

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 programs 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 adjustments, 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 for spouses and children legislated in 1939, and the enactment of assistance programs and insurance for the disabled during the

Social Security Programs in the United States, 1993

This article contains the latest information on the historical development and present status of all the major U.S. social insurance and public aid programs under the Social Security Act: the Social Security program (Old-Age, Survivors, and Disability Insurance); Railroad Retirement; Public Employee Retirement; Unemployment Insurance; Workers' Compensation; State programs for Temporary Disability Insurance; Medicare; Medicaid; Supplemental Security Income; Food Stamps; Aid to Families with Dependent Children; Supplemental Food Program for Women, Infants, and Children; School Lunches; Low-Income Home Energy Assistance; General Assistance; Public and Other Subsidized Housing; and Earned Income Tax Credit. The poverty income guidelines for 1993 are also presented.

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 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 responsibility 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 par-

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ticipation of local government); 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."

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; insurance protection for workers' compensation and temporary disability insurance benefits is underwritten in the private sector; and the States participate in the disability determination for Social Security benefits and SSI payments. 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 domestic product (GDP).

In December 1992, 41.5 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, 1992, the Medicare program covered 31.6 million persons aged 65 or older and 3.6 million disabled persons under age 65. Medicaid benefits were paid on behalf of 31.2 million persons in fiscal year 1992, and the Food Stamp program had 25.4 million participants in fiscal year 1992. Federally administered SSI payments in December 1992 were made to 5.6 million persons, of whom 2.1 million were aged 65 or older. Finally, AFDC payments were received by 14.0 million children and adults in 4.9 million families in December 1992.

Total benefit payments under these

programs were disbursed as follows:

Program	Total payments [In billions]
OASDI.....	\$286.0 in 1992
Medicare.....	133.2 in 1992
Medicaid.....	114.5 in FY 1992
Food Stamp.....	20.9 in FY 1992
AFDC.....	22.1 in FY 1992
SSI.....	22.2 in 1992

Total public welfare expenditures of \$1,045.4 billion represented 19.1 percent of the GDP in fiscal year 1990. They included Federal expenditures amounting to 11.2 percent of GDP, and State and local government expenditures that were 7.9 percent of GDP. Social insurance benefit payments, excluding Medicare, totaled \$406.8 billion; total spending for health and medical care, including Medicare and Medicaid, accounted for \$271.5 billion; and income-support programs, excluding expenditures for health and medical care, came to \$70.3 billion.

Estimated private expenditures for social welfare in 1990 were \$680.7 billion, representing 12.3 percent of GDP. This total includes expenditures of \$383.6 billion for health and medical care; \$66.9 billion for welfare and other services; \$66.9 billion for education; and \$163.4 billion for income-maintenance programs (employee benefits), including employment-related pension benefits, group life insurance, and sickness benefits.

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—*i.e.*, 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 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. While this amount covered the total earnings of 97 percent of those in the labor force, only 56 percent were actually covered by the new program. Although all wage and salary workers in commerce and industry were covered, many individuals—such as self-employed persons, agricultural and domestic service workers, casual laborers, and employees of nonprofit organizations—were not. 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 spouse and children. 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" against dependency resulting from 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.

In the 1970's, a permanent Federal-State program of Extended Benefits (EB) was established which provides additional benefits for workers who have exhausted their regular State benefits during period of high unemployment. The EB program is financed equally from Federal and State funds. Due to the

"triggering" requirement for the program to take effect, only nine States qualified for the extended benefits during the 1991 recession.

To meet more fully the needs of the long-term unemployed during this downturn, legislation providing for a program of Emergency Unemployment Compensation (EUC) was enacted and renewed during 1991-93. The Federal Government pays for all benefits under EUC.

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, provide nearly all revenue for financing benefits and administrative expenses.

In 1992, about 132.9 million individuals were engaged in work covered by the Social Security program. At the end of 1992, 41.5 million persons were receiving cash benefits totaling \$24.4 billion per month. These beneficiaries included 29.3 million retired workers and their family members, 7.3 million survivors of deceased workers, and 4.9 million disabled workers and their family members. Social Security is an important source of retirement income for almost everyone; in 1988, 3 in 5 beneficiaries aged 65 or older relied on their Social Security benefits for at least one-half of their income. It 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 workers aged 21-64 and their families have protection in the event of the workers' 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. Legislation establishing the program was enacted 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 protected effectively 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.—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 reaching 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 an individual's covered employment to determine if it was sufficient enough 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 1940 until 1950, when benefit levels were raised substantially, 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 non-profit 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, farmers, most self-employed professional persons, and State and local government employees under a retirement system under certain conditions) by providing that the 5 years of lowest earnings would 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 through the addition of the Disability Insurance (DI) 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 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 Old-Age and Survivors Insurance program (OASI). The age of first eligibility for retirement benefits was lowered from 65 to 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. 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 the tax rates and the applicable wage base were raised.

In the late 1960's, however, concern was expressed that beneficiaries continued to be vulnerable to substantial declines in purchasing power between benefit adjustments. In 1972, 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 workers who attained age 62, became disabled, or died in 1979 or later. (An alternative transitional formula could be used for workers who attained age 62 during the period 1979-83, if higher benefits resulted.) Under the

rules enacted in 1977, earnings for past periods are updated, or "indexed," to account for changes in the average annual wage in the economy from the time 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 DI 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 for 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, Congress approved a gradual increase in the age of eligibility for full benefits from

65 to 66 for workers reaching age 62 in 2000-2005, and from 66 to 67 for workers reaching age 62 in 2017-2022. 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 beneficiary's disability 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.

Social Security amendments included in the Omnibus Budget Reconciliation Acts of 1987, 1989, and 1990, as well as in the Technical and Miscellaneous Revenue Act of 1988, provided for various administrative and technical improvements in the program. For example, coverage was expanded to include military reservists, additional State and local government workers, and additional farm workers. Also, eligibility requirements for certain adopted children and the definition of disability for disabled widow(er)s were liberalized, and old, little-used computation methods were consolidated and simplified. Some requirements involving service to the public and protection for beneficiaries unable to manage their own benefits were also enacted.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 provided that up to 85 percent of benefits for certain upper-income taxpayers were to be included in taxable income.

Program Principles

Certain basic principles have been adhered to throughout the development of the OASDI program, some of which are detailed on the following pages.

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 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 it. 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 vested interest 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 defined in the 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 types of employment. Today, the OASDI 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 five 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) certain employees of State and local governments who

are covered under a retirement system, (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 not covered under a retirement system are covered under Social Security mandatorily. Those covered under a retirement system 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 the employees a voice in any decisions to cover them under the OASDI program. States are prohibited from terminating such coverage agreements. At present, more than three-fourths 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 pro-

vided 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 reaching age 62 after 1990 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 1994, one credit will be acquired for each \$620 in covered earnings. This earnings figure is updated annually, based on increases 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 full calendar

years elapsing between age 21 and age 62, disability, or death, 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 his or her widow(er) caring for such children under age 16 (these benefits are 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 6 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 he or she must 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 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 is not entitled on the basis of disability and 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 monthly OASDI benefits are increased

automatically. In 1994, the benefits of a beneficiary under age 65 are reduced \$1 for each \$2 in annual earnings in excess of \$8,040; a beneficiary aged 65-69 may earn \$11,160 before his or her benefits are reduced \$1 for each \$3 of additional earnings. 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 "inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months." 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 upon application for the work. The amount of earnings that ordinarily demonstrates SGA is set forth in regulations. At present, earnings averaging more than \$500 a month are presumed to represent SGA, and earnings below \$300 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 un-

Table 1.—Benefits payable and insured-status requirements under the OASDI program, January 1994¹

<i>Retirement insurance benefits</i>		<i>If the worker is:</i>
Monthly payments, equal to 100 percent of the primary insurance amount, are payable to:	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 \$183.40 are payable at age 72 to:	Monthly payments of \$183.40 are payable at age 72 to:	
	A worker who attained age 72 before 1964 (1967 for women).....	Transitionally insured
And monthly payments of \$91.40 are payable at age 72 to a worker's:	Spouse who attained age 72 before 1969.....	Transitionally insured
<i>Survivor insurance benefits</i>		<i>If at death the worker is:</i>
Monthly payments equal to 100 percent ⁴ of the primary insurance amount are payable to a worker's:	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
Lump-sum payment of \$255 may be paid to a worker's:	Dependent parent aged 62 or older, when both parents are entitled.....	Fully insured
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.....	Monthly payments of \$183.40 are payable at age 72 to a worker's:	Either fully or currently insured
Widow(er) who attained age 72 before 1969.....	Widow(er) who attained age 72 before 1969.....	Transitionally insured
<i>Disability insurance benefits</i>		<i>If the worker is:</i>
Monthly payments equal to the amounts payable in retirement cases ⁶ are payable to:	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 and children ⁷		Fully insured
<i>Special age-72 benefits</i>		<i>If the person meets:</i>
Monthly payments of \$183.40 are payable to:	Certain persons who attained age 72 before 1972.....	Reduced requirements for insured status that apply only to this type of payment

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 for workers who reach age 62 in the year 2000. 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). For workers who attain age 62 in 1993-94, the benefit amount is increased by a delayed retirement credit (DRC) of 5/12 of 1 percent for each month (5 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 5-1/2 percent per year for workers attaining age 62 in 1995-96, to 6 percent for workers attaining age 62 in 1997-98, 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 requirement 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.

able to engage in SGA requiring skills and abilities comparable to those required in their past occupations.

Monthly benefits at a permanently reduced rate are payable to disabled widows and disabled widowers beginning at age 50, based on the same definition of disability that applies to workers. The widow(er) must have become totally disabled within 7 years after the spouse's death or within 7 years after the last month the widow(er) was previously entitled to benefits on the worker's earnings record. 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 a State Disability Determination Services (DDS) under regulations established by the Secretary of Health and Human Services. The DDS is usually a division of a State's Department of Vocational Rehabilitation Services. The costs are reimbursed by the Federal Government. If the initial application is denied, the applicant may request a reconsideration. If the reconsideration results in a denial, the applicant may appeal for a hearing before an Administrative Law Judge (ALJ). If the ALJ denies the application, an applicant can appeal that decision to the Appeals Council. An Appeals Council's denial can be appealed to the Federal Courts. 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 for disability benefits are referred to a State's DDS; disability benefits are not payable to persons who, without good cause, refuse vocational rehabilitation services made available to them. Payment may be made from the Social Security Trust Funds for the cost of providing vocational rehabilitation services to DI 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 \$200 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 but within a period of 60 consecutive months), the case is reviewed to see if the person is able to engage in substantial gainful activity. If the person 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 period 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 disabled-worker beneficiaries to return to work. These provisions 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. An individual whose disability benefits are terminated on the basis of work activity may purchase Medicare coverage. Family benefits payable in disabled-worker cases are subject to a lower cap than the one that prevails for other types of benefits, because of concern that some disabled workers might be discouraged from returning to work because their benefits could exceed their predisability net earnings.

Payment of cash benefits abroad and totalization agreements.—Benefits are generally payable to U.S. citizens regard-

less 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 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 Department of the Treasury 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 16 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), Portugal (1989), the Netherlands (1990), Austria (1991), Finland (1992), and Luxembourg and Ireland (1993). An agreement with Greece has been signed and is expected

to enter into force in the second half of 1994.

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, and who is entitled to benefits on the earnings record of the worker. A 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. Benefits are also paid regardless of the child's age if the child has been disabled since before age 22.

Monthly survivor benefits are payable to a widow(er) at age 60, or, if disabled, at age 50; to a widow(cr) 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 benefit of \$255 is also payable to the spouse who is living with the 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 DI 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 full calendar years after 1950 (or, if later, after age 21) and up to the year in which the worker attains age 62, becomes disabled, or dies—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) after 1978, the actual earnings are indexed—updated to reflect increases in average wage levels in the economy. For persons first eligible before 1979, the actual amount of covered earnings is used in the computations. After a worker's average indexed monthly earnings (AIME) or average monthly earnings (AME) have been determined, a benefit formula is applied to determine the worker's primary insurance amount (PIA), on which all Social Security benefits related to the worker's earnings are based. The benefit formula is weighted in favor of low earners since they have less margin for reduction in income than do high earners.

The PIA is \$1,147.50 for workers whose earnings were at or above the maximum amount that counted for contribution and benefit purposes each year and who retire at age 65 in 1994. Beginning with 1982, newly eligible retired workers have not been subject to a statutory minimum benefit amount. The law does, however, provide for 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 1994, the benefit formula provides that the PIA at first eligibility is equal to:

90 percent of the first \$422 of AIME, plus

32 percent of AIME between \$422 and \$2,545, plus

15 percent of AIME above \$2,545.

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 will generally keep pace with future increases in wages. In the future, for example, 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 low wages (45 percent of the average wage), the replacement rate is expected to be about 55 percent. 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 initial 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 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 (currently age 65) 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 account of 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 PIA, 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 65 to 67 beginning with workers who reach age 62 in the year 2000. 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 the normal retirement age has his or her benefits increased based on the delayed retirement credit. This credit takes into account benefits foregone as a result of the earnings test by persons who continue to work past age 65. The size of the delayed retirement credit currently is being raised every other year. The credit is 5 percent of the PIA per year for workers attaining age 62 in 1993-94. It will increase to 5-1/2 percent of the PIA for workers attaining age 62 in 1995-96, and so on, until it reaches 8 percent of the PIA per year for workers reaching age 62 in 2005 or later.

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 amount 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 their 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 to an individual whose entitlement is not based on a disability 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 1994, beneficiaries aged 65-69 may earn up to \$11,160; those under age 65 may earn up to \$8,040. (The exempt amount increases automatically as wage levels rise.) Beneficiaries under age 65 have their benefits reduced \$1 for each \$2 in earnings over the annual exempt amount. This rate of reduction is \$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 disabled worker 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 survivor families. Table 2 shows the number of individuals receiving benefits and the average payment amounts for various benefit categories.

Taxation of Benefits

The Social Security Amendments of 1983 provided that effective for taxable years ending after December 31, 1983, a portion of Social Security and Railroad Retirement Tier I benefits were to be included in gross income for beneficia-

ries whose provisional income exceeded certain base amounts—\$25,000 for unmarried taxpayers, \$32,000 for married couples filing jointly, and \$0 for married couples filing separately (who have lived with their spouses at any time during the year). For purposes of this computation, provisional income is defined as the sum of adjusted gross income (before Social Security and Railroad Retirement Tier I benefits are considered), plus certain nontaxable income, such as tax-exempt interest income, and one-half of Social Security and Railroad Retirement benefits. Beneficiaries whose provisional incomes exceed the base amount that applies to them are required to include as part of gross income for tax purposes one-half of their benefits or one-half of the difference between their provisional incomes and the base amount, whichever is less.

OBRA 93 added a second tier of base amounts—\$34,000 for unmarried taxpayers and \$44,000 for married couples filing jointly—effective for taxable years beginning after December 31, 1993. Beneficiaries with provisional incomes up to and including the second-tier base amounts continue to be subject to income taxes on their benefits under the provisions of the 1983 act. Beneficiaries whose provisional incomes exceed the applicable second-tier base amount must include as part of gross income the lesser of 85 percent of their Social Security and Railroad Retirement Tier I benefits or the sum of \$4,500 (for unmarried taxpayers) or \$6,000 (for married couples filing jointly) plus 85 percent of the excess of their provisional incomes as defined above over the second-tier base amount. For married taxpayers filing separately, gross income includes the lesser of 85 percent of Social Security and Railroad Retirement Tier I benefits and 85 percent of their provisional incomes.

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 (\$60,600

Table 2.—Number of persons receiving monthly benefits under OASDI, December, selected years 1940-92, and average monthly amount, December 1992

Type of beneficiary	1940	1950	1960	1970	1980	1985	1990	1992	Average amount, December 1992
All beneficiaries.....	222,488	3,477,243	14,844,589	26,228,629	35,618,840	37,058,353	39,832,125	41,507,188	\$588.87
Retired workers.....	112,331	1,770,984	8,061,469	13,349,175	19,582,625	22,432,103	24,838,100	25,757,727	652.64
Disabled workers.....	...	...	455,371	1,492,948	2,861,253	2,656,500	3,011,294	3,467,783	626.07
Wives and husbands ¹ of retired or disabled workers.....	29,749	508,350	2,345,983	2,951,552	3,480,212	3,374,602	3,366,975	3,382,189	322.13
Widows and widowers ²	4,437	314,189	1,543,843	3,177,879	4,287,930	4,756,872	5,010,493	5,074,051	607.55
Widowed mothers and fathers ²	20,499	169,438	401,358	523,136	562,798	371,658	303,923	294,176	437.66
Disabled widows and widowers ².....	...	...	...	49,281	126,659	105,945	100,989	131,324	422.65
Children ³	56,648	699,703	2,000,451	4,122,305	4,609,813	3,319,477	3,187,010	3,391,173	324.61
Of retired workers.....	6,410	46,241	268,168	545,708	642,445	457,408	422,200	431,936	285.24
Of deceased workers.....	48,238	633,462	1,576,802	2,687,997	2,608,653	1,916,928	1,776,013	1,807,998	432.33
Of disabled workers.....	...	...	155,481	888,600	1,358,715	945,141	988,797	1,151,239	170.22
Parents.....	824	14,579	36,114	28,729	14,796	9,541	5,908	5,083	526.44
Special age-72 beneficiaries ⁴.....	...	...	...	533,624	92,754	31,655	7,433	3,682	177.76

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.

in 1993; automatically adjusted as wages rise). These taxes (which constitute the preponderant part of program revenues) are automatically deposited in two separate trust funds—the OASI Trust Fund and the DI Trust Fund. (The Hospital Insurance (HI) portion of the Medicare program is also financed in this way, although a separate annual taxable maximum—\$135,000 in 1993—was applicable for 1991, 1992, and 1993. OBRA 93 repealed the limit on covered earnings subject to HI taxes effective for earnings received after December 31, 1993.)

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 income includes amounts transferred from the general fund, and interest on invested assets of the funds. Revenues from the

income tax on Social Security benefits derived from the provisions of the 1983 act are appropriated to the OASI and DI Trust Funds while revenues attributable to the increased portion of benefits taxable as a result of OBRA 1993 are credited to the HI Trust Fund. Transfers from the general funds include payments for gratuitous military service wage credits and for limited benefits to certain very old persons who qualify under special insured status requirements. Interest income on trust fund assets is derived from securities guaranteed by the U.S. Government, or in certain securities issued by federally sponsored agencies.

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. In 1994, OASDI tax rates are 6.2 percent each for the employee and employer and 12.4 percent for the self-employed. The Federal Disability Insurance Trust Fund is allocated a portion of these rates: 0.6 percent each for the employee and employer and 1.2 percent for the self-employed. (With the turn of the century, these figures are scheduled to increase to

0.71 and 1.42 percent, respectively.) Current and future scheduled tax rates are shown in table 3. Table 4 summarizes the status of the OASI and DI Trust Funds for selected years.

Administration

The Secretary of Health and Human Services has the overall responsibility for administering all aspects of the OASDI program except the (1) collection of Social Security contributions, which is performed by the Internal Revenue Service (IRS) 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 (SSA), 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 recommenda-

Table 3.—Tax rate schedule for OASDI and HI programs^{1,2}

Period	Total	OASI	DI	HI
Percent of covered earnings for employee and employer each				
1990-99.....	7.65	5.6	0.6	1.45
2000 and after.....	7.65	5.49	.71	1.45
Percent of covered earnings for the self-employed				
1990-99.....	15.3	11.2	1.2	2.9
2000 and after.....	15.3	10.98	1.42	2.9

¹ In 1994, the OASI and DI tax rates apply to covered earnings up to \$60,600; this maximum taxable amount is subject to an annual automatic adjustment in proportion to increases in national average wage and salary earnings. The maximum taxable amount for purposes of the HI tax was \$135,000 in 1993 but has been repealed entirely, effective for 1994, by the Omnibus Budget Reconciliation Act of 1993.

² The Social Security Amendments of 1983

tions 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.

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 which his or her benefits are based. The same number is used for life and is recorded by each new employer. To date more than 350 million Social Security numbers have been issued; about 132.9 million persons—working in about 95 percent of the jobs in paid employment and self-employment—held jobs covered under the program in 1992.

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

provided for tax credits against OASDI and HI tax liability of (1) the self-employed equal to 2.7 percent of earnings for 1984; 2.3 percent, for 1985; and 2.0 percent, for 1986-89; and (2) employees equal to 0.3 percent of earnings for 1984. Effective for 1990, the tax credits have been replaced with special deduction 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.

contributions in connection with their income tax return. Information from self-employment income reports is sent by the Internal Revenue Service to SSA.

