons or payments to vendors, may be furnished to needy persons who do not qualify for federally financed assistance programs or who require additional assistance.

The eligibility requirements and payment levels of general assistance programs 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 assistance programs. Recipients include unemployed persons who are ineligible for Aid to Families With Dependent Children (AFDC) or unemployment insurance benefits or individuals who have exhausted their unemployment benefits. In addition, persons whose illnesses are not of sufficient severity to qualify them for Supplemental Security Income may receive general assistance. However, about one-third of the States do not provide general assistance to households containing an employable person, except in specific emergency situations such as fire or flood.

General assistance may be administered by the State welfare agency, a local agency, or a local agency under State supervision. The assistance is usually financed by State and/or local funds, but in almost one-fourth of the States it is financed from local funds only.

Thirty-two States plus the District of Columbia, Guam, Puerto Rico, and the Virgin Islands report general assistance data to the Federal Government. In December 1987, 1.1 million persons in the reporting States received general assistance.

Public Housing and Subsidized Housing

Beginning in the 1930's, the Federal Government provided leadership toward a goal of safe, sanitary, and affordable housing for all Americans. Various Federal, State, and local agencies now administer the housing programs for low-income families. Most are funded and administered by the Department of Housing and Urban Development (HUD). Some programs for rural families are funded by the Department of Agriculture. Federal budget outlays in fiscal year 1988 for housing programs administered by HUD for low-income families and individuals were $11.2 billion. In 1988, these programs were assisting 4.3 million families.

Low-rent public housing projects under the Housing Act of 1937 were the earliest of the Federal rental housing programs. The projects are owned, managed, and administered by a local Public Housing Agency (PHA) or an Indian Housing Authority (IHA). Funds are provided by the State or HUD to the PHA/IHA to cover the capital cost of a project or to provide debt service payments to assure the lower-income character of the project. Additional subsidies are available to cover operating and maintenance service costs and to finance the major reconstruction of obsolete existing public housing projects. The beneficiaries are families and individuals with low income, including families with children, the elderly, disabled, or handicapped. Income standards for initial and continuing occupancy vary by local housing authority, although the limits are constrained by Federal guidelines. Rental charges are set by Federal statute and are not to exceed 30 percent of the adjusted monthly money income of the recipient household. Low-rent public housing programs approved prior to October 1986 receive contributions annually for up to 30 years. Annual appropriations of capital grants started with fiscal year 1987. The average capital cost for an additional unit reserved during fiscal year 1987 was approximately $63,500. During fiscal year 1987, budget authority under the program was reserved for 9,801 additional units and for the major reconstruction of 5,503 units.

The major program is the Section 8 Housing Assistance Payment Program for Very Low Income Families. Housing assistance payments (or rent supplements) are made to participating owners of private sector rental housing on behalf of eligible tenants. These rent supplements include Federal, State, and local funds that make up the difference between the approved rent due the owner for the dwelling unit and the occupant family's required contribution toward the rent. The assisted occupant family is required to contribute up to 30 percent of the adjusted family income toward the rent. By the end of fiscal year 1987, a total of 2.2 million units were receiving subsidies under these programs. Of these units, 1.2 million were existing units, 794,000 were either new construction or had substantial rehabilitation, and 76,000 had undergone moderate rehabilitation.

A housing voucher program was initiated by HUD in 1984 under existing legislative authority as another means to provide a rent subsidy to low-income tenants and to make use of existing privately owned housing. The vouchers provide the renters flexibility to select housing near the jobs and schools of their choice rather than housing in a specific project. This program also makes housing assistance payments directly to participating owners on behalf of eligible tenants. For each tenant the housing voucher is equal to the difference between the fair market "standard" rent in the local community and 30 percent of the tenant's income. It is a HUD policy to provide housing vouchers to tenants displaced by the expiration of contracts with developers of the other forms of housing assistance. As of April 1988, more than 106,000 families were receiving housing voucher benefits.

Low-income families have been provided with the opportunity of purchasing their own homes through the Turnkey program. Initially the units are owned by the local PHA and the tenant family makes payments based on the family's current income and also maintains the home. The amounts the PHA budgeted for maintenance are credited to the family's equity account. Ownership is transferred to the family when the family's income and equity amounts increase to the point that it can obtain permanent financing for the unit. Approximately 14,000 units were included under this program in September 1987.

A comparable program known as Mutual Help Housing for Indian Areas is available from the IHAs. Eligible families are required to contribute $1,500 in labor,

materials, cash, or the homesite (or a combination thereof) in the construction of the housing. During fiscal year 1987, annual contributions contract authority was reserved for approximately 3,700 units of such housing in Indian areas.