Reported earnings are posted to the worker's earnings record in the central office of SSA 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 by 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. 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 computer systems are continually being updated, improved, and put to new uses, as new technology becomes available.

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 at 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 about 1,300 offices and a toll-free telephone number which provides the public with one free number on which to reach SSA. The 800-number network received almost 55 million calls in fiscal year 1992. 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 give 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 (ALJ) from the SSA's Office of Hearings and Appeals. If the ALJ'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 Falls Church, Virginia.

In calendar year 1992, the administrative expenses of the cash benefit program amounted to about 0.9 percent of benefit payments.

Table 4.—Status of the Old-Age and Survivors Insurance and Disability Insurance Trust Funds, by selected years, 1940-92

[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
1945.....	1,420	304	274	30	...	7,121
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
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
1988.....	140,770	200,020	195,454	1,776	2,790	102,889
1989.....	264,653	212,489	207,971	1,673	2,845	155,063
1990.....	286,653	227,519	222,987	1,563	2,969	214,197
1991.....	299,286	245,634	240,467	1,792	3,375	267,849
1992.....	311,162	259,867	254,883	1,830	3,148	319,150
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
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
1988.....	22,699	22,494	21,695	737	61	6,864
1989.....	24,795	23,753	22,911	754	88	7,905
1990.....	28,791	25,516	24,829	707	80	11,079
1991.....	30,390	28,571	27,695	794	82	12,898
1992.....	31,430	32,004	31,112	834	58	12,324

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 widow(er)s.

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.

Unemployment Insurance

Unemployment insurance programs, through Federal and State cooperation, 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.

In 1932, the State of Wisconsin established the first unemployment insurance law in the United States, which served as a forerunner for the unemployment insurance provisions of the Social Security Act of 1935. 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.

The Social Security Act, by means of a tax offset, 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 employed 8 or more workers in 20 or more weeks in a calendar year. Employers who paid a tax to a State with an approved unemployment insurance law could credit (offset) up to 90 percent of the State tax against the national tax. Thus, employers in 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 unem-

ployment insurance laws. Later, Puerto Rico adopted its own unemployment insurance program, which was incorporated into the Federal-State system in 1961. Similarly, 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 receive their offset against the Federal tax and if the State is to receive Federal grants for administration. These requirements are intended to assure that a State participating in the program has an unemployment insurance system that is fairly administered and financially secure.

One of these requirements is that all contributions collected under State laws be deposited in the unemployment trust fund in the Department of the Treasury. The fund is invested as a whole, but each State has a separate account to which its deposits and its share of interest on investments are credited. A State may withdraw money from its account in the trust fund at any time, but only to pay benefits.² 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. Private plans cannot be substituted for the State plan.

Aside from Federal standards, each State has major responsibility for the content and development of its unemployment insurance law. The State itself decides the amount and duration of benefits (except for certain Federal requirements concerning Federal-State Extended Benefits); the contribution rates (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 108 million workers were in jobs covered by unemployment insurance by the end of 1992. Originally, coverage had been limited to the employment covered by the Federal Unemployment Tax Act (FUTA), which relates primarily to industrial and commercial workers in private industry. However, several Federal laws added substantially to the number and types of workers protected under the State programs, such as the Employment Security Amendments of 1970 and the Unemployment Compensation Amendments of 1976.

Private employers in industry and commerce are subject to the law if they have one or more individuals employed on 1 day in each of 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 or employing 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 employment and employment of most nonprofit organizations is exempt from FUTA. However, as a result of Federal legislation enacted in 1976, most employment 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 4 workers in 20 weeks in the current or preceding calendar year. Many States have extended coverage beyond that provided by Federal legislation.

Federal civilian employees and ex-servicemembers have been brought under the unemployment insurance system through special Federal legislation. Benefits for these persons are financed through Federal funds but are administered by the States and paid in accordance with the provisions of the State laws. 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 (pages 60-63).

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.³ All workers whose employers contribute to or make payments in lieu of contributions to State unemployment funds, Federal civilian employees, and ex-servicemembers are eligible if they are involuntarily unemployed, able to work, available for work, meet the eligibility and qualifying requirements of the State law, and are free from disqualifications. Individual State information and eligibility requirements are available from local employment offices. 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.

Six States specify a flat minimum amount of earnings, ranging from \$1,000 to \$2,800 in the base period to qualify. One-fourth of the States express their earnings requirements in terms of a multiple of the benefit for which the individual will qualify (such as 30 times the weekly benefit amount). Most of these jurisdictions, however, have an additional requirement that wages be earned in more than one calendar quarter or that a specified amount of wages be earned in the calendar quarter other than that in which the claimant had the most wages. Almost half the States simply require base period wages totaling a specified multiple—commonly 1-1/2—of the claimant's high-quarter wages. Seven States require a minimum number of weeks of covered employment (minimum number of hours in one State), generally reinforced by a requirement of an average or minimum amount of wages per week.

If the unemployed worker 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). Most

States have special disqualification provisions that specifically restrict the benefit rights of students who are considered not available for work while attending school. Federal law also restricts benefit eligibility of some groups of workers under specified conditions: school personnel between academic years, professional athletes between sports seasons, and aliens not 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 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, fraud, or because of disqualifying income. Also, no State may deny unemployment insurance benefits when a claimant undergoes training in an approved program.

The Federal Unemployment Tax Act also provides that no State can deny benefits 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.

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

Types and Amounts of Benefits

During 1992, average weekly insured unemployment under the regular programs (including State programs and programs for Federal employees and ex-servicemembers) was 3.3 million persons. Benefit payments under the regular programs totaled \$26.0 billion, of which \$25.2 billion was expended under State programs and \$800 million expended to Federal employees and ex-servicemembers. The average weekly benefit under the regular programs was \$174 and the average duration of benefits was 16.2 weeks.

Average weekly insured unemployment under the Emergency Unemployment Compensation (EUC) program was 1.5 million persons, and benefit payments was \$13.5 billion. Under both the regular and emergency programs in 1992, benefit payments totaled \$39.5 billion. 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.

Three-fourths of the 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 because this quarter most nearly reflects full-time work. In most of these States, the same fraction is used at all benefit levels. The other laws use a weighted schedule that gives a greater proportion of the high-quarter wages to lower-paid workers than to those earning more.

Three States compute the weekly benefit amount as a percentage of annual wages. Six 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 the ceiling. The maximum may be either a fixed dollar amount or a flexible amount. Under the latter arrangement, which has been adopted in 35 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 amending the flat maximum statutory dollar amount as wage levels change.

The maximum weekly benefit for all States varies from \$133 to \$335 (excluding allowances for dependents provided by 14 jurisdictions). Because statutory increases in the maximum tend to lag behind the increase in wage levels, the maximum in States with fixed amounts often operates to curtail the benefit amounts of workers to below the 50-percent level. Minimum limits on benefits—ranging from \$5 to \$69 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.

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 States include a nonworking spouse; and 3 States consider other dependent relatives. The amount allowed per dependent varies considerably by State but generally is \$20 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 one 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 if the employee returns to work within a specified period.

All but 2 jurisdictions provide a statutory maximum duration of 26 weeks of benefits in a benefit year. However, only 9 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.

Extended Benefits

In the 1970's, a permanent Federal-State program of Extended Benefits was established for workers who exhaust their entitlement to regular State benefits during periods of high unemployment. The program is financed equally from Federal and State funds. 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 State 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's benefit period ends, Extended Benefits to individual workers also end, even if they have received less

Table 5.—Significant provisions under State unemployment insurance laws, January 3, 1993

State	Weekly benefit amount for total unemployment ¹			Duration of benefits (weeks) ³	
	Computation (fraction of high-quarter wages unless otherwise indicated) ²	Minimum	Maximum	Minimum ⁴	Maximum
Alabama	1/24 of average of two highest quarters	\$22	\$165	15 +	26
Alaska	4.4-0.90% of annual wages, plus \$24 per dependent up to \$72	44-68	212-284	³ 16	³ 26
Arizona	1/25	40	185	12 +	26
Arkansas	1/26, up to 66 $\frac{2}{3}$ % of State average weekly wage	43	240	9	26
California	⁵ 1/23-1/33	40	230	³ 14 +	³ 26
Colorado	60% of 1/26 of two highest quarters, up to 50% of base period wages	25	250	13 +	26
Connecticut	1/26 up to 60% of State average weekly wage, plus \$10 per dependent up to 1/2 weekly benefit amount or five dependents	15-22	306-356	³ 26	³ 26
Delaware	See footnote 5	20	245	24	26
District of Columbia	1/23 up to 55% of State average weekly wage, plus \$5 per dependent up to \$20	13	¹ 335	³ 26	³ 26
Florida	1/2 of claimant's average weekly wage	10	250	10	26
Georgia	1/50 of wage in two highest quarters ⁵	37	185	9 +	26
Hawaii	1/21 up to 70% of State average weekly wage	5	322	³ 26	³ 26
Idaho	1/26 up to 60% of State average weekly wage	44	223	10	26
Illinois	49.5% of claimant's average weekly wage in two highest quarters, up to 49.5% of State average weekly wage ⁵	51	227-300	26	26
Indiana	5% of first \$1,000 in high quarter, 4% of remaining high-quarter wages	50	140-181	14	26
Iowa	See footnotes 2,5	30-36	200-245	11 +	26
Kansas	4.25% of high quarter wages up to 60% of State average weekly wage	59	239	10	26
Kentucky	1.185% of base period wages, up to 55% of State average weekly wage	22	217	15	26
Louisiana	1/25 of 4 quarters ^{6,7}	10	181	8	26
Maine	1/22 up to 52% of State average weekly wage, plus \$10 per dependent up to 1/2 weekly benefit amount ⁷	35-52	198-297	21 + -22	26
Maryland	1/24, plus \$8 per dependent up to \$40	25-33	¹ 223	26	26
Massachusetts	1/21-1/26, up to 57.5% of State average weekly wage, plus \$25 per dependent up to 1/2 weekly benefit amount ²	14-21	312-468	10 + -30	30
Michigan	70% of claimant's after-tax earnings, up to a maximum of 58% of State average weekly wage	42	293	13 +	26
Minnesota	⁵ 1/26	38	279	10 +	26
Mississippi	1/26	30	165	13 +	26
Missouri	4.5%	45	175	11 +	26
Montana	1% of base period wages or 1.9% of wages in two high quarters up to 60% of State average weekly wage	52	209	8	26
Nebraska	1/20-1/24	20	154	20	26
Nevada	1/25 up to 50% of State average weekly wage	16	217	12 +	26
New Hampshire	0.8-1.4% of annual wages	32	188	26	26
New Jersey	60% of claimant's average weekly wage plus dependents' allowance, up to 56 $\frac{2}{3}$ % of State average weekly wage	69	¹ 325	15	26
New Mexico	1/26; not less than 10% nor more than 50% of State average weekly wage	38	191	19	26
New York	50% of claimant's average weekly wage	40	300	26	26
North Carolina	1/52 of two highest quarters, up to 66 $\frac{2}{3}$ % of State average weekly wage	22	267	13-26	26
North Dakota	1/65 of two highest quarters and 1/2 total wages in third quarter, up to 60% of State average weekly wage ⁶	43	212	12	26

See footnotes at end of table.

Table 5.—Significant benefit provisions under State unemployment insurance laws, January 3, 1993—Continued

State	Weekly benefit amount for total unemployment ¹			Duration of benefits (weeks) ³	
	Computation (fraction of high-quarter wages unless otherwise indicated) ²	Minimum	Maximum	Minimum ⁴	Maximum
Ohio	1/2 claimant's average weekly wage, plus dependents' allowance of \$1-\$83 based on claimant's average weekly wage and number of dependents ^{2,8}	\$42 16	\$228-306 ¹⁰ 229	920 20+	26 ⁹ 26
Oklahoma	¹⁰ 1/25				
Oregon	1.25% of base period wage, up to 64% of State average weekly wage	63	271	35+	326
Pennsylvania	1/23-1/25 up to 66 2/3% of State average weekly wage plus \$5 for one dependent; \$3 for second	35-40	⁹ 317-325 133	16 ³ 26	26 ³ 26
Puerto Rico	1/11-1/26 up to 50% of State average weekly wage	7			
Rhode Island	4.62% of high quarter wages up to 67% of State average weekly wage, plus greater of \$10 or 5% of the benefit rate per dependent up to five dependents	41-51	294-367	15+	26
South Carolina	1/26 up to 66 2/3% of State average weekly wage	20	191	15	26
South Dakota	1/26 up to 62% of State average weekly wage ⁷	28	154	18+	26
Tennessee	1/26-1/32 of average two highest quarters	30	170	12+	26
Texas	⁸ 1/25	40	245	9+	26
Utah	1/26 up to 60% of State insured average fiscal year weekly wage	14	240	10	26
Vermont	See footnote 5	25	199	26	26
Virgin Islands	1/26 up to 50% of State average weekly wage	32	203	13+	26
Virginia	1/50 of wage in two highest quarters	65	208	12	26
Washington	1/25 of average of two highest quarters, up to 55% of State average weekly wage ⁶	68	273	16+-30	30
West Virginia	1.0% of annual wage up to 66 2/3% of State average weekly wage	24	270	26	26
Wisconsin	4% of high-quarter wages up to maximum weekly benefit amount	45	240	13+	26
Wyoming	4% of high-quarter wages up to 55% of State average weekly wage ¹⁰	40	200	12-26	26

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

² When States use a weighted high-quarter, annual wage, or average weekly wage formula, approximate fractions or percentages are figured at midpoint of lowest and highest normal wage brackets. When dependents' allowances are provided, the fraction applies to the basic weekly benefit amount. In some States, variable amounts above maximum basic benefits are limited to claimants with specified number of dependents and earnings in excess of amounts applicable to maximum basic weekly benefit amount. In Indiana, dependents' allowances are paid only to claimants with earnings in excess of that needed to qualify for a basic weekly benefit amount and who have one to three dependents. In Iowa and Ohio, claimants may be eligible for an augmented amount at all benefit levels but benefit amounts above the basic maximum is available only to claimants in dependency classes whose high-quarter wages or average weekly wage are higher than that required for a maximum basic benefit. In Massachusetts, for claimants with an average weekly wage in excess of \$66 the weekly benefit amount is computed at 1/52 of the two highest quarters of earnings or 1/26 of highest quarter if the claimant has no more than two quarters work.

³ Benefits extended under State programs when unemployment in State reaches specified levels: Alaska and California by 50%; Oregon by 25%; Connecticut by 13 weeks; District of Columbia by

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

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

⁵ To 58.5% State average weekly wage if claimant has nonworking spouse; 65.5% if claimant has dependent child, Illinois; 1/19-1/23 up to 65% of the State average weekly wage for claimants with dependent, Iowa; 1/46 of wages in highest two quarters if the trust fund balance is at least \$90 million or is 1/52 of wages in highest two quarters if the trust fund balance is less than \$90 million, and the maximum weekly benefit amount will be \$205, Delaware; a State average weekly wage ranging from 60% to 66 2/3% depending on the balance of the fund, Minnesota; wages in the two highest quarters divided by 45, Vermont; if high quarter wages exceed \$4,966.99, the maximum weekly benefit amount will be 39% of these wages divided

by 13. California; 1/25 of highest quarter if alternative qualifying wages are used, Georgia.

⁶ Up to 66 2/3% of State average weekly wage, Louisiana, 62% of State average weekly wage depending on the trust fund reserves or 65% of State average weekly wage depending on trust fund reserves and the State's average contribution rate if below the nationwide average for the preceding year, North Dakota; 60% of State average weekly wage if fund balance equals or exceeds 2.4% of total contributions paid, Washington.

⁷ The minimum and maximum weekly benefit amounts are frozen indefinitely in Louisiana. The maximum weekly benefit is frozen indefinitely in South Dakota; in Maine, until June 1993.

⁸ Maximum amount adjusted annually by same percentage increase as occurs in State average weekly wage. (Ohio) by \$7 for each \$10 increase in average weekly wage of manufacturing production workers (Texas).

⁹ Duration can be much less than 26 weeks for individuals with only one employer in a base.

¹⁰ Weekly benefit amount will be reduced by 5% or by the reduction determined by a trigger mechanism, but the weekly benefit amount may not be reduced to 85% of the computed amount when revenues in the fund are inadequate to pay benefits, Wyoming; the greater of \$197 or 60%, 57.5%, 55%, 52.5%, or 50% of State average weekly wage of the second preceding calendar year depending on the condition of the fund, Oklahoma.

Source: *Comparison of Unemployment Insurance Laws*, Department of Labor, Washington, DC, January 9, 1993.

than their potential entitlement and are still unemployed. Further, once a State's benefit period ends, another Statewide period cannot begin for at least 13 weeks.

Most eligibility conditions for Extended Benefits 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 duration of benefits for a maximum of 13 weeks of Extended Benefits. 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.

Because of the way Extended Benefits are triggered into effect, only nine jurisdictions qualified for them during the economic downturn of 1991: Alaska, Maine, Massachusetts, Michigan, Oregon, Puerto Rico, Rhode Island, Vermont, and West Virginia. Thus, there was broad interest in considering legislation to change how the Extended Benefits program is activated.

The Extended Benefits program is based on the insured unemployment rate (IUR)—the number of unemployed workers receiving benefits in a State as a percent of the number of persons in unemployment-insurance covered employment in that State. By definition, the IUR does not include workers who have exhausted their benefits but are still unemployed. It was thought by some that the IUR worked well until the proportion of unemployed persons receiving unemployment insurance dropped well below 100 percent—to about 80 percent. Another perceived problem with the IUR is that it was seen by some to have the effect of deactivating Extended Benefits in a State when substantial numbers of workers were exhausting their benefits, which reduced insured unemployment and therefore the IUR. The Extended Benefits program was revised in 1992 by P.L. 102-318, as discussed later.

Emergency Unemployment Compensation

Between 1991 and 1993, five Emergency Unemployment Compensation laws went into effect to provide continuation of benefits for the long-term unemployed, with the Federal Government paying all of the EUC benefits.

Public Law 102-164 was passed by Congress on November 15, 1991, and approved by the President the same day. This Emergency Unemployment Compensation Act of 1991 provided a three-tier system of 6, 13, or 20 weeks of emergency benefits and also provided for direct financing of unemployment benefits.

During debate on the bill, H.R. 3575, several Senators indicated that they considered the formula unfair to their States because it would provide only 6 weeks of added benefits in 23 States; the remaining States would receive 13 or 20 weeks. To meet these concerns, a compromise was reached. Congress, wishing to expedite emergency unemployment benefits to workers who had exhausted their benefits, agreed to let the measure become law (P.L. 102-164). However, an amendment was added to a trade bill, H.R. 1724, to allow jobless workers who had exhausted their regular benefits at any time after February 28, 1991, either 13 or 20 weeks of emergency benefits. On December 4, 1991, H.R. 1724 was signed into law (P.L. 102-182), thus amending P.L. 102-164. The expiration date of this legislation was June 13, 1992.

Under P.L. 102-164 (but before it was amended by P.L. 102-182), all States became eligible to provide EUC benefits to unemployed workers who exhausted their unemployment benefits under existing programs. There were three levels of eligibility. The number of weeks of benefits payable to an unemployed worker in a particular State was determined by a combination of the State's adjusted insured unemployment rate (AIUR), its exhaustion rate (ER), and its total unemployment rate (TUR). Definitions of these terms follow:

- The AIUR for a State adjusts the insured unemployment rate by add-

ing to the numerator the number of workers who have exhausted their regular State benefits in the past 3 months.

- The ER is the percentage obtained by dividing the average monthly number of workers who have exhausted their regular State benefits during the past 12 months by the average monthly number of individuals filing initial claims for regular State benefits during the past 12-month period ending 6 months earlier.
- The TUR is the ratio of all unemployed workers in a State to all workers in that State's labor force during the previous 6 months for which data are available.

Under P.L. 102-164, States could receive the following 6, 13, or 20 weeks of emergency benefits:

- All States could provide at least 6 weeks.
- States with an AIUR of at least 4 percent, or an AIUR of at least 2.5 percent and an ER of at least 29 percent could provide at least 13 weeks.
- States with an AIUR of at least 5 percent or a TUR of at least 9 percent could provide 20 weeks.

Once a State triggered on for a period of 6, 13, or 20 weeks of EUC benefits, the State remained in that tier for at least 13 weeks—even if the State dropped to a lower tier during that period. If a State moved to a higher tier during that period, workers in that State qualified for the additional benefits. Also, once an unemployed worker became eligible for 6, 13, or 20 weeks of EUC benefits, the worker was paid for all weeks to which he or she was entitled—even if the State dropped to a lower tier or the program expired before the worker received the full number of weeks of benefits.