The HUD programs also provide for other areas of assistance. One is interest free loans to cover 80 percent of preconstruction expenses for private nonprofit sponsors developing housing projects for the elderly or handicapped. Another is for loans to finance construction or rehabilitation of rental or cooperative housing and related facilities—such as central dining—for the elderly or handicapped. Among the other programs are provisions for loans to finance repairs, additions, and improvements to any multifamily project insured or held by HUD.

The Comprehensive Improvement Assistance Program provides capital cost funding to improve the physical condition and upgrade the management and operation of cost effective, existing public and Indian housing projects to assure their continuing availability to serve low-income families. Through September 1987, approximately $10.4 billion of capital improvements had been financed by this program, and $1.7 billion was available for capital funding of projects in fiscal year 1988. The terms of the contract expect the work to be completed within 36 months and the units to remain available to assist lower income families for a 20-year period. Starting with fiscal year 1987 commitments, funding was changed from loans to capital grants to the PHA/IHAs.

The homeless, and shelter for this segment of the low-income population, are a growing concern. Studies have found that the majority of homeless persons are single. However, in recent years the number of homeless families has grown more rapidly than the number of homeless persons and an increasing share of the homeless population is composed of children. The Stewart B. McKinney Homeless Assistance Act of 1987 is regarded as a first step, an emergency program directed to the problem of the homeless. The act authorizes assistance to deinstitutionalized homeless individuals, homeless individuals with mental disabilities, homeless families with children, and other homeless persons. Initially the budgeted funds are to be used exclusively for transitional housing for these various homeless groups.

Title II of this act establishes an Interagency Council on the Homeless. The Council is to inform the States, local governments, and other public and private nonprofit organizations regarding Federal resources available to assist the homeless. The areas of assistance, in addition to housing, include health care, food, education, job training, and community services, such as assistance in applying for benefits under Federal and State programs. Further, this Council is directed to provide assistance on the ways in which the Federal programs, other than those authorized under this act, may best be coordinated to complement the objectives of this legislation.

Poverty Income Guidelines

The Federal poverty income guidelines are used to determine financial eligibility for assistance or services under certain Federal programs. For specific programs, authorizing legislation or regulations indicate whether a program uses the poverty guidelines or a modification of the guidelines (for example, 130 percent or 185 percent of the guidelines) as one of several eligibility criteria, or for purposes of targeting assistance or services.

The poverty income guidelines are a simplified version of the Federal poverty thresholds that were originally developed by the Social Security Administration for statistical purposes. Since 1973, the poverty income guidelines, which vary by family size, have been computed from the official poverty threshold by increasing the weighted average poverty thresholds from the Bureau of the Census by the percentage change in the Consumer Price Index for Urban Consumers (CPI-U) during the preceeding year and, for a family of four, rounding the value to the next higher $50. Family sizes above and below four are computed by adding or subtracting equal dollar amounts derived from the average difference between poverty guidelines, and rounding to the nearest multiple of $20.

A set of poverty income guidelines is established for the contiguous 48 States and the District of Columbia; separate sets are established for Alaska and Hawaii. They become effective on the date of issuance and remain in effect until the next set is issued. The poverty income guidelines issued in February 1989 are shown in the accompaning table.

Federal poverty income guidelines, February 1989[1]

Family size	The 48 Contiguous States and the District of Columbia	Alaska	Hawaii
1	$5,980	$7,480	$6,870
2	8,020	10,030	9,220
3	10,060	12,580	11,570
4	12,100	15,130	13,920
5	14,140	17,680	16,270
6	16,180	20,230	18,620
7	18,220	22,780	20,970
8	20,260	25,330	23,320

[1] For family units with more than 8 members, add the following amount for each additional family member: $2,040 in the 48 contiguous States and the District of Columbia; $2,550 in Alaska; and $2,350 in Hawaii.

Section V: Sources of Information on Social Security Programs in the United States

This article brings together information on the present status of the major social insurance and means-tested programs in the United States. Because the technical and programmatic details of each program are beyond the scope of the article this list of selected publications relevant to the various programs discussed may be useful. Unless otherwise noted, these publications are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Social Insurance Programs

The **Social Security Handbook 1988** presents the provisions of the Social Security Act as amended through December 31, 1988. It gives a detailed description of the programs under the act: how they operate, who is entitled to benefits, and how benefits may be obtained. The **Handbook** is issued biennially by the Office of Information, Social Security Administration.

The **Annual Statistical Supplement** to the **Social Security Bulletin** presents a compilation of current and historical data on Social Security beneficiaries and covered workers and the economy in general. The 1988 edition contains 228 detailed tables, as well as sections dealing with program definitions, historical program summaries, and current legislative developments in the areas of OASDI, Medicare, SSI, AFDC, the Low Income Home Energy Assistance program, and other related income-maintenance programs. The Supplement is prepared by the Office of Research and Statistics, Office of Policy, Social Security Administration.

Social Security Programs Throughout the World—1987 charts the principal features of the social insurance programs of 141 countries and territories. The programs covered include old-age, invalidity, and death; sickness and maternity; work injury; unemployment; and family allowances. The data are based on laws, implementing decrees, and regulations in force at the beginning of 1987. This report is issued biennially by the Office of International Policy, Office of Policy, Social Security Administration.

The **Health Care Financing Review** is published quarterly by the Health Care Financing Administration's Office of Research and Demonstrations. The journal reports on today's changes and tomorrow's trends in health care financing at the Federal, State, local, and private levels. The

contents of a recent issue include "National health expenditures, 1987," "Medicare: Short-stay hospital services, by leading diagnosis-related groups, 1983 and 1985," and "Medicaid eligibility for persons in nursing homes."

The Medicare and Medicaid Data Book 1988 provides a broad overview of the Medicare and Medicaid programs and provides comprehensive descriptive data for each program. The **Data Book** is issued annually by the Office of Research and Demonstrations, Health Care Financing Administration.

Your Medicare Handbook is written for Medicare beneficiaries. It provides a comprehensive explanation of the Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) plans under the Medicare program. The **Handbook** is issued by the Office of Public Affairs, Health Care Financing Administration.

Comparison of State Unemployment Insurance Laws reports the types of workers and employers who are covered under each State law, the methods of financing the program, the benefits that are payable, the conditions to be met for payment, and the administrative organizations established to do the job. Information also is given on the temporary disability insurance programs. The report is issued and updated semiannually by the Employment and Training Administration, U.S. Department of Labor.

State Workers' Compensation Laws summarizes the provisions of the State laws in 20 tables. In addition to describing the basic provisions on employee coverage and benefits, this publication provides detailed information on statutory coverage of farm and domestic service employees, on permanent partial disability benefits including disfigurement awards, on offset provisions integrating workers' compensation and other program benefits, and on attorney fees. It is issued semiannually by the Employment Standards Administration, U.S. Department of Labor, Room N-414, 200 Constitution Ave., NW., Washington, DC 20210. Copies may be obtained from that office.

Analysis of Workers' Compensation Laws 1988 contains 16 detailed tables on the important provisions of workers' compensation statutes. This document is intended to provide a basis for comparing the various State laws. Besides tables on the main coverage and benefit provisions, this report describes coverage of minors and of occupational diseases; maximum benefits for 14 categories of scheduled injuries; administration, including claims filing procedures and employer reports; and second injury funds. It also contains a directory of State administrators. It is prepared and published annually by the Chamber of Commerce of the United States. Copies are for sale by the Chamber of Commerce of the United States, 1615 H Street, NW., Washington, DC 20062.

Programs for Special Groups

The **Informational Conference Handbook, January 1989** provides detailed descriptions of the history, provisions, and financing of the Railroad Retirement and Railroad Unemployment Insurance programs. It is issued annually by the Office of Public Affairs, U.S. Railroad Retirement Board, 844 Rush Street, Chicago, IL 60611.

Federal Benefits of Veterans and Dependents (IS-1 Fact Sheet) gives a comprehensive summary of the Federal benefits available to veterans and their dependents. It is issued by the Department of Veterans Affairs.

Income Support Programs

Supplemental Security Income Program for the Aged, Blind, and Disabled: Characteristics of State Assistance Programs for SSI Recipients, January 1989 focuses on eligibility provisions and basic levels of assistance payments for persons who receive supplementary payments in the 50 States and the District of Columbia. Additional data on Federal-State administrative responsibility for making payments, on optional State supplementation payments, and payments for special needs are also presented. It is issued anually by the Office of Supplemental Security Income, Social Security Administration, 3-G-3 Operations Building, 6401 Security Boulevard, Baltimore, Maryland 21235. Copies may be obtained from that office.

A Guide to SSI for Groups and Organizations describes the SSI program in detail. This booklet is designed to assist institutions, groups, and organizations that have contact with potential or present SSI recipients. It is issued by the Office of Information, Social Security Administration, 4-J-10 West High Rise, 6401 Security Boulevard, Baltimore, MD 21235. Copies may be obtained from that office.

Quarterly Public Assistance Statistics presents a comprhensive tabular presentation of AFDC State caseload data, AFDC and emergency assistance payments, AFDC applications and case discontinuances, requests for hearings in AFDC, disposition of cases involving a question of fraud under AFDC, and public assistance recipients by metropolitan statistical areas. This report is issued by the Family Support Administration. Copies may be obtained from the Family Support Administration, OFA/DPE, 370 L'Enfant Promenade, SW., Washington, DC 20447.

Analysis of State Medicaid Program Characteristics, 1986 contains the following information on a State-by-State basis: State eligibility policies; service coverage and limitations; provider reimbursement policies; administration and finance characteristics; demographic, economic, and medical sector characteristics; and State-only programs. The report is issued by the Office of the Actuary, Health Care Financing Administration.