Unemployed workers who exhausted their benefits under the regular unemployment program between March 1 and November 16, 1991 (the 8.5-month pe-

riod prior to enactment of EUC benefits), were eligible to receive EUC benefits in States that qualified as 13- or 20-week States or had an AIUR of at least 3 percent. This was known as the "reachback" provision. Qualifying States were eligible for a minimum of 6 weeks of reachback benefits. However, States on the second and third tier were eligible to pay for 13 or 20 weeks, respectively.

P.L. 102-182 amended P.L. 102-164 by eliminating the 6-week benefit tier and providing 13 or 20 weeks of benefits. The amendment was financed by cutting the program back from July 4, 1992, to June 13, 1992.

By February 1992, there were 16 jurisdictions whose unemployed workers could receive 20 weeks of benefits: Alaska, Arkansas, California, Connecticut, Maine, Massachusetts, Michigan, Mississippi, New Jersey, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Washington, and West Virginia. These jurisdictions had total unemployment rates of at least 9 percent or adjusted insured unemployment rates of at least 5 percent. Unemployed workers in the remaining States, the District of Columbia, and the Virgin Islands were qualified to receive 13 weeks of benefits.

Public Law 102-164, as amended, also made a permanent change in law to provide unemployment benefits to ex-servicemembers on the same basis as benefits provided to unemployed civilians. In addition, reserve members called to active duty could receive benefits after serving a continuous period of 90 days (instead of having to meet the previous 180-day requirement).

EUC benefits are federally funded from the Extended Unemployment Compensation Account of the Unemployment Trust Fund. However, P.L. 102-164, as amended, contained several provisions for financing benefits in accordance with the 1990 budget legislation. These provisions were intended to increase Federal revenues to the extent needed to offset the cost of providing emergency unemployment benefits, which included: extending for one year (from 1995 through 1996) the 0.2 percentage point Federal Unemployment Tax Act surtax; making

estimated tax payments conform more closely to a taxpayer's actual tax liability; making permanent the tax refund offset program for collecting nontax debts owed to the Federal Government; and improving the collection provisions for Guaranteed Student Loans in default.

P.L. 102-244, The Emergency Unemployment Compensation Extension Act was enacted on February 7, 1992. It extended an additional 13 weeks of benefits for all EUC claimants so that a maximum of 33 or 26 weeks of benefits was available through June 13, 1992.

As described earlier, P.L. 102-164, as amended, was effective from November 17, 1991, through June 13, 1992, and provided for 13 or 20 additional weeks of emergency benefits beyond the 26 weeks of benefits available under regular State unemployment insurance programs. P.L. 102-244 increased by 13 the number of weeks of emergency benefits payable to unemployed workers who qualified through June 13, 1992. Therefore, a total of 33 weeks of emergency benefits could be paid to workers in States that were previously eligible for 20 weeks. Workers in all other States were entitled to a total of 26 weeks of emergency benefits. This law extended the emergency benefits program from June 13 to July 4, 1992. The total number of weeks of emergency benefits payable to unemployed workers who first became eligible for benefits after June 13 remained at 13 or 20 weeks. Unemployed workers who qualified for benefits before the July 4 expiration date would receive the full number of weeks to which they were entitled, even if some of those weeks came after the expiration date. Including the 26 weeks of benefits payable under the regular unemployment program, unemployed workers in jurisdictions with high unemployment could receive a maximum of 59 weeks of benefits, and those in all other jurisdictions could receive a maximum of 52 weeks of benefits.

P.L. 102-318, the Unemployment Compensation Amendments of 1992, passed both Houses of Congress on July 2, 1992. On July 3 (the day before the Federal Emergency Unemployment Compensation program was due to ex-

pire), the President signed the bill into law. The new law extended the Emergency Unemployment Compensation program until March 6, 1993. For new claims filed after June 13, 1992, workers who exhausted their regular unemployment compensation benefits could receive up to 26 additional weeks of benefits (for a total of 52 weeks) in States where the adjusted insured unemployment rate was at least 5 percent or the total unemployment rate was at least 9 percent. Workers in all other States could receive up to 20 weeks of additional benefits (for a total of 46 weeks). This number of weeks of benefits would be continued as long as the seasonally adjusted national unemployment rate remained at 7 percent or higher. However, if for 2 consecutive months the national unemployment rate fell below 7 percent, the additional benefits would be reduced to 15 and 10 weeks. The number of weeks of additional benefits would be further reduced (to 13 and 7 weeks) if for 2 consecutive months the unemployment rate fell below 6.8 percent. The legislation was to expire March 6, 1993, and no new emergency claims could be filed after that date. Also, no emergency payments could be made after June 19, 1993.

In mid-October 1992, 8 jurisdictions qualified for 26 weeks of emergency unemployment compensation benefits under P.L. 102-318: Alaska, California, Connecticut, Michigan, New Jersey, Puerto Rico, Rhode Island, and West Virginia. All other jurisdictions (including the District of Columbia and the Virgin Islands) qualified for 20 additional weeks of benefits.

This legislation also modified the permanent Federal-State Extended Benefits program to provide more effective protection on an ongoing basis. P.L. 102-318 provided States the option of adopting an additional formula for triggering the permanent Extended Benefits program. Effective March 7, 1993, States had the option of amending their laws to use alternative total unemployment rate triggers, in addition to the current insured unemployment rate triggers. Under this option, Extended Benefits would be paid when: (1) the State's seasonally

adjusted total unemployment rate for the most recent 3 months is at least 6.5 percent, and (2) that rate is at least 110 percent of the State average total unemployment rate in the corresponding 3-month period in either of the 2 preceding years.

States triggering on to the Extended Benefits program under other triggers would provide the regular 26 weeks of unemployment benefits, in addition to 13 weeks of Extended Benefits (which is the same number of weeks of benefits provided previously). In addition, States that have chosen the total unemployment rate option will also amend their State laws to add an additional 7 weeks of Extended Benefits (for a total of 20 weeks) where the total unemployment rate is at least 8 percent and is 110 percent of the State's total unemployment rate for the same 3 months in either of the 2 preceding years.

The new legislation clarified present law to ensure that States could continue short-time compensation provisions under their unemployment insurance programs. Under these provisions, States may pay pro-rata benefits to individuals who are working less than full time because their employers have a State-approved plan that provides for a reduction in work hours for employees rather than temporary layoffs. Also, eligible employees may participate in employer-sponsored training programs to enhance their job skills if such programs have been approved by their respective State agencies.

Financing

Rather than funding EUC benefits from the Extended Unemployment Compensation Account of the Unemployment Trust Fund, benefits under P.L. 102-318 were financed from Federal general revenues by: (1) accelerating the estimated tax liability for large corporations; (2) providing tax withholding for pension plan distributions that are not rolled over to another pension plan, annuity, or Individual Retirement Account; and (3) delaying through the end of 1996 expiration of the phaseout of personal exemptions for higher income individuals.

Public Law 103-6, the Emergency Unemployment Compensation Amendments of 1993, enacted March 4, contains provisions to: (1) extend the authorization for new claims of Emergency Unemployment Compensation benefits from March 6, 1993, through October 2, 1993, with benefit eligibility to be phased out over a 3-month period ending January 15, 1994 (that is, recipients who file claims by October 2, 1993, could continue to collect emergency unemployment compensation benefits through January 15, 1994); (2) develop automated systems for identifying dislocated workers and referring them to re-employment services; and (3) declare all direct spending and authorized appropriations under the legislation to be designated as emergency requirements within the meaning of the Balanced Budget and Emergency Deficit Control Act of 1985.

Under P.L. 102-318, authorization for new claims of EUC benefits expired on March 6, 1993. Even though P.L. 102-318 permitted States to adopt an optional trigger mechanism under the permanent Extended Benefits program, no State did so in part because the recession depleted their trust funds. Many State officials believed they could not afford the 50-percent State costs of the program.

As under P.L. 102-318, the extension of the Federal EUC program under P.L. 103-6 provided 20 or 26 weeks of benefits for workers who exhausted their regular State benefits, depending on unemployment in their States. States with adjusted insured unemployment rates (AIUR's) of at least 5 percent or total unemployment rates (TUR's on a 6-month moving average basis) of at least 9 percent would be eligible to pay 26 weeks of benefits. All other States would be eligible to pay 20 weeks of benefits. For the week of February 20, 1993, 20 weeks of benefits were available in all State programs, except for Alaska, California, Oregon, Puerto Rico, Rhode Island, Washington, and West Virginia, which qualified for 26 weeks of benefits.

The EUC program was most recently extended by P.L. 103-152, the Unem-

ployment Compensation Amendments of 1993, enacted November 24, 1993. Under this legislation, authorization of new claims under the EUC program was extended from October 2, 1993, to February 5, 1994. Individuals qualifying for EUC after October 2, 1993, will be eligible for up to 7 or 13 weeks of additional benefits, depending on the unemployment rates in their respective States. (As under current law, States with adjusted insured employment rates of at least 5 percent or total unemployment rates of at least 9 percent would be eligible to pay benefits for the longer period.) The EUC program will be phased out by allowing individuals who qualify on or before the new expiration date of February 5, 1994, to collect the balance of their benefits, except that no benefits could be paid after April 30, 1994.

The \$1.1 billion cost of the new extension would be paid for by: (1) instituting a more comprehensive and accelerated job assistance program for individuals deemed to need such assistance, who will be identified through a system of worker profiling in order to help the long-term unemployed find re-employment faster; and (2) increasing the immigration sponsor-to-alien deeming period under the Supplemental Security Income (SSI) program.

Under SSI, the income and resources of an immigration sponsor of an alien SSI applicant are considered in determining eligibility and amount of payment. After allowance for the needs of the sponsor and his or her family, the remaining income and resources of the sponsor are deemed available for the support of the alien applicant for a 3-year period after admission to the United States for permanent residence. This provision is not applicable to those who become blind or disabled after admission, to refugees, or to persons granted political asylum. P.L. 103-152 extended the sponsor-to-alien deeming period of 5 years, effective January 1, 1994, to October 1, 1996.

Financing Provisions

The Unemployment Trust Fund in the Federal unified budget consists of 53

separate State program accounts and three Federal accounts. The State program accounts cover all States, the District of Columbia, the Virgin Islands, and Puerto Rico. States deposit their respective unemployment taxes in these accounts and withdraw funds to cover the costs of regular State benefits and half of the Extended Benefits program. There are three Federal accounts for administration, extended benefits, and loans to States. The Federal unemployment tax funds the accounts.

Effective January 1985, 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 workers' covered wages. However, employers do not pay the full amount because they may credit toward their Federal tax the payroll tax contributions that they paid 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 have obtained such loans when their reserves for paying benefits were depleted during periods of high unemployment. As of September 30, 1992, only four States had outstanding loan balances.

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. 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 pay the Federal share of ex-

tended benefits and EUC payments. This surcharge, enacted in 1976, was extended to December 31, 1996, by 1991 legislation, and through 1998 by 1993 legislation. All States finance unemployment benefits almost completely through employer contributions. There is no Federal tax on employees, and only three States collect employee contributions. In January 1993, 39 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 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 those with less favorable experience.

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, 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 1992, the estimated national aver-

age employer contribution rate actually paid was 2.2 percent of taxable payroll, or 0.8 percent of total wages in covered work. The average contribution rate varied widely by State, however. The percent of State taxable payroll ranged from 0.6 to 5.4. The percent of total wages ranged from 0.3 to 2.9. 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.

Several States collect a supplementary tax for the administration of the unemployment insurance laws because funds 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 have not proved adequate.

Administration

States have the direct responsibility for establishing and operating their own unemployment insurance programs, while the Federal Government finances the cost of administration. State unemployment insurance tax collections are used solely for the payment of benefits. Federal unemployment insurance tax collections are used to finance expenses deemed necessary for proper and efficient administration of State unemployment insurance laws; to reimburse State funds for one-half the costs of Extended Benefits paid under the provisions of State laws, which conform to the provisions of the Social Security Act and the Federal Unemployment Tax Act; and to make repayable advances to States when needed to pay benefit costs. Funds used for benefit payments may not be used for any program administration costs, nor for training, job search, or job relocation payments. Disaster Unemployment Assistance (DUA) is paid out of funds provided by the Federal Emergency Management Agency (FEMA). Benefits for former Federal civilian employees, including postal workers (and, after October 1, 1983, former members of the

Armed Forces) are paid out of the Federal Employees Compensation Account (FECA) in the Unemployment Trust Fund, subject to reimbursement by the former employing agency.

Federal regulations do not specify the form of the organization administering unemployment insurance or its place in the State government. Twenty-eight States have placed their employment security agencies in the Department of Labor or under some other State agency. The others have independent departments, boards, or commissions to administer the program. Advisory councils have been established in all but 3 jurisdictions; 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 also provide a range of job development and placement services. State employment offices were established by Congress in 1933 under the Wagner-Peyser Act, and thus actually antedate the unemployment insurance provisions of the Social Security Act. Federal law provides that the personnel administering the program must be appointed on a merit basis, with the exception of those in policymaking positions.

The Federal functions of the unemployment insurance program are chiefly the responsibility of the Employment and Training Administration's Unemployment Insurance Service in the U.S. Department of Labor. The Internal Revenue Service in the Department of the Treasury collects FUTA taxes, and the Treasury also maintains the Unemployment Insurance Trust Fund. The Unemployment Insurance Service ascertains each year whether State programs conform with Federal requirements, provides technical assistance to the State

agencies, and serves as a clearinghouse for statistical data.

Generally, 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. They must continue to be filed throughout the period of unemployment, usually biweekly and by mail. Benefits are paid on a biweekly basis in most States.

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

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

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 deaths result from work-related accidents, 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 7 States and the District of Columbia 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' com-

pensation programs cover Federal Government employees and longshore and harbor workers throughout the country. A Federal program also protects coal miners suffering from pneumoconiosis, or "black lung" disease. Under this program, which was enacted 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 1991, State and Federal workers' compensation laws covered about 93.6 million employees, or 88 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 common exemptions are domestic service, agricultural employment, and casual labor. However, 39 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 3 employees in 8 States, fewer than 4 in 3 States, and fewer than 5 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 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 covered jobs in private industry except in New Jersey, South Carolina, and Texas. In these States, the programs are elective—that is, employers may accept or reject coverage under the law; but if they reject 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 risks. 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 17 jurisdictions, State funds have been established that compete with private insurance carriers although these funds are currently operational in only 13 jurisdictions. 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 to 3 years) or if the claim is filed within a similar time after manifestation of the disease or after disability begins. Some programs restrict the scope of benefits in cases of dust-related diseases such as silicosis and asbestosis.

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

Types and Amounts of Benefits

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

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

dent 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 setting the maximum weekly benefit amounts, basing them on automatic adjustments in relation to the average weekly wage in the jurisdiction. Without these automatic adjustments, annual legislation would be required to increase the maximum weekly benefit amount; consequently, an even greater number of injured workers would fail to receive a benefit equal to the State's percentage.

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

Compensation is payable in all juris-

dictions, 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 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 it has been determined that the worker is permanently and totally disabled for any type of gainful employment, permanent total disability benefits are payable. Both temporary and permanent total disability are usually compensated at the same rate. 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,

State maximum weekly benefits (excluding dependents' allowances) range from \$225 to \$737 (\$65 in Puerto Rico, \$1,204.36 for Federal civilian employees). The median State maximum in January 1992 was \$409.

Most programs provide for temporary disability benefits for the duration of the disability and if the possibility exists for further improvement with medical treatment. But 17 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 9 programs where permanent total disability benefits are limited in duration, amount, or both, the periods range from 260 weeks to 700 weeks. Some programs provide additional payments for an attendant if one is required.

In 9 States, injured persons who are

Table 6.—Benefits and costs under State and Federal workers' compensation programs, selected years, 1940-91¹

Year	Benefits paid during year (in millions)				Type of benefit		Percent of covered payroll ⁵	
	Total	Insurance losses paid by carriers ²	State fund disbursements ³	Employers' self-insurance payments ⁴	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	24,613	13,827	6,248	4,538	8,642	15,971	1.99	1.37
1987	27,318	15,453	6,782	5,082	9,912	17,406	2.07	1.43
1988	30,733	17,512	7,477	5,744	11,518	19,215	2.16	1.49
1989	34,316	19,918	7,965	6,433	13,424	20,892	2.27	1.58
1990	38,238	22,222	8,658	7,358	15,187	23,051	2.36	1.70
1991	42,169	24,515	9,711	7,944	16,832	25,337	2.40	1.79

¹ Beginning in 1960, includes Alaska and Hawaii.

² Net cash and medical benefits paid during calendar year by private insurance companies under standard workers' compensation policies.

³ Net cash and medical benefits paid by competitive and exclusive State funds, the Federal program for Government employees, and,

beginning in 1970, by the Federal Black Lung benefits program.

⁴ 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.

⁵ Excludes programs financed from general

revenues—most Federal black lung benefits and supplemental pensions in a few States.

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.

Table 7.—Minimum and maximum benefits for temporary total disability under workers' compensation laws, January 1, 1992

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	\$106 or worker's average wage, if less ²	\$385.00	100	...
Alaska	80% of spendable earnings	\$110 (\$154 if employee shows proof of wages) or worker's spendable weekly wage, if less	\$700.00	...	Duration of disability until date of medical stability
Arizona.....	66 2/3	...	³ \$323.08	...	...
Arkansas	66 2/3	\$20.00	\$241.93	70	450 weeks
California.....	66 2/3	\$126.00	\$336.00	66 2/3	...
Colorado	66 2/3	...	\$395.71	91	...
Connecticut.....	80% of spendable earnings	\$147.40 or 80% of worker's average wages, if less ²	\$737.00	150	...
Delaware	66 2/3	\$104.13 or average wage, if less ²	\$312.39	66 2/3	...
District of Columbia.....	66 2/3, or 80% of spendable earnings whichever is less	² \$153.27	\$613.09	100	...
Florida	66 2/3	\$20.00 or actual wage, if less	\$409.00	100	260 weeks
Georgia	66 2/3	\$25.00 or average wage, if less	\$225.00	...	...
Hawaii	66 2/3	\$109 or worker's average wage if less, but not less than \$38 ²	\$437.00	100	...
Idaho	567	² \$162.00 ²	\$324.00	90	52 weeks; thereafter, 67% of State average weekly wage
Illinois.....	66 2/3	\$109.90 to \$124.30 or worker's average wage, if less	\$655.73	133 1/3	...
Indiana.....	66 2/3	\$50 or worker's average wage, if less	\$328.00	...	500 weeks or \$164,000
Iowa	80% of worker's spendable earnings	\$128.00 or actual wage, if less ²	\$733.00	200	...
Kansas	66 2/3	\$25	\$289.00	75	\$100,000
Kentucky	66 2/3	² \$76	\$380.00	100	...
Louisiana.....	66 2/3	\$79 or actual wage, if less ²	\$295.00	75	...
Maine	66 2/3	\$25	\$518.42	166 2/3	...
Maryland	66 2/3	\$50 or actual wage, if less	\$475.00	100	...
Massachusetts	60	\$103.10 or worker's average wage, if less ²	³ \$515.52	100	156 weeks or 250 times State average
Michigan	80% of worker's spendable earnings	...	\$441.00	90	...
Minnesota	66 2/3	\$221.50 or actual wage, if less, but not less than \$88.40	\$443.00	100	...
Mississippi.....	66 2/3	\$25	\$227.18	...	450 weeks or \$102,231
Missouri	66 2/3	\$40	\$431.26	105	400 weeks
Montana.....	66 2/3	...	\$336.00	100	...
Nebraska.....	66 2/3	\$49 or actual wage, if less	\$265.00	...	...
Nevada.....	66 2/3	...	\$421.26	100	...

See footnotes at end of table.

Table 7.—Minimum and maximum benefits for temporary total disability under workers' compensation laws, January 1, 1992—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	\$168.80 or worker's after-tax earnings, if less ²	\$633.00	150	...
New Jersey.....	70	² \$109	\$409.00	75	400 weeks
New Mexico.....	66 2/3	\$36 or actual wage, if less	\$307.30	85	700 weeks
New York.....	66 2/3	\$40 or actual wage, if less	\$350.00	...	...
North Carolina.....	66 2/3	\$30	\$429.00	110	...
North Dakota.....	66 2/3	\$201 or employee's actual wage, if less ²	³ \$334.00	100	...
Ohio	72% for 12 weeks; 66 2/3 thereafter	\$147.67 or actual wage, if less ²	\$443.00	100	...
Oklahoma	66 2/3	\$30 or actual wage, if less	\$246.00	66 2/3	300 weeks
Oregon.....	66 2/3	\$50 or 90% of actual wage, if less	\$429.71	100	...
Pennsylvania	66 2/3	² \$227.50	\$455.00	100	...
Puerto Rico.....	66 2/3	\$20	\$65.00	...	312 weeks
Rhode Island.....	66 2/3	...	³ \$427.00	100	...
South Carolina.....	66 2/3	\$75 or worker's average wage, if less	\$379.82	100	500 weeks
South Dakota.....	66 2/3	\$154 or worker's average wage, if less ²	\$308.00	100	...
Tennessee.....	66 2/3	\$35.00	\$294.00	...	\$117,600
Texas	70% of earnings over \$8.50 per hour; 75% for all others	^{2, 5} \$66.00	⁵ \$438.00	100	...
Utah	66 2/3	\$45.00	³ \$378.00	100	312 weeks
Vermont.....	66 2/3	\$198 or worker's average wage, if less ²	³ \$592.00	150	...
Virgin Islands.....	66 2/3	\$60 or actual wage, if less	\$271.00	66 2/3	...
Virginia.....	66 2/3	\$104 or actual wage, if less ²	\$418.00	100	500 weeks
Washington.....	⁴ 60-75	\$44.05 to \$83.81	\$415.13	100% of State's monthly wage	...
West Virginia.....	70	² \$131.34	\$394.02	100	208 weeks
Wisconsin	66 2/3	\$20 or actual wage, if less	\$450.00	100	...
Wyoming	66 2/3 of actual monthly earnings	...	\$392.00	100% of monthly wage	...
United States:					
Federal employees....	66 2/3	\$186.13 or actual wage, if less	\$1,204.36	(6)	...
Longshore workers.....	66 2/3	\$174.99 or actual wage, if less ²	\$699.96	200% of national weekly wage	...

¹ Benefits payable for duration of disability without any dollar limit.

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, \$25 monthly per dependent residing in United States; Massachusetts, \$6 per dependent if weekly benefits are below \$150; North Dakota, \$10 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 According to current law, marital status and number of dependents.

weekly wage at a specified future date.

⁵ Minimum increased by \$1 and maximum by \$7 for each \$10 increase in weekly wage for manufacturing.

⁶ Based on 75 percent of the pay of specific grade level in the Federal civil service.

compensated for temporary and/or permanent total disability receive additional benefits for dependents. In two of these programs, such payments are made in case of temporary disability only, and in two others these allowances are only for permanent disability. The effect of these allowances in general is to increase the maximum weekly payments that a disabled worker receives. Under a few programs, however, the additional allowances are limited by the same weekly maximum benefit amount or aggregate maximum that is payable whether or not there are dependents. 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 earning capacity. The typical law recognizes two types of permanent partial disabilities: Specific or "schedule" injuries (such as the loss of an arm, leg, eye, or other part of the body) and general or "non-schedule" 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 16 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 35 programs, there are limitations on the maximum amounts and/or periods of payment ranging from 200 weeks to 1,000 weeks, and amounts ranging from \$12,000 to \$382,980.

Under a majority of programs, the compensation payable for permanent partial disability is in addition to that

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

Death benefits.—Generally, compensation related to earnings and graduated by the number of dependents is payable to the survivors of workers who die from work injury. Thirty-seven programs, including those covering Federal employees and longshore and harbor workers, provide weekly or monthly death payments to the spouse for life or until remarriage (regardless of the spouse's age at the death of the worker). All programs provide payments to children until age 18 or later if they are incapacitated or are students. Under 9 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 \$700 to \$6,000. The median State maximum payment is \$3,000. States pay these amounts regardless of the availability of monthly survivor benefits, except in Oklahoma where \$3,000 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 limit on time or amount for accidental injuries (except that the Virgin Islands limits medical care to \$40,000 per injury). A few programs provide for only limited medical benefits when occupational disease, dental care, or prostheses and appliances are involved.

Under 32 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 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. New 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, pre-

mium or "manual" rates may be less than 0.1 percent of payroll; in very hazardous occupations, the rates may exceed 20 percent.

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 1990 the cost to employers for obtaining insurance or for self-insuring the risk of employment injury averaged 2.36 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 1990, the programs were about evenly divided in the method used to defray administrative costs.

Administration

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

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 by 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 compensation is to be paid. 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.

Rehabilitation

All workers' compensation programs provide for physical rehabilitation when needed. In addition, all but six 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 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 26 programs, the second-injury fund legislation is broad enough to apply to any preexisting impairment. Under each of the remaining programs—except Wyoming, which does not have a second-injury fund—legislation is limited to workers who have certain specified im-

pairments 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.

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 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 autho-

rized 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 1991, about 275,000 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 disease 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 1993, this monthly benefit amount was \$418.20. 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 \$836.40. A widow, widower, or other surviving dependent (child, parent, brother, or sister) of a disabled miner who died also receives the basic benefit of \$418.20. 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 earnings test. 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 1991, total black lung benefit payments amounted to \$1.4 billion, of which \$0.8 billion was made through the part of the program administered by SSA and \$0.6 billion was made through the Department of Labor. About three-fifths of the payments were made to miners and their dependents; the remainder was paid to survivors. These payments include \$117 million in medical benefits.

Financing and administration.—The original part of the Black Lung 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 those originally enacted, 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 principal and interest owed to the 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 temporary 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 was amended in 1946 to permit States where employees made contribu-

tions 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 employers or unions through group

disability insurance or formal paid sick-leave plans established through collective bargaining or the employers' 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 in 1991, through voluntary and government mandated coverage—that is, temporary disability insurance—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 \$14.2 billion in wage-replacement benefits (including formal sick leave), of which \$2.8 billion was paid under temporary disability insurance laws.

Coverage

Some 21.2 million employees, or 22 percent of the country's wage and salary labor force in private industry, were covered in 1991 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 the other State programs generally provide elective coverage for some or all public employees.

Agricultural workers are covered in California, Hawaii, New Jersey, and Puerto Rico but are not covered in other jurisdictions. Coverage for agricultural workers in California is based on wages earned in private industry, with maximum benefits ranging from \$50 to \$266 per week. 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 exception, the laws make coverage against the risk of wage loss due to short-term nonoccupational disability mandatory for all employees subject to the law.

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 coverage through a union-employer benefit plan. Coverage by the State fund is automatic unless or until an employer or the employees take positive action by substituting a private insurance 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 plans 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 unem-

ployed 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 1991, private insurance plans accounted for 21 percent of the covered workers in New Jersey and only 5 percent in California. In contrast, private plans cover all workers in Hawaii, almost all in New York, and 61 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, a claimant may be disqualified if he or she receives 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 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 insurance plans, the plans either insure workers immediately upon their employment or, in some cases, require a short probationary period of employment, usually from 1 to 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.)

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 any week for which he or she receives unemployment benefits. The New Jersey law deducts from disability

payments the amount of any pension received if the pension was contributed to by the claimant's most recent employer. Puerto Rico disallows 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 one-half the weekly wage loss for a limited time. All the laws, however, specify minimum and maximum amounts payable for a week. As of January 1993, the maximum weekly amount ranged from \$104 in Puerto Rico to \$336 in California. In three States, the maximum amount is recomputed annually so that it will equal a specified percentage of the State's average weekly wage in covered employments: 66-2/3 percent in Hawaii, 53 percent in New Jersey, and 75 percent in Rhode Island, which also pays benefits to dependents.

The maximum duration of benefits varies between 26 and 52 weeks. Hawaii, New York, and Puerto Rico provide for benefits of a uniform duration of 26 weeks for all claimants; California and the railroad program have maximum benefit periods of 52 weeks; New Jersey, 26 weeks; and Rhode Island, 30 weeks. Under the railroad program, duration varies between 26 weeks and 52 weeks, based on the total number of years of employment in the industry. In the other jurisdictions, limited predisability "base-period" wages reduce benefit duration.

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 Is-

land, 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 insurance plan can be substituted for the State plan, it must afford benefit rights greater than those under the State-operated plan. In Hawaii, New Jersey, and Puerto Rico, private plan benefits must be at least as favorable as those under the government plans. Hawaii permits deviation from statutory benefits if the aggregate benefits provided under the private plan are actuarially equal or better. In New York, adherence to precise statutory benefits is not required; the benefit package provided by private plans must be "actuarially equivalent" to the statutory formula and must meet certain minimum standards. Some features of a private insurance 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 1991, the average payment for a week of disability in Puerto Rico was \$74 under the publicly operated fund, and \$100 under private plans. In New York, the average weekly benefit for both public and private plans was \$185; in California, \$204 under the public plan (which covers most of the workers), and \$284 for the workers covered under private plans. The average duration per period of disability was only 4.8 weeks in Hawaii, but was 14.5 weeks in California (State-operated fund).

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

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

Financing

Under each of the laws, except for that governing the railroad program, employees may be required to contribute to the cost of the temporary disability 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 1.3 percent on a worker's wage up to a taxable wage base of \$38,000. Railroad employers pay a joint unemployment insurance/temporary disability insurance contribution on wages of up to \$810 a month per employee. The contribution is the same for all employers but can vary each year from 0.65 percent to 12 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 of up to \$12,000 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 the first \$120 of weekly 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 costs to the States of supervising these plans. In Hawaii, the administrative costs are paid from general revenues. In New Jersey, employers covered by the State-operated plan pay an extra assessment for the costs of maintaining separate accounts for experience-rating purposes.

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

Administration

Five of the seven temporary disability insurance programs are administered by the same agency that administers unemployment insurance. Under these five programs, unemployment insurance ad-

ministrative machinery is used to collect contributions, to maintain wage records, to determine eligibility, and to pay benefits to workers under the State-operated funds. The New York law is administered by the State Workers' Compensation Board, and the Hawaii law is administered separately in the Department of Labor and Industrial Relations.

By way of contrast, claims in New York and Hawaii are filed with and paid by either the employer, the insurance carrier, or the union health and welfare fund that is operating the private plan. The State agency limits its functions

with respect to employed workers to exercising general supervision over private plans, setting standards of performance, and adjudicating disputed claims arising between claimants and carriers. A similar situation applies to claimants under private plans in California, New Jersey, and Puerto Rico.

All the laws require the claimant to be under the care of a physician (or, in California and Hawaii, the claimant may be in the care of an authorized religious practitioner of the claimant's faith). The first claim must be supported by a physician's certification. It must include a diagnosis, the date of treatment, an

opinion as to whether the illness or injury prevents the claimant from carrying on his or her customary work, and an estimate of the date when the claimant will be able to work again.

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

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 \$751.8 billion for 1991. This amount constituted 13.2 percent of the gross domestic product (GDP). Fifty-six percent of these expenditures originated in the private sector and 44 percent represented expenditures by Federal, State, and local governments.

More than 70 percent of the public expenditures for health and medical care were for the Medicare and Medicaid programs—39 percent and 32 percent, respectively. Hospital and medical care costs for the Department of Defense and for veterans accounted for 8 percent; workers' compensation payments for 6 percent; and various public health expenditures, medical research, and construction of medical facilities accounted for most of the remainder.

Through the Medicare and Medicaid programs, public health and medical care expenditures in the United States target 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 initiated 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 programs of 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. However, none of these bills was ever brought to a vote.

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 vendor payments in a given month for some recipients became eligible for Federal cost-sharing as long as the payments were offset by zero or low 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 there was general agreement on the need for congressional action, 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 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, home health agencies, and hospices. The program is financed by payroll taxes on employers, employees, and the self-employed. The SMI program covers services and supplies furnished by physicians, outpatient hospital services, durable medical equipment, and other specified expenses. Participation in the SMI program is voluntary for persons entitled under the HI program and is funded through premiums from participating persons and a matching Federal contribution from general revenues.

The 1965 legislation also created Medicaid (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, uni-

fied 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 somewhat too high—under the income-support programs. In addition, Federal participation under the Medicaid legislation required States to liberalize certain eligibility rules besides those regarding income and resources.

The Medicare and Medicaid programs have been subject to numerous legislative changes subsequent to their enactment in 1965. Some changes are noted below.

The Social Security Amendments of 1967 established the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program under Medicaid to improve child health. The Social Security Amendments of 1972 extended coverage under Medicare to persons entitled, due to their disability, to Social Security or Railroad Retirement benefits, and to certain persons with end-stage renal (kidney) disease.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 provided hospice care to Medicare Part A beneficiaries who were terminally ill. The Social Security Amendments of 1983 introduced a prospective payment system for Medicare reimbursement of inpatient hospital services in an attempt to control rising hospital costs. Legislation in 1984-87 gave the States the option to improve the coverage of pregnant women and children under Medicaid by easing categorical restrictions and income limitations. Legislation in 1988-90 went further by requiring the States to cover

pregnant women and infants under age 1 and to phase in the coverage of children born after September 30, 1983, who meet specified eligibility conditions. Legislation in 1987-91 liberalized mental health benefits under Medicare by eliminating the annual reimbursement limit and covering partial hospitalization and the services of independent clinical psychologists and social workers.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 provided the largest expansion of Medicare since the program's inception in 1965. Beneficiaries were to be protected from the costs of catastrophic medical bills and provided with the first broad coverage of outpatient prescription drugs. These benefits were to be financed by a premium increase and a new income-related supplemental premium to be paid by individuals eligible for Medicare Part A. The Medicare Catastrophic Coverage Repeal Act (MCCRA) of 1989 repealed the Medicare catastrophic benefits and the special premiums, and generally restored Medicare benefit levels to those available prior to January 1989.

The MCCRA of 1989 did not affect the expanded Medicaid provisions in MCCA of 1988. One of the provisions requires State Medicaid programs to pay for the Medicare premium, deductibles, and coinsurance for aged, blind, and disabled “qualified Medicare beneficiaries”—in 1991, those with income below 100 percent of the Federal poverty level and resources at or below twice the standard allowed under the SSI program. Another provision accelerated Medicaid eligibility for some nursing home patients by protecting more income and assets for the institutionalized person's spouse living at home.

The Omnibus Budget Reconciliation Act (OBRA) of 1989 introduced a fee schedule for determining reasonable charges for physicians' services under Medicare. The fee schedule, based on a relative value scale for physicians' services that takes into account such factors as skill, time expended, and geographic cost variations, is being phased in over the period 1992-95. It replaces the previous reimbursement method based on customary and prevailing charges.

Medicare: Health Insurance for the Aged and Disabled

The Social Security Amendments of 1965 established two separate but coordinated health insurance plans for persons aged 65 or older. The compulsory program of Hospital Insurance (HI) is Part A of Medicare and a voluntary program of Supplementary Medical Insurance (SMI) is Part B. Benefits were first available in July 1966, although post-hospital extended care services in skilled-nursing facilities (SNF) were not covered until January 1967. The 1972 Amendments extended Medicare coverage to certain severely disabled persons under age 65 and to certain persons suffering from kidney disease.

In 1992, 35.2 million persons were enrolled for Medicare Part A, and 33.9 million under Medicare Part B. Medicare benefit payments for 1992 totaled \$133.2 billion, of which HI accounted for \$83.9 billion and SMI accounted for \$49.3 billion.

Table 8 presents data on persons served under the Medicare program and the amounts reimbursed by the type of service provided in 1991. Inpatient hospital care accounted for 55 percent of the total amount reimbursed under the Medicare program (Parts A and B).

Hospital Insurance

Individuals eligible for Social Security or Railroad Retirement benefits are eligible for premium-free HI benefits when they reach age 65, whether they have claimed monthly benefits or not. Workers and their spouses in Federal, State, or local government employment with a sufficient period of Medicare-only coverage also are eligible at age 65.

Additionally, HI protection is provided to disabled beneficiaries (but not their dependents) who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months (or government employees with Medicare-only coverage who have been disabled for more than 29 months), and to insured workers (and their spouses and

children) with end-stage renal disease who require dialysis or a kidney transplant. The Social Security Amendments of 1980 (P.L. 96-265) eliminated the requirement (effective December 1, 1980), that the 24 months be consecutive. Months from previous periods of disability benefit entitlement may be counted in determining whether or not the monthly qualifying period requirement is met, provided the current onset begins within certain time limits following the earlier period of entitlement.

Also eligible for HI enrollment under transitional provisions are persons aged 65 or older with specified amounts of earnings credits less than those required for monthly benefit eligibility. (Not eligible under the transitional provisions are retired Federal employees covered by the Federal Employees' Health Benefits Act of 1959 or aliens admitted for permanent residence, unless they have 5 consecutive years of residence and the required covered quarters under these provisions.)

The Tax Equity and Fiscal Responsibility Act of 1982 required that as of January 1983, Federal employees be covered for HI protection. Federal workers employed during January 1983 were permitted upon retirement to use Federal wage quarters earned before 1983 to help establish entitlement to HI benefits if they were needed. Since July 1973, most persons aged 65 or older and otherwise ineligible for HI have been permitted to enroll voluntarily and pay a monthly premium for HI protection if enrolled for SMI.

Benefits provided.—Under the HI program, beneficiaries receive the following four kinds of medically necessary care: (1) inpatient hospital care; (2) inpatient care in a skilled-nursing facility (SNF) following a hospital stay; (3) home health care; and (4) hospice care.

- Inpatient hospital care. Effective January 1, 1994, once a Medicare

beneficiary has paid the inpatient hospital deductible (\$696 in 1994), all remaining costs of covered hospital services for the first 60 days in a benefit period will be paid by Medicare. From the 61st through the 90th day in a benefit period, the patient pays a daily coinsurance amount equal to one-fourth the inpatient hospital deductible (\$174 in 1994). Each HI beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once and the daily coinsurance amount is one-half the inpatient hospital deductible (\$348 in 1994). Covered hospital care includes all those services ordinarily furnished by a hospital to its patients: 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. Benefits include reimbursement for inpatient tuberculosis and psychiatric hospital services—with a lifetime limit of 190 days of care in a psychiatric hospital—and emergency inpatient care in a nonparticipating hospital. Psychiatric care in general hospitals, rather than in free-standing psychiatric hospitals, is not subject to the 190-day limit and is treated the same as other Medicare inpatient hospital care.

- Certain post-hospital care. Following hospitalization for at least 3 consecutive days, if a patient requires a skilled level of nursing care or skilled-rehabilitation services on a daily basis, but not hospital care, such services are covered in an institution or section of a hospital that qualifies as a skilled-nursing facility.

Table 8.—Aged and disabled persons enrolled and served under the Medicare program—Hospital Insurance (HI-Part A) and Supplementary Medical Insurance (SMI-Part B)—and total amount reimbursed, by type of coverage and service, 1991¹

Type of coverage and service	Aged	Disabled
Persons enrolled (in thousands)		
HI and/or SMI	31,485	3,385
HI	31,043	3,385
SMI	31,185	3,052
Persons served (in thousands)		
HI and/or SMI	25,190	2,466
HI	6,576	706
Inpatient hospital	6,052	666
Skilled-nursing	648	23
Home health	2,082	141
SMI	25,053	2,439
Physicians' and other medical	24,492	2,304
Outpatient	14,787	1,583
Home health	32	(2)
Amount reimbursed (in millions)		
HI and/or SMI	\$98,384	\$12,503
HI	61,474	7,512
Inpatient hospital	54,366	7,045
Skilled-nursing	2,151	87
Home health	4,958	379
SMI	36,910	4,991
Physicians' and other medical	28,965	3,054
Outpatient	7,870	1,937
Home health	76	(2)
Amount reimbursed per person served		
HI and/or SMI	\$3,906	\$5,070
HI	9,349	10,634
Inpatient hospital	8,983	10,572
Skilled-nursing	3,321	3,846
Home health	2,381	2,696
SMI	1,473	2,047
Physicians' and other medical	1,183	1,326
Outpatient	532	1,224
Home health	2,360	526

¹ Data for persons enrolled are as of July 1; for persons served and amount reimbursed, data are for calendar year.

² Less than 500.

Payment for up to 100 days of care per benefit period is covered with no coinsurance for the first 20 days, and daily coinsurance for days 21 through 100. This daily coinsurance rate is one-eighth of the inpatient hospital deductible (\$87.00 per day in 1994).

- Home health care (part-time or intermittent skilled-nursing care, physical therapy, or speech therapy). Unlimited home visits are covered if the beneficiary is homebound (but need not be bedridden), and if a physician sets up a home health plan after determining that the individual requires skilled-nursing care on an intermittent basis, and/or physical or speech therapy. (Intermittent is defined as no more than 4 days per week, and daily skilled-nursing visits are permitted for up to 8 hours a day for up to 3 weeks, if medically reasonable and necessary.) Other services can include necessary part-time or intermittent home health aide services, occupational therapy, medical-social services, and medical supplies. Effective October 1, 1990, new quality standards were required for Medicare participating skilled-nursing facilities and home health agencies. 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 a 20-percent coinsurance (that is, the beneficiary must pay 20 percent of the cost).

- Hospice care. Added in 1983, services are provided to beneficiaries certified as terminally ill. These services cover two 90-day hospice benefit periods, a subsequent period of 30 days, and a subsequent extension of unlimited duration. When these services—often provided in the beneficiary's home—are furnished by a Medicare-certified facility, the coverage includes: physician services, nursing care, medical appliances and supplies, drugs for symptom management and pain relief, short-term inpatient care, counsel-

ing, therapies, home health aide, and homemaker services. Part A and Part B deductibles do not apply to services and supplies furnished under the hospice benefit, and the beneficiary pays only limited charges for outpatient drugs and inpatient respite care. The beneficiary pays deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

Financing and administration.

Hospital insurance is financed by a tax on earnings that is separate from the tax used to finance Old-Age, Survivors, and Disability Insurance (OASDI) benefits. Before January 1, 1991, OASDI and HI taxes were applied to the same maximum earnings base (\$51,300 in 1990). However, under Public Law 101-508, beginning in 1991, annual earnings up to \$125,000 were subjected to HI taxes, with the amount indexed to increases in average wages in the economy after 1991 (for 1993, the maximum earnings base for OASDI was \$57,600, and \$135,000 for HI). The Omnibus Budget Reconciliation Act of 1993 (OBRA 93)—P.L. 103-66—repealed the dollar limit on wages and self-employment income subject to HI taxes. The HI contribution rate of 1.45 percent applies equally to employers and employees. The rate for the self-employed equals the combined employer and employee rate of 2.9 percent.⁴ The income is channeled into a separate Federal Hospital Insurance Trust Fund established on a basis similar to that of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. All HI benefits and administrative costs are paid from this trust fund. Under a special provision, the HI Trust Fund is reimbursed from general revenues for the cost of providing HI coverage for certain aged persons not entitled to OASDI or Railroad Retirement benefits.

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). Responsibility for administering the Federal Medicare program and the combined Federal-State Medicaid programs rests with HCFA. The Social Security Administration is responsible for the initial determination of an individual's entitlement and has overall responsibility for maintaining the master beneficiary records.

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. HCFA develops regulations and guidelines for determining if hospitals, skilled-nursing facilities, home health agencies, hospices, and other providers 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 insurance companies serve as intermediaries whose responsibilities include:

- determining costs and reimbursement amounts;
- maintaining records;
- establishing controls;
- safeguarding against fraud and abuse or excess use;
- conducting reviews and audits;
- making the payments to providers for services, and;

- assisting both providers and beneficiaries as needed.

Skilled-nursing facilities, home health agencies, and some hospitals are reimbursed on the basis of reasonable costs, subject to certain monetary limits. Most hospitals are paid under 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.

Ordinarily, payments 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.

To improve the quality and effectiveness of Medicare services, the 1972 amendments authorized the establishment of medical review groups, called Professional Standards Review Organizations (PSRO's). The 1982 amendments replaced the PSRO's with Peer Review Organizations (PRO's). A PRO (one in each State) 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, provided in the appropriate setting (hospital versus nonhospital), reviewing the validity of hospitals' diagnostic information, reviewing the appropriateness of admissions and discharges, deciding if professionally accepted standards of quality are being met, and reviewing the appropriateness of care for which additional payment is sought for extraordinarily costly cases. To receive Medicare payments, each hospital must have an agreement with a PRO.

Supplementary Medical Insurance

A person is generally eligible to enroll in the SMI (Part B) program on a voluntary basis by paying a monthly premium, if he or she is:

- (1) Entitled to premium-free hospital insurance protection; or
- (2) Age 65 or older, a resident of the United States, and either: (a) a citizen of the United States, or (b) an alien lawfully admitted for perma-

manent residence who has resided in the United States continuously during the 5 years immediately prior to the month in which he or she applies for enrollment.

For Part B, "cost-sharing" contributions are required of beneficiaries, which include: one annual deductible (now \$100); the monthly premiums; coinsurance payments for Part B services (usually 20 percent of allowable charges); a blood deductible; charges above the Medicare allowed charge (for claims not on assignment); and payment for any services that are not covered by Medicare.

For 1994, enrolled individuals pay a monthly premium of \$41.10, which is deducted from their Social Security benefit, Railroad Retirement annuity, or Federal Civil Service Retirement annuity. Enrollees not yet receiving their benefits are billed quarterly. Each year the premium rate is adjusted. SMI costs not covered by premiums are financed from general revenues (72 percent of SMI Trust Fund income in 1992). Individuals may either pay the premium or be eligible to have the State social service or medical assistance agency pay the premium on their behalf.

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 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 some covered services furnished by chiropractors, podiatrists, dentists, and optometrists (except routine physical examina-

tions and routine care of the eyes, ears, and feet, and most immunizations and cosmetic surgery). Also covered are the following Medicare approved practitioners who are not physicians:

- Certified registered nurse anesthetist.
- Clinical psychologists.
- Clinical social workers (other than in a hospital or skilled-nursing facility).
- Physician assistants.
- Nurse practitioners and clinical nurse specialists in collaboration with physicians.
- Services in an emergency room or outpatient clinic, including same day surgery.
- Laboratory tests, X-rays, and other radiology services billed by the hospital, as well as approved independent laboratory services, portable diagnostic X-ray services, pap smear screening, and mammography.
- Mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without ...

- Ambulatory surgical center services in Medicare-approved facilities.
- Physical and occupational therapy, and speech pathology services under a plan established by a physician on an outpatient basis in a participating hospital, skilled-nursing facility, participating home health agency, rehabilitation agency, or public health agency.
- Comprehensive outpatient rehabilitation facility services, nonhospital treatment of a mental illness, and partial hospitalization for mental health treatment.
- Rural health clinic services and services provided in a federally qualified health center, and ambulance transportation under certain conditions.
- Radiation therapy, renal (kidney) dialysis and transplants, and heart

and liver transplants under certain limited conditions.

- Approved durable medical equipment for home use, such as oxygen equipment and wheelchairs; prosthetic devices; surgical dressings, and splints and casts.
- Drugs and biologicals, which cannot be self-administered, such as pneumococcal pneumonia vaccine, hepatitis B vaccine, hemophilia clotting factors, transfusions of blood and blood components, antigens, immunosuppressive drugs, and epogen when used to treat anemia related to chronic kidney failure, or HIV positive beneficiaries.

For most covered services, the beneficiary is liable for an annual deductible and 20 percent of costs in addition to that deductible. The 1990 law increased the deductible to \$100, effective January 1, 1991. For outpatient mental health treatment services, the beneficiary is liable for 50 percent of the approved charges.

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 the reasonable cost

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. The physician may submit the bill for the beneficiary without accepting assignment, and the patient remains responsible for the total bill and is paid by Medicare. However, the law limits what doctors may charge beneficiaries over the fee allowed by Medicare. Doctors who do not accept assignments may charge no more than 115 percent of Medicare-approved fees in 1993 and thereafter. 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 assignments instead of making the decision each time a service is provided. A beneficiary who uses a participating physician or supplier is assured that the beneficiary will not be responsible for more than the initial deductible and the coinsurance applicable to the reasonable charge.

The Medicare reasonable charge prior to 1992 was 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 three out of four 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. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) provided for the replacement of customary and prevailing charges with fee schedules for physicians' services starting in 1992. The fee schedules are based on a relative value scale. The fee schedule amount is equal to the product of the procedure's relative value, a conversion factor, and a geographic adjustment factor. Payments are based on the lower of the actual charge and the fee schedule amount. For the 4-year period from 1992 to 1995, the fee schedule amounts will be adjusted to reflect the prevailing charges in each fee screen area.

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 insurance companies 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; granting hearings to individuals with contested claims; maintaining quality of performance records; assisting in fraud and abuse investigations; and assisting both suppliers and beneficiaries as needed. Some institutional providers of services, such as home health agencies, hospital outpatient departments, and comprehensive outpatient rehabilitation centers, are served by HI intermediaries.

Coordinated Care Plans

Coordinated care plans are prepaid, managed care plans, most of which are health maintenance organizations (HMO's) or competitive medical plans (CMP's). Both HMO's and CMP's contract with Medicare and follow the same contracting rules.

HMO's and CMP's provide or arrange for all Medicare covered services, and generally charge fixed monthly premiums and only small copayments.⁵ Joining a coordinated care plan and receiving all services through an HMO or CMP means out-of-pocket costs for the beneficiary are usually more predictable. Depending on the beneficiary's health needs, these costs may be less than would be paid if the beneficiary had

to pay the regular Medicare deductible and coinsurance amounts. Coordinated care plans may also offer benefits not covered by Medicare, such as preventive care, dental care, and products such as hearing aids and eyeglasses. HMO's and CMP's with Medicare contracts have an annual open enrollment period.

Medigap Insurance

The term Medigap describes private insurance that, within limits, pays the health care service charges not covered by Part A or B of Medicare. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90)—P.L. 101-508—directed that standards be set for Medicare supplemental insurance (Medigap) policies. These required an open enrollment period for new beneficiaries aged 65 or older and forbade insurers to deny coverage or discriminate in the price of the policy. The 1990 law also required that the Medigap policy could not be cancelled or a renewal refused by the insurer solely on the basis of the health of the policyholder.

In 1992, regulations went into effect in nearly all States, U.S. territories, and the District of Columbia, that generally limited the number of different Medigap policies which could be sold in any of these jurisdictions to no more than 10 standard benefit plans.

Each of the 10 plans must cover specific expenses either not covered or not fully covered by Medicare, with "A" being the most basic policy and "J" the most comprehensive. To make it easier to compare plans and premiums, the same format, language, and definitions must be used in describing the benefits of each of the 10 standard plans. A uniform chart and outline of coverage also must be used to summarize those benefits. With standardization, each company's products are alike, so they are competing on service, reliability, and price. Federal law permits States to allow an insurer to add "new and innovative benefits" to a standardized plan, which must be cost-effective, not otherwise available in the marketplace, and offered in a manner consistent with the goal of simplification.

Secondary Payer Provisions

Some persons who have Medicare may also have group health coverage. Usually, Medicare is their primary payer, which means that Medicare pays first on their health care claims. In some instances, the other plan must pay first. In that case, Medicare is the secondary payer. Until 1980, Medicare was the primary payer in all cases except those involving workers' compensation (including black lung benefits) or veterans benefits. Since 1980, legislation has made Medicare the secondary payer for several additional categories.

Medicare is secondary payer to some group health plans for services provided to Medicare beneficiaries as follows:

- (1) employed persons aged 65 or older; and persons aged 65 or older with employed spouses of any age, who elect to be covered by employment-based health insurance through an employer having 20 or more employees;
- (2) persons under age 65 who are entitled to Medicare on the basis of disability (other than those with permanent kidney failure), who elect to be covered by employment-based health insurance as current employees (or as a family member of such an employee) through an employer with at least 100 employees;
- (3) during a period (generally 18 months) for beneficiaries who have Medicare solely on the basis of permanent kidney failure, if they have employer-group health plan coverage themselves or through a family member; and also
- (4) in cases where no-fault insurance or liability insurance is available as the primary payer.

The Omnibus Budget Reconciliation Act of 1993

Legislation affecting the Medicare and Medicaid programs was included in OBRA 93, which became P.L. 103-66 on August 10, 1993. Various provisions were designed to restrain Medicare cost increases, increase contributions to the

HI Trust Fund, and make changes in Medicare Part A and Part B premiums. Following are some of the highlights of the new legislation.

Restraints on Costs

Prospective payment system (PPS) hospital update.—Payments to urban hospitals under the PPS will be updated by the increase in the market basket minus 2.5 percentage points for fiscal years 1994 and 1995, by market basket minus 2.0 percentage points for fiscal year 1996, and by market basket minus 0.5 percentage point for fiscal year 1997. Payments to rural hospitals will be updated by the increase in the market basket minus 1.0 percentage point in fiscal year 1994 and whatever increase is needed to equalize the rural and "other urban" standardized amounts in fiscal year 1995. In fiscal year 1996 and thereafter, rural hospitals will receive the same update factor as urban hospitals. For fiscal years 1998 and thereafter, the update for PPS hospitals is set equal to the percentage increase in the hospital market basket.

PPS exempt hospitals.—Cost limits applied to hospitals exempt from the PPS will be updated by the market basket increase minus 1.0 percentage point each year for fiscal years 1994 through 1997, with an exemption for low-threshold hospitals. For fiscal year 1998 and thereafter, the update for hospitals exempt from the PPS is set equal to the percentage increase in the hospital market basket.

Physicians' services.—Under prior law, payments for services covered under Part B are generally updated each year by an inflation index. Under the new legislation, for 1994 the update for physician services is reduced by 3.6 percentage points for surgical services, and 2.6 percentage points for all other services (including anesthesia services), with the exception of primary care services, which will receive the full update. For 1995, the update will be reduced by 2.7 percentage points for surgical and all other services (including anesthesia services), with the exception of primary care services, which will receive the full update.

The 1993 legislation also includes cost restraint provisions applicable to skilled-nursing facilities, hospices, laboratory services, anesthesia care teams, and other services and expense computations.

Tax Increase

Repeal of the Health Insurance wage base cap.—OBRA 93 repealed the dollar limit on wages and self-employed income subject to the Medicare HI tax. This provision became effective for wages and self-employment income received after December 31, 1993.

Premiums

Reduction in the Part A premium.—The legislation reduces Part A premiums on a phased-in basis for individuals and their spouses who have at least 30 quarters of Social Security coverage. (Part A premiums apply to those beneficiaries who are not eligible for Social Security or Railroad Retirement benefits.) Premium reductions begin at 25 percent in fiscal year 1994 and increase by 5 percentage points for the next 4 years. Beginning in fiscal year 1998, the reduction would remain at 45 percent.

Part B premium.—From 1984 through 1990, the Part B premium was set to 25 percent of the program costs for aged beneficiaries. The remaining 75 percent was covered by general revenues. OBRA 90 established the monthly Part B premium in statute through 1995 to cover 25 percent of program costs as follows: \$29.90 in 1991, \$31.80 in 1992, \$36.60 in 1993, \$41.10 in 1994, and \$46.10 in 1995. OBRA 93 extends the provision requiring that the Part B premium cover 25 percent of program costs in 1996, 1997, and 1998.

Miscellaneous

Expansion of physician ownership ban.—Under present law, physicians (or immediate family members of such physicians) with a financial relationship with clinical laboratories are prohibited from referring Medicare patients to these entities. OBRA 93 extends the self-referral ban with specified exceptions to

additional services. Effective December 31, 1994, it applies to the furnishing of "designated health" services under Medicare and Medicaid. These include clinical laboratory services; physical and occupational therapy services; radiology or other diagnostic services; radiation therapy services; durable medical equipment; parenteral and enteral nutrients; equipment and supplies; prosthetics, and orthotics and prosthetic devices; home health services, outpatient prescribed drugs; and inpatient and outpatient hospital services.

Medicare and Medicaid coverage

data bank.—OBRA 93 established a new health insurance reporting system for all employers required to file a W-2 form. A Medicare and Medicaid coverage data bank will be established within the Department of Health and Human Services to be used to identify and collect amounts from liable third party payers to reimburse costs incurred for items and services furnished to Medicare and Medicaid beneficiaries. Beginning with calendar year 1994 and ending in calendar year 1997, employers will be required to report annually the following information for each employee: name

and taxpayer identification number (TIN) of the electing individual; type of group health plan coverage (single or family) elected; the name, address, and identifying number of the group health plan elected by the employee; the name and TIN of other individuals (for example, spouses and dependents) covered under the group health plan; the period during which coverage is elected; and the name, address and TIN of the employer. A health plan will be permitted to file the report on behalf of an employer. The first filing will occur on February 28, 1995.

Medicaid

The Social Security amendments of 1965 established the Medicare and Medicaid programs. The latter was enacted as Title XIX of the Social Security Act—Grants to States for Medical Assistance Programs.

Medicaid is a Federal-State matching entitlement program, which provides medical assistance for certain individuals and families with low incomes and resources. It is a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of more adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people.

Within broad national guidelines, which the Federal Government provides, each of the States: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Thus, the Medicaid program varies considerably from State to State, as well as within each State over time.

In 1992, the Medicaid program provided health care services to over 31 million recipients who were aged, blind, or disabled persons; pregnant women; or certain individuals in families with dependent children. Total outlays for the

Medicaid program increased from \$90.5 billion in 1991 to \$114.5 billion in 1992 (\$65.9 billion in Federal and \$48.6 billion in State funds), plus administrative costs. This amount includes vendor payments of \$91.5 billion; payments for premiums (for example, health maintenance organizations (HMO's) and Medicare) of almost \$6 billion; and payments to disproportionate share hospitals (special payments to certain hospitals with a large proportion of low-income and Medicaid patients) of nearly \$17 billion. These latter payments have grown considerably in recently years.

Eligibility

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. However, to be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. The following are the mandatory Medicaid eligibility groups:

- Recipients of Aid to Families with Dependent Children (AFDC);
- Supplemental Security Income
- (SSI) recipients (or aged, blind, or disabled individuals in States that apply more restrictive eligibility requirements);
- Children under age 6 who meet the State's AFDC financial requirements or whose family income is at or below 133 percent of the Federal poverty guidelines;
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;
- All children born after September 30, 1983, in families with incomes at or below the Federal poverty guidelines. (They must be given full Medicaid coverage until age 19. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered);
- Pregnant women whose family income is below 133 percent of the Federal poverty level (services are limited to pregnancy, complications of pregnancy, delivery, and post-partum care);
- Certain Medicare beneficiaries (described later); and
- Special protected groups. (These

are usually individuals who lose their cash assistance because of the cash program's rules, but who may keep Medicaid for a period of time. Examples are (1) persons who lose AFDC or SSI payments due to earnings from work or increased Social Security benefits; and (2) two-parent, unemployed families whose cash AFDC assistance is limited by the State. These families are protected and are provided a full 12 months of Medicaid coverage).

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. The broadest optional groups that States may cover (and for which they will receive Federal matching funds) under the Medicaid program include:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is below 185 percent of the Federal poverty guidelines (the percentage to be set by each State);
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty guidelines;
- Children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC;
- Institutionalized individuals with income and resources below specified limits;
- Persons receiving care under home- and community-based waivers;
- Persons receiving only State supplementary SSI payments; and
- "Medically needy" (MN) persons (described below).

The option to have a medically needy program allows States to extend Medicaid eligibility to additional qualified

persons who have income in excess of the mandatory or optional categorically needy levels. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan. States may also allow families to establish eligibility for MN coverage by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the threshold allowance for income eligibility. Federal matching monies apply to MN programs.

The medically needy Medicaid program does not have to be as extensive as the categorically needy program. However, if a State does not elect to have a medically needy program, it is required to provide coverage to children under age 18 and pregnant women. A State also may choose to provide eligibility to other MN persons: aged, blind, and/or disabled persons; caretaker relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. In 1992, 41 States had a medically needy program for at least some groups.

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons) the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the groups designated earlier. Low income is only one test for Medicaid eligibility; assets and resources also are tested against established thresholds determined by each State.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 made significant changes that impacted Medicaid. Although much of the MCCA was repealed, the Medicaid portions remain in effect. Changes in the law accelerated Medicaid eligibility for some nursing home patients by protecting more income and assets for the institutionalized

person's spouse living at home. Before an institutionalized person's money is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted for bringing the income of the spouse living in the community up to a moderate level; and a State-determined level of resources is preserved for the community spouse.

Once entitlement to Medicaid is determined, coverage generally is retroactive to the third month prior to application. Coverage generally stops at the end of the month in which a person's circumstances change. In addition to the Medicaid program, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal matching funds are not provided for these State-only programs.

Scope of Services

Title XIX of the Social Security Act requires that, in order to receive Federal matching funds, certain basic services must be offered in any State program:

- Inpatient hospital services;
- Outpatient hospital services;
- Prenatal care;
- Physician services;
- Nursing facility (NF) services for individuals aged 21 or older;
- Home health care for persons eligible for skilled-nursing services;
- Family planning services and supplies;
- Rural health clinic services;
- Laboratory and X-ray services;
- Pediatric and family nurse practitioner services;
- Certain federally qualified ambulatory and health center services;
- Nurse-midwife services; and
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21.

States may also receive Federal assistance for funding if they elect to provide

other optional services (currently 31 options). The most commonly covered optional services under the Medicaid program include:

- Clinic services;
- Nursing facility services for the aged and disabled;
- Intermediate care facilities for the mentally retarded (ICF's/MR);
- Optometrist services and eyeglasses;
- Prescribed drugs;
- Prosthetic devices; and
- Dental services.

States may now provide home- and community-based care to certain individuals who are either medically needy or eligible for Medicaid due to receipt of SSI benefits: those who have limitations in specified activities of daily living (toileting, transferring, and eating), and are at least 65 years of age. The services to be provided to these persons may include personal care services, chore services, respite care services, adult day care, homemaker/home health aide, and nursing services. Another option allows up to eight States (as a demonstration project) to establish and provide community-supported living arrangement services for individuals with mental retardation or a related condition.

Amount and Duration of Services

Within broad Federal guidelines, States determine the amount and duration of services offered under their Medicaid programs. They may limit, for example, the days of hospital care or the number of physician visits covered. However, States are prohibited from limiting the duration of coverage for medically necessary inpatient hospital services provided to Medicaid-eligible children under age 6 in disproportionate share hospitals and to infants in all hospitals.

With certain exceptions, a State's Medicaid plan must allow recipients freedom of choice among participating providers of health care. States may provide and pay for Medicaid services

through various pre-payment arrangements, such as an HMO. In general, States are required to provide comparable services to all categorically-needy eligible persons. There are two important exceptions:

- (1) Health care services identified under the EPSDT program as being medically necessary for eligible children must be provided by Medicaid, even if those services are not included as part of the covered services in that State's plan; and
- (2) States may request home- and community-based services "waivers" under which they offer an alternative health care package for persons who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they can provide under such waivers as long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients).

Payment for Services

Medicaid operates as a vendor payment program, with payments made directly to the providers. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. Each State has broad discretion in determining (within federally imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with two exceptions: (1) for institutional services, payment may not exceed amounts that would be paid under Medicare payment rates; and (2) for hospice care services, they must pay providers no less than Medicare rates.

States may impose nominal deductibles, coinsurance, or co-payments on some Medicaid recipients for certain services. Certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and cat-

egorically needy HMO enrollees. Emergency services and family planning services must be exempt from co-payments for all recipients.

The amount of total Federal outlays for Medicaid has no set limit (cap); rather, the Federal Government must match (at a predetermined percentage) the mandatory services plus the optional services the individual State decides to provide for its eligible recipients. Reimbursement rates, on which the matching is made, must be sufficient to enlist enough providers so that Medicaid care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area. Also, States must augment payment to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or other low-income persons.

The portion of the Medicaid program that is paid by the Federal Government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each State by a formula that compares the State's average per capita income level with the national average. By law, the FMAP cannot be lower than 50 percent nor greater than 83 percent. The wealthier States have a smaller share of their costs reimbursed. In 1992, the FMAP's varied from 50 percent (paid to 12 States and the District of Columbia) to 79.99 percent (to Mississippi), with the average Federal share among all States being 57.4 percent for Medicaid service expenditures. The Federal Government also shares in the State's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50 percent for all States. Depending on the complexities and need for incentives for a particular service, higher matching rates (75, 90, or 100 percent) are authorized for certain functions and activities.

Medicare-Medicaid Relationship

Some aged and/or disabled persons are covered under both Medicaid and Medicare (Title XVIII of the Social Security Act).

The Medicare program provides Hospital Insurance (HI, also known as Part A) and Supplementary Medical Insurance (SMI, also known as Part B). For persons aged 65 or older (and for certain disabled persons) who have insured status under Social Security or Railroad Retirement, coverage for HI is automatic. Coverage for SMI, however, requires payment of a monthly premium.

The State Medicaid agency may pay SMI premiums for Medicaid recipients entitled to Medicare. This allows recipients who cannot afford the premiums to maintain full Medicare coverage. For the Medicare-entitled persons who are also fully eligible for Medicaid, Medicare coverage is supplemented by health care services that are available under the State's Medicaid program but not provided under Medicare. As each State elects, services such as prosthetic devices and nursing facility care beyond the 100-day limit covered by Medicare may be provided by the Medicaid program. In addition, there are other persons (described below) who are not fully eligible for Medicaid but who do receive some help through the State Medicaid program's payment of part or all of the person's Medicare premiums and cost-sharing expenses.

Qualified disabled and working individuals (QDVID's).—Disabled persons who lost Medicare benefits because of their return to work are allowed to purchase Medicare HI and SMI coverage. However, the HI premium must be paid by the State Medicaid program for those disabled working persons with incomes below 200 percent of the Federal poverty guidelines. The State Medicaid programs are not required to pay SMI premiums for these recipients.

Qualified Medicare beneficiaries (QMB's) and specified low-income Medicare beneficiaries (SLMB's).—Medicaid assists certain other Medicare beneficiaries known as qualified Medicare beneficiaries or specified low-income Medicare beneficiaries if they apply for help. For the QMB's (those Medicare-entitled persons with resources at or below twice the standard allowed

under the SSI program, and with incomes below Federal poverty guidelines), the State pays all the premiums and cost-sharing expenses for HI and SMI. For the SLMB's (who are like QMB's, but with slightly higher incomes—less than 110 percent of Federal poverty guidelines in 1993 and 1994, and less than 120 percent in 1995), the State Medicaid programs are required to pay only the SMI premiums. If a person is a Medicare beneficiary, payments for any services covered by Medicare is paid by the Medicare program before any payments are made by the Medicaid program. Medicaid is always the "payer of last resort."

Trends

Medicaid was initially formulated as a medical care extension of federally funded income-maintenance programs for the poor, with an emphasis on dependent children and their mothers. Over time, however, Medicaid has been diverging from a firm tie to eligibility for cash programs. Recent legislation assures Medicaid coverage to an expanded number of low-income pregnant women, poor children, and some Medicare beneficiaries who are not eligible for any cash assistance program. These persons would not have been eligible for Medicaid under the earlier rules. Legislative changes also focused on increased access, continuation of specific benefits, restrictions on service limits, better quality of care, and enhanced outreach programs.

Medicaid policies for eligibility and services are complex, and vary considerably even among similar-sized and/or adjacent States. A person who is eligible in one State might not be eligible in another State. Services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State, and can change within a State during the year.

Since its inception, the increase in expenditures for the Medicaid program has exceeded the percentage increase in the consumer price index, the increase in the number of persons served, and the

types of services provided. Continued growth in Medicaid expenditures seems primarily due to:

- The increases in rates of payments to providers of medical and health care services, when compared to general inflation;
- The increase in the size of the Medicaid-covered population (a result of the economic recession and Federal mandates);
- The increase in the numbers of very old and disabled persons requiring extensive acute and/or long-term health care and related services; and
- The results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive and in need of continuing very expensive care.

Total 1992 payments by Medicaid averaged \$2,937 per recipient (table 9). Many Medicaid recipients require relatively small expenditures per person per year. For example, preliminary data for 1992 indicate that Medicaid vendor payments for over 15 million children under age 21 averaged \$971 per child. Other groups have larger expenditures per person. The average vendor payment for the 1,573,000 persons receiving skilled-nursing facility services was \$14,970, and those 151,300 recipients requiring ICF/MR care had average vendor payments of \$56,000 per person (plus the cost of other services and acute care provided outside of the ICF/MR facility). Medicaid pays the medical costs of at least 40 percent of persons with acquired immunodeficiency syndrome (AIDS).

Although their relative number is small, some individual patients (for example, organ transplant patients, medically fragile very premature babies, severely burned patients, accident victims with multiple severe head and organ injuries, and others requiring very specialized, extensive, and intensive medicare care) can cost \$3,000 per day. And

a few persons with continuing extensive and very complex medical care needs require several hundreds of thousands of dollars of Medicaid vendor payments each year for many years.

There were over 35.6 million persons enrolled in Medicaid in 1992. Of these, 31.2 million received at least some health care services through the Medicaid program. Total outlays for the Medicaid program increased from \$90.5 billion in 1991 to \$114.5 billion for 1992 (\$65.9 billion in Federal and \$48.6 billion in State funds). Federal outlays for the Medicaid program have increased 67 percent in just the two years from 1990 to 1992. Medicaid's compound rate of growth between fiscal year 1992 and fiscal year 1998 is projected to be 13.8

percent per year. Thus, if the current expenditure trends continue, and there are no significant changes to the Medicaid program, payments for the total (Federal and State) Medicaid program for 1998 may reach \$250 billion.

The Medicaid program must function within the Federal and State constraints of economic, social, and political factors. Congress, the Department of Health and Human Services, and the individual States continually seek to make improvements in Medicaid's quality, effectiveness, and extent of health care services. The need for expanded eligibility and for more extensive and enduring services is obvious. However, there is also great pressure to limit the Federal and State budgets. As a balance for these factors is

sought, frequent revisions occur in Federal laws, in the Health Care Financing Administration's regulations, and in the States' Medicaid plans. Thus, the Medicaid program is continually changing.

Omnibus Budget Reconciliation Act of 1993

Under the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), enacted on August 10, 1993 (P.L. 103-66), substantive changes were made in the Medicaid program. Some of these provisions are discussed below.

(1) *Personal care services.*—Under prior law, personal care services would have been included within the framework of home health care services as a mandatory service, starting in fiscal year 1995. Under OBRA 93, States are allowed to cover personal care services furnished outside the home on an optional basis, effective October 1, 1994.

(2) *Optional coverage of tuberculosis (TB)-related services.*—Effective January 1, 1994, States may cover prescribed drugs, directly observed therapy, and other ambulatory services for low-income individuals infected with TB.

(3) *Transfers of assets: treatment of certain trusts.*—Prior to enactment of OBRA 93, Medicaid eligibility of applicants for institutional care could be delayed if they had transferred assets for less than fair market value within 30 months. OBRA 93 provides for a delay in Medicaid eligibility for institutionalized individuals (or their spouses) receiving nursing facility services or an equivalent level of care, and to non-institutionalized persons receiving specified home- or community-based services designed as an alternative to such care, who dispose of assets for less than fair market value on or

Table 9.—Number of Medicaid recipients and total and average vendor payment amounts, by eligibility category and type of service, fiscal year 1992

Eligibility category and type of service	Number of recipients ¹ (in thousands)	Total payment amount (in millions)	Average payment amount
<i>Category</i>			
All recipients.....	31,150	\$91,480	\$2,937
Dependent children under age 21.....	15,200	14,758	971
Adults in families with dependent children.....	7,040	12,403	1,762
Persons aged 65 or older.....	3,749	29,089	7,759
Blind persons.....	84	530	6,293
Permanently and totally disabled persons.....	4,402	33,474	7,604
Other.....	675	1,226	1,817
<i>Service</i>			
Inpatient—			
General hospital.....	5,790	23,686	4,091
Mental hospital.....	77	2,200	28,460
Skilled-nursing facility.....	1,573	23,547	14,970
Intermediate care facility for the mentally retarded.....	151	8,552	56,517
Prescribed drugs.....	22,070	6,790	308
Physician.....	21,683	6,122	282
Outpatient hospital.....	15,167	5,296	349
Home health.....	926	4,888	5,276
Other care.....	12,674	4,637	366
Clinic.....	4,128	2,825	684
Laboratory and radiological.....	11,850	1,040	88
Dental.....	5,717	853	149
Other practitioner.....	4,725	539	114
Family planning.....	2,559	504	197

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

after a specified look-back date (36 months prior to either the date of application for benefits or the date of institutionalization, whichever is later). The number of months of delay in eligibility is equal to the total cumulative uncompensated value of all assets transferred on or after the look-back date, divided by the average monthly cost to a private patient of nursing facilities in the State. The period of delay begins with the first month during which the assets were disposed of. Penalties are not applied to transfers to spouses, minor or disabled children under certain conditions, or transfers to trusts solely for the benefit of disabled individuals under age 65. This provision became effective with respect to assets disposed of on or after enactment of OBRA 93.

OBRA 93 sets forth rules under which funds and other assets of an individual placed in trust by or on behalf of an individual (or the

individual's spouse) are treated as resources available to the individual, and under which payments from the trust are to be considered assets disposed of by the individual. The legislation specified that, for purposes of applying transfer of asset prohibitions, the look-back period with respect to trusts is 60 months. Exceptions are provided for trusts containing the assets of a disabled individual under age 65, specified income trusts in certain States, and "pooled" trusts for disabled individuals. In cases of undue hardship, States are required to establish procedures for waiving application of these rules. This provision also became effective with respect to trusts established on or after the date of enactment of the new legislation.

(4) *Medicaid estate recoveries.*—Effective October 1, 1993, States are required to recover from the estates of Medicaid beneficiaries the costs of nursing facility and other long-term care services furnished to them,

with established procedures for waiver of recovery in hardship cases. At State option, the estate against which recovery is sought may include any real or personal property, or other assets in which the Medicaid beneficiary had any legal title or interest at the time of death, including the home. Different estate recovery provisions apply to certain individuals who purchase specified long-term care insurance policies in designated States.

(5) *Assuring proper payments to disproportionate share hospitals and liability of third parties.*—The new legislation included provisions to assure proper payments to disproportionate share hospitals for Medicaid reimbursement, applicable to public hospitals in State fiscal years beginning in 1994 and to private hospitals in 1995. OBRA 93 also requires States to enact laws giving the State rights to payments by liable third parties, effective October 1, 1993.

Section III: Programs for Special Groups

Veterans of the Armed Forces 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, police officers, and firefighters—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 police officers and firefighters, 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, industry wide 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 servicepersons and veterans of military service. Included in these programs are disability payments, educational assistance, hospitalization and medical care, vocational rehabilitation, survivors' and dependents' benefits, special loan programs, and hiring preference for certain jobs. Most of the veterans' programs are administered by the Department of Veterans Affairs.

During fiscal year 1992, total benefits to veterans and their dependents, exclusive of career retirement and Social Security benefits, reached \$30.8 billion. This amount included \$16.3 billion for disabled veterans, their dependents, and survivors; \$13.7 billion for medical programs; and \$752 million for educational programs. As of February 1, 1993, 2,664,300 veterans were receiving disability benefits and 676,600 widows and

widowers were receiving survivors' 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 dis-

abled veterans and to the widows and dependents of those who died on active duty. Coverage was broadened early in the 19th century with the introduction of programs for domiciliary care and incidental and 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 servicepersons 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 ben-

efits and a home loan program. Legislation in 1989 replaced the Veterans' Administration with the Cabinet-level Department of Veterans Affairs.

Cash Benefits

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

Compensation for service-connected disabilities.—The disability compensation program pays monthly cash benefits to veterans whose disabilities resulted from injuries or diseases incurred or aggravated by active military duty, whether in wartime or peacetime. 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 \$85 a month for a 10-percent disability to \$1,730 a month for total disability. In addition, specific rates of up to \$4,943 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 allowance for dependents. The amount is based on the number of dependents and degree of disability.

Pensions for nonservice-connected disabilities.—Monthly benefits are provided to wartime veterans with limited income and resources who are totally and permanently disabled because of conditions not attributable to their military service. To qualify for these pensions, a veteran must have served in one or more of the following designated war periods: the Mexican Border Period, World War I, World War II, the Korean Conflict, the

Vietnam Era, or the Persian Gulf War. Generally, the period of service must have lasted at least 90 days and the discharge or separation cannot have been dishonorable.

Effective December 1, 1992, maximum benefit amounts for nonservice-connected disabilities range from \$634 per month for a single veteran without a dependent spouse or child to \$1,212 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 \$108 per month. Benefits to veterans without dependents are reduced to \$90 per month if they are receiving long-term domiciliary or medical care from the Department of Veterans Affairs. 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 servicepersons 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 (VA).

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 nonservice-connected death of a veteran with a service-connected disability requires a marriage of at least a 1-year duration before the veteran's death. A surviving spouse is generally required to have lived continuously with the vet-

eran from marriage until his or her death. Eligibility for benefits generally ends with the spouse's remarriage.

If the veteran died prior to January 1, 1993, the amount payable to the surviving spouse depends on the last military grade of the deceased serviceperson or veteran. The basic benefit amount ranges from \$634 to \$1,744 a month. If the veteran died on or after January 1, 1993, the amount payable to a surviving spouse is not based on pay grade. A basic monthly rate of \$750 is payable. A surviving spouse is paid an additional \$165 per month if, at the time of the veteran's death, the veteran was in receipt of or entitled to receive compensation for a service-connected disability rated totally disabling for a continuous period of at least 8 years immediately preceding death and the surviving spouse was married to the veteran for those same 8 years. The amounts payable to eligible parents are lower, ranging from \$5 to \$349 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. A spouse whose condition requires the regular aid and attendance of another person is entitled to an allowance of \$191 a month in addition to the basic benefit. A spouse whose condition does not require the regular aid and attendance of another person, but whose physical condition confines him or her to the house, is entitled to an allowance of \$93 a month in addition to the regular benefit. Death compensation under prior provisions is payable for service-connected deaths before 1957.

Pensions for nonservice-connected death.—Pensions are paid, on the basis of 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 nonservice-connected dis-

ability 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 \$425 a month for a surviving spouse without dependent children to \$812 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 \$108 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 two categories: "Mandatory" and "Discretionary." Within these two categories, veterans with nonservice-connected disabilities must also have limited income and resources to be eligible for cost-free VA medical care.

Hospital care.—An eligible veteran is provided free hospital care and medical services if he or she is:

- Disabled because of an injury or disease incurred or aggravated during active military duty.
- A former prisoner of war.
- 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.
- A veteran of the Spanish-American War, the Mexican Border Period, or World War I.

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 co-payment 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.

Vocational Rehabilitation

Vocational Rehabilitation benefits provide services and assistance to enable veterans and servicemembers with service-connected disabilities to become employable, and to obtain and to maintain suitable employment. Generally, an applicant must be rated 20 percent or more disabled by VA or have a serious employment handicap, but veterans with a 10-percent compensable disability may also be eligible if they first applied for vocational rehabilitation prior to November 1, 1990. The program also assists those for whom employment is not feasible to achieve maximum independence in daily living.

An initial evaluation is provided to all eligible individuals requesting vocational rehabilitation services. Disabled veterans who complete the education and training phase of their rehabilitation programs and others who are found to have suitable jobs are offered specialized employment services and assistance. Comprehensive counseling and assessment services are provided upon request to veterans, servicepersons, and other eligible persons who plan to use VA educational benefits.

Educational Assistance

Several Educational Assistance programs are available to eligible servicepersons and veterans. The Post-Vietnam Veterans' Educational Assistance program (VEAP) is a voluntary contributory matching program for persons entering service after December 31, 1976. For every \$1 contributed to the program, the Government will contribute \$2. The Department of Defense may contribute an additional amount. Participants contribute between \$25 and \$100 monthly to a maximum of \$2,700. While on active duty, a lump-sum contribution may be made. Maximum entitlement under VEAP is 36 months or the number of months of participation, whichever is

less. The basic cutoff date is 10 years after the last release or discharge from active duty. The serviceperson must have initially contributed to VEAP before April 1, 1987, to be eligible.

The Montgomery GI Bill-Active Duty program (chapter 30) provides education benefits for individuals entering military service after June 30, 1985, and for certain other individuals. Servicepersons entering active duty have their basic pay reduced \$100 a month for the first 12 months of their service unless they specifically elect not to participate. The money is nonrefundable. Basic entitlement is 36 months based on 3 years of continuous active duty. There is also an additional discretionary allowance to the basic benefit. Individuals who serve an additional 5 years may receive a supplemental benefit for 36 months plus a supplemental discretionary allowance. Benefits may also be payable to individuals who are released or discharged early under certain circumstances. Eligibility will end after 10 years beginning on the date of release from active duty, or on the last day on which the individual becomes entitled, whichever is later.

The Montgomery GI Bill-Selected Reserve program (chapter 106) is an entitlement program available to members of the Selected Reserve, including

the National Guard, who after June 30, 1985, enlist, reenlist, or extend an enlistment in the Selected Reserve for a period of 6 years or more. An individual must complete his or her initial period of active-duty training. In addition, the reservist must have completed the requirement for a high school diploma or the equivalent before completing initial active duty. An eligible reservist is entitled to a maximum of 36 months of educational assistance. Eligibility will end 10 years from the date eligibility began, or the date of separation from the Selected Reserve, whichever is earlier.

The Department of Veterans Affairs also pays educational assistance for dependents. If a veteran is permanently and totally disabled from a service-related cause, or dies as a result of or while completely disabled from service-related causes, VA will pay a monthly benefit to help educate the spouse and the children. The benefit is usually provided for children aged 18-26. In some instances, disabled children may begin a special vocational or restorative course as early as age 14. Spouses and children of service personnel who are currently detained in the line of duty by a foreign power for more than 90 days are also eligible for educational benefits.

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 of 1991, 2.9 million Federal workers were covered. This figure included workers covered by the Civil Service Retirement System (CSRS) and those under the more recently established

Federal Employees Retirement System (FERS).

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

vice. 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-service employees with retirement benefits approximately equal to 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 who were not covered by the Federal retirement system—primarily part-time or temporary employees—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 program.

The FERS program was established by legislation enacted in June 1986 to cover all employees hired after December 31, 1983, and any others who chose to switch from CSRS. The benefits provided by the new system are analogous to those provided under CSRS, but the structure of FERS is quite different.⁵

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 consecutive 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 1993 their combined contribution rate for Social Security, Medicare, and 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 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 up to 5 percent of the salary. Contributions and interest earnings are not taxable until they are withdrawn, usually at retirement. These funds may be invested in U.S. Government securities, in a private sector fixed-income fund, or in a common stock index fund.

The Federal pension segment of FERS is administered by the Civil Service Retirement and Disability Trust Fund, as is the CSRS. In 1991, the Fund paid \$26.4 billion to 1.6 million retired and disabled annuitants, and \$4.7 billion to 570,000 survivor annuitants. More than 99 percent of all annuitants received benefits under the CSRS.

The group life and health insurance programs available to Federal employees are optional and are financed by joint contributions from the worker and his or her employing agency. The Government pays one-third of the cost of basic life insurance and an average of 70 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 non-contributory, 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 pre-retirement basic pay, although the retiree may elect to have this amount reduced in order to provide a survivor benefit for his or her spouse. This survivor benefit is a proportion (up to 55 percent) of the retired service member's unreduced benefit at the time of death. During 1991, 1.7 million retired service members and their survivors received \$22.8 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 age. Other workers normally must meet age and service requirements. In 1990, State and local governments paid \$36 billion in retirement benefits to 4 million persons; 3.5 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- 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 State'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 1991, an estimated 11.8 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. Legislation enacted in 1990 extended Social Security coverage on a mandatory basis to State and local government employees who were not covered by a State or local government retirement plan.

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

Railroad Retirement⁷

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 1992 that

number was 270,000. There were 854,000 beneficiaries on the rolls at the end of fiscal year 1992, of whom 380,700 were employee annuitants and 212,000 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 and in later years. Continuing financing problems led to legislation in December 1987 to establish a Commission on Railroad Retirement Reform. The Commission's mandate was 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 was to assure the provision of retirement benefits to current and future retirees on an actuarially sound basis. The seven-member Commission represented railroads, labor, and the public. The Commission submitted a report to the President and both Houses of Congress on September 14, 1990.

The Commission concluded that the Railroad Retirement Account is financially sound in both the short and the intermediate term. However, it recommended two financial changes:

- (1) Make permanent the present temporary assignment of income taxes collected on Railroad Retirement benefits to the Account.
- (2) Replace the current payroll tax system with one that uses an actuarially frozen employment pool. The tax rates would then be determined annually according to the ratio of the opening balance in the Account to its anticipated yearly outlay.

As of the end of the 1992 legislative session, Congress had enacted neither of these provisions. The assignment of the income taxes collected on Railroad Retirement benefits to the Account has been renewed each year, but not made permanent. The payroll tax structure is unchanged.

Eligibility for Benefits

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 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 if 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 preceding retirement will meet the current connection requirement. An annuity based on disability cannot be paid until the employee stops working for a railroad, 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 of service) 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 female spouse of an employee who is qualified to receive an age and service annuity may receive a spouse annuity at any age if she is caring for a child of the employee and that child is under age 18 or became disabled before age 22. A male spouse is eligible only

when the child is under 16. 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.

An annuity may also be payable to the divorced spouse of a retired employee, if their marriage lasted for at least 10 years, both have attained age 62, and the divorced spouse has not remarried. The amount of a divorced spouse's annuity is, in effect, equal to what Social Security would pay under the same circumstances, and therefore less than the amount of a regular spouse annuity.

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.

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 a family maximum based on the highest 2 years creditable earnings in the previous 10-year period. This maximum applies only at the time of 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. There is 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 1993, annual earnings of up to \$10,560 for those aged 65-69 and \$7,680 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 \$5,000.

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.

In 1993, the tier I increase was 3 per-

cent and the tier II increase was 1 percent.

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—7.65 percent in 1993. In addition, both employers and employees pay tier II taxes to finance the industry pension segment of the annuities. In 1993, the employer tax rate was 16.10 percent, and the employee tax rate was 4.90 percent. The earnings base for tier I taxes is the same as for Social Security—\$57,600 in 1993. The tier II earnings base for the same year was \$42,900. (Tax contributions to the Medicare program are levied on an earnings base of \$135,000.) 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 3 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, financed by railroad employers and administered by the Railroad Retirement Board.

In 1946, Congress extended the railroad unemployment insurance program

to include cash payments for temporary sickness and special maternity benefits. Both programs are financed by the contributions of railroad employers only, based on the taxable earnings of their employees. In 1993, the taxable earnings base was the first \$810 of each employee's monthly 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 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, and could meet its obligations only with assistance of loans from the Railroad Retirement Account. To balance this account, a special repayment tax of 4 percent of the taxable earnings base is being levied on rail employers until the loan has been repaid with interest.

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, there was a growing acceptance of 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. 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 enacted 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 the 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 1990, 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 federally administered 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 Stamps program, which provides coupons used to purchase food. In addition, various Federal-State programs provide energy assistance, public housing, and subsidized housing to individuals and families with low income. General assistance may also be available at the State or local level.

The earned income tax credit (EITC), a refundable Federal income tax credit available to low earning taxpayers with dependent children, was enacted in 1975. The rate of the credit, the maximum allowable credit amount, and the phase-out rate have been adjusted frequently. The Omnibus Budget Reconciliation Act (OBRA) of 1993 extended the EITC, in modified form, to taxpayers without dependent children.

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. 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. The program went into effect in January 1974.

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 estab-

lished uniform amounts of income that are excluded when determining the eligibility of an individual or couple.

Eligibility

To be eligible for SSI payments a person must be either a U.S. citizen, an alien lawfully admitted for permanent residence, or an alien permanently residing in the United States under color of law. The individual must also be a resident of one of the 50 States, the District of Columbia, the Northern Mariana Islands, or a child who is a U.S. citizen and resides abroad with a person who is a member of the Armed Forces.

The SSI program provides monthly cash payments to any aged, blind, or disabled person whose countable income is less than \$5,352 per year, as of January 1, 1994. 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 almost the same as those used for the Social Security Disability Insurance program. That is, an individual is considered to be disabled if he or she is unable to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment that can be expected to result in death or which has lasted or can be expected to last for a continuous period of 12 months. This 12-month requirement does not apply to the blind in SSI. Those who received assistance under their State's 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 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's definition.

Benefit Amounts

For the year beginning January 1, 1994, a maximum Federal monthly SSI payment of \$446 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 \$669. In addition, as discussed subsequently, the Federal payments are supplemented by 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 1992, 5.2 million persons

were receiving Federal SSI payments averaging \$330 per month (table 10).

Factors Affecting Benefits

The basic SSI payment is reduced by the amount of other income and in-kind support and maintenance available to the recipient. A recipient who lives in another person's household and receives support and maintenance there receives only two-thirds of the 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. 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 or if the individual is receiving educational or vocational training designed to prepare the individual for gainful employment. In addition, payments may be made to persons who are residents of public emer-

Table 10.—Number of persons receiving federally and State-administered SSI payments and average monthly benefit amount, by reason for eligibility and type of payment, December 1992

Type of payment	Total ¹	Aged	Blind	Disabled
	Number of persons (in thousands)			
Total	5,647	1,505	86	4,055
Federally administered:				
Federal SSI payments.....	5,202	1,304	² 78	³ 3,820
Federal SSI payments only.....	3,195	¹ 797	44	2,354
Federal SSI and federally administered State supplements.....	2,008	508	34	1,466
State supplement:				
Federally administered supplements only	364	167	8	190
State-administered supplements only	81	34	(1)	45
Average monthly benefit amount				
Total	\$362	\$234	\$366	\$409
Federal SSI payments.....	330	195	308	376
Federally administered State supplements	118	119	166	116
State-administered State supplements	149	154	177	144

¹ Includes persons for whom reason for eligibility was not available.

² Includes approximately 21,900 persons aged 65 or older.

³ Includes approximately 606,800 persons aged 65 or older.

gency shelters for the homeless for a period of up to 6 months in any 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 based on the rate that was applicable in the month prior to the first full month of institutionalization for medical care. Continued payments may also be made for up to 2 months after entering certain medical or psychiatric institutions for individuals who were eligible under section 1619 of the Social Security Act (related to work incentives) provided that the institution had agreed to permit the individual to retain these benefits.

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.

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 certain income from scholarships, certain amounts of earnings of students, work expenses of blind persons, impairment-related work expenses of the disabled, payments for providing foster care to an ineligible child, and the Earned Income Tax Credit. Income necessary for an approved plan of self-support for blind and disabled recipients is also disre-

garded. 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 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 usually 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 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 or a member of the individual's household uses it for transportation for em-

ployment or medical treatment, it is modified to be operated by or used for transportation of a handicapped person, or it is needed for essential daily activities. If an automobile cannot be excluded based on the nature of its use, up to a current market value of \$4,500 may be excluded.

A recipient's life insurance policies are not countable if the face values do not exceed \$1,500 per insured. Real property can be excluded for as long as the owner's reasonable efforts to sell it are not successful.

Special exclusions are applicable to the resources necessary for an approved plan of self-support for blind or disabled recipients and for property essential to self-support. The value of burial spaces for a recipient, spouse, and immediate family member is excluded. There also is a provision for the exclusion of up to \$1,500 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 were initially 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. Through fiscal year 1993, SSA assumed the cost of administering these supplements and was reimbursed by the State only for the amount of the supplementary payments.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 requires States to

pay fees for Federal administration of their supplementary SSI payments. The fees are \$1.67 for each monthly supplementary payment in fiscal year 1994, \$3.33 in fiscal year 1995, and \$5.00 in fiscal year 1996. Fees for subsequent years will be \$5.00 or another amount determined by the Secretary to be appropriate. The Secretary may charge States additional fees for services they request that are beyond the level customarily provided in administering State supplementary payments. If a State chooses to administer its own payments, it processes applications and makes eligibility determinations separately from the Federal Government. As of January 1993, 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 one State. A sixth living arrangement variation is permitted provided it applies only to individuals in Medicaid facilities—that is, facilities receiving title XIX payments with respect to such persons for the cost of that care. States may also differentiate among geographic regions, although not more than three may be recognized in one State. States may also differential between geographic regions, although not more than three may be recognized in one State. States that administer their own supplementary programs have even greater discretion over their supplementation criteria.

In December 1992, 2.7 million persons were receiving State supplements averaging \$122. Of the 2.7 million recipients, nearly 2.4 million were receiving federally administered supplements, and 313,000 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 1992 were \$22.2 billion, of which \$18.3 billion was for Federal SSI benefit payments. Federally administered State supplements totaled \$3.4 billion and State-administered supplements totaled \$550 million.

Applications for SSI payments are taken at SSA district offices where the supporting documentation is examined, and the district office staff determines whether 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 \$446 to an eligible individual and \$669 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 and 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, and Puerto Rico 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 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 Administration for Children and Families, Department of Health and Human Services. To qualify for grants, the States must comply with 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.

Additionally, 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 need 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, 1993, for example, the monthly need standard for a family of three was \$577 in New York, \$368 in Mississippi, and \$421 in Colorado.

In computing its need 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 need 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 need standards. Need and 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.

In calendar year 1992, 4.8 million families—consisting of 13.4 million recipients—received \$22.1 billion in AFDC payments in the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

In fiscal year 1992, average monthly payments per family ranged from a low of \$121.58 in Mississippi to a high of

\$743.22 in Alaska. Average monthly payments per recipient ranged from \$41.69 in Mississippi to \$251.65 in Alaska. Nationwide, the average benefit per family was \$383.49; per recipient it was \$134.21.

Payments are usually made directly to AFDC recipients. However, when mismanagement exists, States may change the form of payment, at their option, to that of protective, vendor, or two-party payments. 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

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, physical or mental incapacity of a parent, or unemployment of a parent who is a principal wage earner. The children must be living in the home of a parent or other relative.

Prior to October 1, 1990, 28 States, the District of Columbia, and Guam had unemployed parent programs that permitted children to receive payments if the principal wage earner in the family was 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 were required to have an unemployed parent program. The same requirement became effective in the outlying areas on October 1, 1992.

A State may, at its option, provide assistance to a pregnant woman during the last 4 months of her 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 must have their sponsor's income and resources deemed—considered—in determining the amount of the AFDC payment. This has the effect of reducing the AFDC payment or, in some instances, determining the AFDC assistance unit to be ineligible. 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 need, income, and resources of parents and siblings (except Supplemental Security Income recipients or those who receive foster care, or, in most cases, those who receive adoption assistance) 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. 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 total income after applicable disregards is at or below 185 percent of the State's standard of need. To encourage recipients toward self-support, Federal

law provides for disregarding some earned income in determining the need and 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 more 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 children under age 2—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, unless it is required or permitted to be disregarded by a Federal law or regulation.

Assets held by AFDC applicants and recipients 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 resource 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 were required to establish and have in place a Job Opportunities and Basic Skills Training (JOBS) program, which replaced the Work Incentive (WIN) program. All States now have an approved JOBS program in operation. By October 1, 1992, JOBS had to be offered in all political subdivisions of a State, unless it was not feasible because of the local economy and/or other factors. 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, at least two of the following four services are required:

—group and individual job search;

- on-the-job-training;
- work supplementation; and
- community work experience programs or other work programs approved by the Secretary.

States must make an initial assessment of the education, child-care needs, work experience, skills, and 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 availability of necessary supportive services, resource ability, employment opportunities and, to the maximum extent possible, participant preferences will be taken into consideration in developing the plan.

Child Support Enforcement

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. The first \$50 of child support collected in the month when due is passed on to the family. State and local child support enforcement agencies enforce the collection of child support payments. They provide services to AFDC families, such as locating absent parents, establishing paternity, and obtaining support payments. Not only do AFDC recipients receive these services, but these agencies also assist individuals who apply for the services, regardless of income level.

States use a number of methods to collect child support payments and past due amounts. These methods include: (1) withholding wages and other income, (2) withholding Federal and State income tax refunds, (3) withholding unemployment compensation, (4) imposing liens on property, (5) establishing secu-

rity and bonding conditions, (6) notifying credit bureaus about overdue child support payments, and (7) using full collection services of the Internal Revenue Service.

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 AFDC 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 monies.

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 about 50 percent to 83 percent of the aggregate amount spent for cash payments and medical assistance to recipients. In 1992, all States used this more generous formula for calculating reimbursements, 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 Govern-

ment 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 Work Incentive (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. For fiscal year 1993, the Federal appropriation for JOBS is \$1 billion.

Federal participation in the AFDC program is administered by the Administration for Children and Families 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 operating 43 projects, serving 350,000 people. Under current law, the Food Stamp Act of 1977, as amended (P.L. 95-113), has been extended to all 50 States, the District of Columbia, Guam, and the Virgin Islands. Authorization for this program extends through September 30, 1995.

Under this program, single persons and individuals living in households meeting nationwide standards for income and assets may receive coupons⁸ redeemable for food for human consumption and garden seeds and plants.⁹ The coupons are accepted at most retail food stores.

The value of the coupons that a unit receives each month is determined by household size and income. Households without income receive an amount equal to 103 percent of the June monthly cost of the Thrifty Food Plan, which is a nutritionally adequate diet. This amount is updated every October for the new fiscal year to account for food price increases. As of October 1993, an eligible four-person household with no income receives \$375 per month in food stamps.

Households with income receive food stamps valued at the difference between the maximum allotment and 30 percent of their income, after certain allowable deductions.

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), (2) gross income below 130 percent of the poverty guidelines for the household size, and (3) net income, after subtracting the five deductions listed below, of less than 100 percent of the poverty guidelines. Households with a person aged 60 or older or a disabled person receiving either Supplemental Security Income (SSI), Social Security (OASDI), State general assistance, veterans' disability benefits (or interim disability assistance pending approval of any of the above programs) 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 guidelines. One- and two-person households that meet the applicable standard receive at least \$10 a month in food stamps. Households in which all members receive Aid to Families with Dependent

Children (AFDC) or SSI are categorically eligible for food stamps without meeting these income or resource criteria.

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

- (1) Twenty percent of earned income.
- (2) A standard deduction of \$131 (this amount is updated in October of each year).
- (3) The amount paid for dependent care (up to \$160 a month per dependent) while the dependent's caretaker is working or looking for work.
- (4) Any out-of-pocket medical expenses in excess of a \$35 deductible for a person aged 60 or older or a disabled person. If more than one person in the household is aged or disabled, \$35 is subtracted once before deducting combined medical expenses.
- (5) An excess shelter deduction, which is total shelter costs including utilities minus 50 percent of income after all the above deductions have been subtracted. Effec-

tive October 1, 1993, the monthly limit is \$207 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. Moreover, 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 the homeless, drug addicts, alcoholics, blind or disabled residents in certain group living arrangements, residents of shelters for battered spouses and children, and persons aged 60 or older to use their coupons for meals prepared at a nonprofit facility. The elderly and homeless may also use their coupons to purchase concession-priced meals from authorized restaurants. Households with members who are elderly (aged 60 or older), disabled, or lack transportation to the food stamp office 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. (Since July 1982, Puerto Rico receives a block grant for nutrition assistance rather than participating 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 agencies share administrative costs.

History of Provisions

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 established uniform national eligibility standards and uniform national benefit levels, required family allotments large enough to purchase a nutritionally adequate diet, 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 under age 18). Legislation in 1973 expanded the program (while phasing out the family food distribution program), provided for semi-annual adjustments of coupon allotments, and broadened the categories of persons eligible to participate.

The 1974 legislation extended the program nationwide, requiring all States to participate in the Food Stamp program.

Major legislative changes in 1977 eliminated the purchase requirement and allowed households to receive only the bonus portion of their coupon allotments. Deductions from income were limited to a standard deduction, a 20-percent earnings deduction, and a limited combined excess shelter and child-care deduction. The poverty guidelines became the new eligibility limits and, for the first time, households receiving AFDC or SSI payments were required to meet asset and income limits. The work registration requirements were tightened for students and for caretakers, whose children now had to be under age 12. Previously exempt, parents of children aged 12 or older were required to register for work. The age at which the registration exemp-

tion for older persons became effective was lowered from age 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 semi-annual, adjustment to benefit levels and the amount of the standard deduction. This legislation also restricted student 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. The updates to deduction limits and to Thrifty Food Plan (TFP) increases to account for inflation, were postponed until July 1983 and October 1982, respectively. For new participants, benefits for the first month were prorated from 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 monthly reporting/retrospective accounting systems were made mandatory for all States, effective October 1983. However, households composed solely of all 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 changes, the maximum allotments were reduced from 100 percent to 99 percent of the TFP and adjustments to the standard and shelter deductions were delayed until October 1, 1983. (P.L. 98-473 restored maximum food stamp allotments to the full cost of the TFP beginning November 1, 1984.) A net 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 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 (P.L. 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. Portions of the income received under the Job Training Partnership Act were now considered 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 (P.L. 100-435) made several changes in the program. It raised the maximum food stamp allotments and established allotments as specified percents of the TFP as of the preceding June. For fiscal year 1989, the allotments were 100.65 percent of the TFP as of June 1988; for fiscal year 1990, they were 102.05 percent of the TFP for June 1989; and for fiscal years 1991 and on, they are to be 103 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 extended disability status to individuals who receive interim assistance pending the receipt of SSI, Social Security, or State disability payments, and allowed the elderly, disabled, and those without transportation to apply for food stamps via telephone interviews. It required States to process food stamp applications jointly with AFDC and general assistance applications. It raised the dependent care deduction from \$160 per household to \$160 per dependent. 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.

The Mickey Leland Memorial Domestic Hunger Relief Act of 1990 reauthorized the Food Stamp program and the Nutrition Assistance Program in Puerto Rico with no major changes through fiscal year 1995.

Legislation enacted in 1992 prevented a one-time decrease of food stamp allotments. For the year beginning October 1, 1992, even though the cost of the TFP had declined slightly.

Other provisions of 1992 legislation include the following:

- The earnings of elementary or high school students who are aged 21 or younger are disregarded.
- Households that have breaks in participation of less than a month are allowed to receive a full month's benefit for the period of the break.

- The children of drug addicts and alcoholics living in treatment centers are permitted to qualify for food stamps.

- Food stamp households participating in demonstration projects are permitted to accumulate up to \$10,000 in resources.

The Omnibus Budget Reconciliation Act of 1993 (Mickey Leland Childhood Hunger Relief Act) made a number of program revisions including the following:

- The shelter cap will be raised to \$231 beginning July 1, 1994, \$247 beginning October 1995, and be eliminated entirely in 1997.
- The deduction for care of a child or other dependent will be raised to \$200 per month for a child under age 2, and \$175 per month for all other dependents, effective September 1, 1994.
- State agencies will be given the option to provide deductions for legally binding child support payments made to persons outside the household, effective September 1, 1994. This deduction becomes mandatory October 1, 1995.
- The definition of a food stamp household has been simplified to allow adult siblings who live together and adult children who live with their parents to form separate households if they purchase or prepare food separately.

An estimated 25.4 million persons per month participated in the Food Stamp program during fiscal year 1992. The average monthly value of food stamps per person was about \$69 and the total value of benefits issued during the year was \$20.9 billion.

Special 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 \$30.17 per person per month in fiscal year 1992), 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 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 guidelines. Currently, 2 States have set income eligibility criteria below 185 percent of the poverty 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 31 Indian tribal organizations. Local public or nonprofit private health or welfare agencies apply to their respective States to qualify for funds from this program. Individual participants apply to one of the approximately 8,900 approved local clinics that provide WIC services.

The WIC program operates under the authority of the Child Nutrition Act of 1966, as amended, and the WIC Reauthorization Act of 1989 (P.L. 101-147)—which extended the program's authorization through September 30, 1994.

Federal program costs in fiscal year 1992 were \$2.6 billion, of which 75 percent was used to fund benefits. Average monthly participation was 5.4 million individuals—1,226,000 women, 1,684,000 infants, and 2,494,000 children. The appropriation for fiscal year 1993 was \$2.86 billion. More than 40 percent of the infants born in the United States participate in this program.

School Breakfasts and Lunches

The national school breakfast and lunch programs are designed to help safeguard the health and well-being of the Nation's children by assisting the States in providing an adequate supply of nutritious food for all children at a moderate cost. These programs are also designed to encourage the domestic consumption of nutritious agricultural commodities. All students, regardless of their ability to pay, eating breakfasts and/or lunches prepared at participating schools, pay less than the total cost of the meals. 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 meals, receive their breakfasts and lunches free or at reduced prices. Children from house-

holds certified to receive food stamps, the Food Distribution Program on Indian Reservations, or Aid to Families with Dependent Children (AFDC) are automatically eligible for free meals.

Beginning with school year 1990-91, schools meeting eligibility conditions may be reimbursed for meal supplements served to children enrolled in after school hours programs.

Before January 1981, children were eligible for free school lunches if the income for their household was below 125 percent of the poverty 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 guidelines for free lunches and between 130 percent and 185 percent of the poverty guidelines for reduced-price lunches. This same income eligibility criteria is used for school breakfasts. The Secretary of Agriculture revises income eligibility requirements each July 1 to reflect the latest Federal poverty guidelines.

The school breakfast and the national school lunch programs are administered by the Food and Nutrition Service of the

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 breakfast and lunch they serve. Reimbursement is, in part, from funds made available under Section 4 of the Child Nutrition Act of 1966, as amended, and 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 National School Lunch 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 all Urban Consumers. Schools eligible for com-

modity distributions, referred to as 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 1992, 852 million breakfasts and 4,102 million lunches were served. Total program costs for fiscal year 1992 under the school breakfast program were \$787 million, and under the lunch program costs were approximately \$4.5 billion, exclusive of State administrative costs and bonus commodity donations. The value of bonus commodities was \$125 million.

For the period July 1, 1993, through June 30, 1994, general cash assistance for each breakfast served to children regardless of their household income is 19.00 cents. Lunches were reimbursed at the rate of 16.50 cents in schools in which fewer than 60 percent of lunches

were served free or at reduced price and at 18.50 cents in schools in which 60 percent or more are served free or at reduced price.

Each reduced-price breakfast served to children living in households that met the eligibility guidelines received an additional reimbursement of 47.00 cents in non-severe need schools and 65.25 cents in severe need schools. Each reduced-price lunch received an additional 116.00 cents.

Free meals were reimbursed an additional 77.00 cents for each breakfast served in non-severe need schools and 95.25 cents in severe need schools; and 156.00 cents for each lunch. The national average value of donated commodities was 14 cents for each lunch.

The maximum reduced price charged for breakfast was 30 cents and for lunch 40 cents.

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 1993, a total of \$1.346 billion was appropriated by the Congress for low-income home energy assistance. For fiscal year 1992, the appropriation was \$1.50 billion.

The number of households receiving

home energy assistance in fiscal year 1992, by type of assistance, is shown below. (An unduplicated total of households assisted cannot be derived from these estimates because the same household may be included under more than one type of energy assistance.)

[In thousands]

Heating.....	5,906
Cooling.....	384
Energy crisis intervention:	
Winter.....	950
Summer.....	26
Low-cost energy weatherization/ energy related repair.....	106

Eligible households may receive funds for heating and cooling costs and for weather-related and supply shortage emergencies. Each State 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 program purposes.
- 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.

- Provide alternate sites (for those States that operate their program through the welfare department at the local level) for intake of applications and outreach to potentially eligible households.

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. Beginning with fiscal year 1986, no household may be excluded from eligibility if its income is less than 110 percent of the poverty guidelines.

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 dura-

tion 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 (SSI) 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.

In fiscal year 1992, 36 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands reported general assistance data to the Federal Government. During that period, 1.1 million persons in the reporting States received general assistance.

Public and Other Assisted Housing

Starting in the late 1930's, the Federal Government has provided leadership and a commitment toward a goal of providing decent, safe, sanitary, and affordable housing for all Americans. Various Federal, State, and local agencies administer housing programs for low-income families and individuals. Most are funded and administered by the Department of Housing and Urban De-

velopment (HUD). Some programs for rural families are funded by the Department of Agriculture through the Farmers Home Administration (FmHA).

Public Housing

Low-rent public housing projects under the Housing Act of 1937 were the earliest of the Federal rental housing programs. The projects are owned, man-

aged, and administered by a local Public Housing Agency (PHA) or an Indian Housing Agency (IHA). Funds are provided by HUD to the PHA/IHA to cover the capital cost of a project to assure the lower-income character of the project. Additional subsidies are available to cover operating and maintenance service costs. The beneficiaries are families and individuals with low incomes, including

families with children, the elderly, disabled, or handicapped. Eligibility for admission to public housing is primarily limited to families whose income does not exceed 50 percent of the median income for the area, although up to 25 percent of new admissions to public housing can be families whose income is above 50 percent, but below 80 percent, of the median income for the area.

Rental charges are set by Federal statute, usually at 30 percent of the monthly adjusted income of the recipient's household.¹⁰ Federal outlays for public housing programs in fiscal year 1992 were \$2.8 billion and covered 1.4 million housing units. The public housing outlays include \$1.36 billion under the Comprehensive Improvement Assistance Program (CIAP). The CIAP provides capital cost funding to improve the physical condition and upgrade the management and operation of existing public and Indian housing projects to assure their continuing availability to serve low-income families.

The Indian Housing Program is federally assisted through local Indian housing authorities to provide affordable housing and related facilities for eligible lower-income Indians and Alaskan Natives. In its basic structure, this program is similar to public housing in general, but with some differences reflecting the special needs and conditions of native American communities. In Mutual Help Home Ownership projects, the home buyer-occupant (or tribe on the homebuyer's behalf) must contribute either the site, building materials, labor, and/or cash to the construction costs. Under a lease-purchase arrangement, home buyers have the opportunity to eventually own their homes.

Rental Assistance

The HUD rental assistance programs (Section 8) accounted for Federal outlays of \$12.3 billion in 1992. These programs include rental certificates, rental vouchers, and moderate rehabilitation. Approximately 2.8 million housing units were included under rental assistance programs in 1992.

The Section 8 Rental Certificate and Rental Voucher Programs are tenant-

based subsidy programs designed to give an assisted family the opportunity to lease rental housing that is suitable to the family's needs and desires. When a family is selected to participate in one of these programs, the PHA issues a rental voucher or certificate and the family is then free to locate a suitable dwelling unit that meets program housing quality standards. In the rental certificate program, families generally pay 30 percent of their income toward the rent, and the total rent to the owner must be below a maximum amount. In the rental voucher program, the monthly assistance payments are based on the difference between a payment standard for the area (not the actual rent) and 30 percent of the family's monthly adjusted income. Families may pay more than 30 percent of their income towards the rent if they select a unit that rents above the payment standard, or less than 30 percent if the unit rents below the payment standard. There is no maximum rent to the owner as in the rental certificate program.

Under the Section 8 Moderate Rehabilitation Program, eligibility and tenant rent requirements are the same as those for the Rental Certificate Program. However, assistance under the Moderate Rehabilitation Program is limited to certain buildings which have been rehabilitated and made available for families needing assistance.

Eligibility for rental assistance is limited to very low-income families, that is, families whose incomes do not exceed 50 percent of the median income for the area and, on an exception basis, to lower income families whose incomes do not exceed 80 percent. Nearly 15 percent of the 1992 rental assistance housing units—426,000—were covered by rental vouchers. Legislation enacted in 1990 contains a requirement that rents in housing assisted under the voucher program be reasonable in comparison with rents charged in the private unassisted market, as was previously required for the rental certificate program.

Programs for the Homeless

The Department of Housing and Urban Development administers a variety of programs that provide housing and

supportive services for homeless persons. These programs provide for a range of housing, from emergency to transitional to permanent housing for persons with disabilities.

The Housing and Community Development Act of 1992 combined the Transitional and Permanent Housing components of the Supportive Housing Program and the Supplemental Assistance for Facilities to Assist the Homeless (SAFAH) under one program. In fiscal year 1992, appropriations for homeless programs was \$450 million.

[In millions]

Emergency Shelter Grants Program.....	\$ 73.2
Supportive Housing Demonstration Program.....	150.0
Supplemental Assistance for Facilities to Assist the Homeless (SAFAH).....	11.2
Rental Assistance—Section 8, Moderate Rehabilitation, Single Room Occupancy (SRO).....	105.0
Shelter Plus Care.....	110.5

In addition to the above programs, HUD in conjunction with the Department of Health and Human Services and the General Services Administration, administers the Federal Surplus Property Program. Two other programs Congress authorized but for which funding is not appropriated are Safe Havens and Rural Housing Homeless Assistance.

Emergency Shelter Grants (ESG) help improve the quality of emergency shelters and other housing for the homeless, make available additional shelters, meet the costs of operating shelters, provide essential social services, and help to prevent homelessness.

Supportive Housing Program (SHP) funds provide: (1) transitional housing designed to enable homeless persons and families to move to permanent housing within a 24-month period, which may include up to 6 months of follow-up services after residents move to permanent housing; (2) permanent housing provided in conjunction with appropriate

supportive services designed to maximize the ability of persons with disabilities to live as independently as possible within permanent housing; (3) supportive housing that is, or is part of, a particularly innovative project for, or alternative methods of meeting the immediate and long-term needs of homeless individuals and families; (4) supportive services for homeless individuals not provided in conjunction with supportive housing, or (5) facilities in which supportive services are provided for homeless persons. Eligible activities are:

- Acquisition of structures for use as supportive housing or in providing supportive services;
- Rehabilitation of structures for use as supportive housing or in providing supportive services;
- New construction of buildings for use as supportive housing or in providing supportive services;
- Operating costs of supportive housing; and
- Supportive services costs of supportive housing or the cost of supportive services provided to homeless persons who do not reside in supportive housing.

Section 8 Moderate Rehabilitation

Program for Single Room Occupancy (SRO) Dwellings for Homeless Individuals provides rental assistance on behalf of homeless individuals in connection with the moderate rehabilitation of SRO dwellings.

The Shelter Plus Care program provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources other than this program. Assistance is targeted primarily to homeless persons who are severely mentally ill; have chronic problems with alcohol, drugs, or both; or have acquired immunodeficiency syndrome (AIDS) or related diseases. Grants are through four components: Tenant-based Rental Assistance (TRA); Sponsor-based Rental Assistance (SRA); Project-based Rental Assistance (PRA); and Single Room Occupancy for Homeless Individuals (SRO).

The HUD-Owned Single Family Property Disposition Program is an initiative to aid homeless persons by making HUD-held properties available to nonprofit providers and governmental entities.

Properties are available for purchase, lease, or for lease-option under the McKinney Act Supportive Housing Program. Homeless providers make the housing available to homeless persons

and arrange for the provision of supportive services.

Other Programs

Prior to legislative revision in 1990, the Housing for the Elderly or Disabled program provided financing for the construction or rehabilitation of housing for low-income individuals by nonprofit organizations and consumer cooperatives. Funding was by means of long-term loans and Section 8 rental assistance.

The National Affordable Housing Act of 1990 restructured this activity into two separate programs: Supportive Housing for the Elderly and Supportive Housing for Persons with Disabilities. The new legislation emphasizes accommodating the special needs of the elderly and disabled and providing supportive services.

The funding mechanism was revised to a combination of capital advances and rental assistance. Capital advances are no-interest loans to be repaid only if the housing is no longer available to very low-income persons. Tenant rents were established at a level of 30 percent of monthly adjusted income (or the alternatives described under rental assistance). The housing units must be made available to very low-income elderly or to disabled persons for a period of at least 40 years. In fiscal year 1992, Federal outlays for the programs were \$501 million.

Earned Income Tax Credit

The earned income tax credit (EITC) is a refundable Federal income tax credit available to families with dependent children in which a family member works and the family income is below a specific amount. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) extended the EITC in a modified form to low-income workers aged 25-64, without qualifying children.

The credit amount rises with earned income as a percent of annual earnings up to a statutory limit on creditable earnings. The maximum credit amount ap-

pplies to any eligible tax filer with earnings at or above the creditable limit; and whose earnings (or adjusted gross income (AGI), if greater), are at or below a threshold income level. Beyond the threshold level, the credit amount is reduced by the phaseout percentage, declining as income rises, and falling to \$0 at the "break-even" income level. At this level, "excess" income above the threshold completely offsets the maximum credit amount.

The EITC provides the family with either a reduction in income tax liability,

or if the credit exceeds tax liability, a direct grant of the amount by which tax liability is exceeded.

A worker may elect to receive the EITC on an advance basis by furnishing a certificate of eligibility to his or her employer. For such a worker, the employer makes an advance payment of the credit at the time wages are paid. However, the advance is limited to 60 percent of the maximum credit available to a worker with a qualifying child, in order to avoid large end-of-year tax liability.

The maximum amount of earned

income on which the EITC may be claimed and the income threshold for EITC phaseout are indexed for inflation.

Current Provisions

Under OBRA 93, EITC provisions effective in 1994 are shown in table 11. For a family with one child, the credit rate increases to 34 percent for 1995 and thereafter. However, the limit on creditable earnings drops to an estimated \$6,170 for 1995. (This is a \$6,000 base in 1994, adjusted for projected inflation.) The phaseout rate remains at 15.98 percent.¹¹

For a family with 2 or more children, the credit rate increases to 36 percent in 1995 and 40 percent for 1996 and thereafter. The creditable earnings limit does not change except for inflation indexing. The phaseout rate is 20.22 percent in 1995, and 21.06 percent for 1996 and thereafter.

The EITC is administered by the Internal Revenue Service as part of its responsibility for collection of Federal income taxes.

Actual data on the number of tax filers who claimed an EITC and the total credit amount received for 1991 are shown in table 12. Estimated data are also shown for 1992-94.

History of EITC Provisions

The Earned Income Tax Credit was first enacted as part of the Tax Reduction Act of 1975, as a means of helping the working poor—families with income below the poverty level despite having working members. Under the 1975 legislation, the EITC was equal to 10 percent of the first \$4,000. For income above \$4,000, the EITC was reduced by 10 percent, thereby reaching \$0 at an adjusted gross income (AGI) of \$8,000. The EITC was authorized for only one year.

The following examples assume earned income at the maximum of \$4,000, and AGI of \$6,000 and \$8,000, respectively.

$$\begin{aligned} \$4,000 \times .10 &= \$400 \\ \text{Less } (\$6,000 - \$4,000) \times .10 &= \$200 \\ \text{EITC} &= \$200 \end{aligned}$$

$$\begin{aligned} \$4,000 \times .10 &= \$400 \\ \text{Less } (\$8,000 - \$4,000) \times .10 &= \$400 \\ \text{EITC} &= \$0 \end{aligned}$$

The Revenue Adjustment Act of 1975 extended the EITC through the 1976 tax year. It also included a provision requiring that, beginning July 1, 1976, the EITC be disregarded in determining benefit amounts under any Federal of federally supported assistance programs but not in determining eligibility. The Tax Reform Act of 1976 required that the EITC be disregarded in determining both eligibility and benefit amounts and extended the program through the 1977 tax year. The Tax Reduction and Simplification Act of 1977 extended the EITC through 1978.

The Revenue Act of 1978 made major revisions in the EITC. It raised the maximum credit to \$500, allowed EITC payments in advance of annual tax filing, and made the EITC permanent. The EITC was made equal to 10 percent of the first \$5,000 of earned income. The maximum credit of \$500 was payable for earnings between \$5,000 and \$6,000. For AGI above \$6,000, the EITC was reduced by 12.5 percent, reaching \$0 at an AGI of \$10,000.

The Technical Corrections Act of 1979 required that both advance and lump-sum EITC's be treated as earned income by the Aid to Families With Dependent Children (AFDC) and Supplemental Security Income (SSI) programs effective January 1, 1980. The Omnibus Budget Reconciliation Act of 1981 provided that, regardless of whether working AFDC recipients applied for advance EITC payments, welfare agencies were to assume that EITC

eligibles received advance EITC payments and, that their AFDC benefits be reduced.

The Deficit Reduction Act of 1984 raised the maximum credit by 10 percent, from \$500 to \$550. It established the EITC at 11 percent of the first \$5,000 of earnings. Earnings between \$5,000 and \$6,500 qualified for the maximum credit of \$550. For AGI above \$6,500, the EITC was reduced by 12.22 percent. The credit was phased out when AGI reached \$11,000. This legislation repealed the requirement that welfare agencies reduce AFDC benefits to account for EITC payments for which they were eligible regardless of actual receipt. The States were required to count the EITC only when actually received.

The Tax Reform Act of 1986 indexed the credit amount and the phaseout levels for inflation. For tax year 1987, the EITC was increased from 11 percent of the first \$5,000 of earnings to 14 percent of the first \$5,714 of earnings, increased by the percentage rise in the average consumer price index (CPI) from the 12-month period ending August 31, 1984, to the 12-month period ending August 31, 1986. The phaseout income level was increased for 1987 from \$6,500 in current dollars to \$6,500 in 1984 dollars (current dollars plus the adjustment for inflation described earlier). For 1988, the income level at which the phaseout began was increased from \$6,500 in 1984 dollars to \$9,000 in 1984 dollars (current dollars plus an adjustment for inflation occurring between August 31, 1984, and August 31, 1987). The phaseout rate was reduced from 12.22 percent to 10 percent beginning with 1987.

Table 11.—The number of tax filers who claimed an earned income tax credit (EITC) and the total credit amount received, 1991-94

Year and type of beneficiary	Tax filers claiming EITC (in millions)	Credit amount (in billions)
1991.....	13.9	\$11.4
1992.....	14.1	13.1
1993.....	14.6	14.8
1994.....	19.4	21.0
Families with children.....	14.6	20.2
Families without children.....	4.8	.8

The Hunger Prevention Act of 1988 excluded EITC as countable income in determining food stamp benefits, and the Family Support Act of 1988 excluded EITC as countable income in determining AFDC benefits.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) expanded EITC and added one family-size related variation—families with two or more children. In addition, two new supplemental credits were added: a credit for children under age 1, and a credit for health insurance premiums paid by the taxpayer for a qualifying child. The first phase of the EITC expansion began in 1991; the final increase is to take place in 1994.

The credit rates for a family with one child increased from 14 percent in 1990 to 23 percent in 1994. For a family with two or more children, the credit rate increased from 14 percent in 1990 to 25 percent in 1994. In 1990, creditable earnings were \$7,140.

The EITC amount can be affected by receipt of other types of public program benefits when they are counted in determining AGI and thus serve to reduce the EITC benefit (for example, unemployment insurance benefits are included in AGI). The major need-based assistance programs have treated EITC benefits in a variety of ways over the life of the provision. However, under OBRA 90, EITC benefits are not counted as either income or assets in determining eligibility or benefit amounts for the following programs: AFDC, Food Stamps, Medicaid, SSI, Low-Income Home Energy Assistance, and the program for low-income housing.

OBRA 93 both expanded and simplified the EITC. It extended credits to taxpayers with no qualifying children who are aged 25 or older and under age 65. EITC's to families with children were increased and phased in over the period 1994-96. The supplemental young child credit and the supplemental health insurance credit were both repealed. The "Current Provisions" section on p. 00 provides a description of OBRA 93.

Eligibility

The basic EITC was available in 1993 to taxpayers who met the following requirements:

- (1) There must have been a qualifying child who lived in the home for more than 6 months (12 months for an eligible foster child) and the home must have been in the United States (50 States and the District of Columbia).
- (2) The taxpayer must have earned income during the year.
- (3) The earned income and adjusted gross income must each have been less than \$23,050.

A qualifying child is required to meet tests of relationship, residency, and age. To meet the relationship test, the child must be a son, daughter, adopted child, grandchild, stepson, stepdaughter, or an eligible foster child. An adopted child includes a child placed with the taxpayer for adoption by an authorized agency. A foster child must have lived in the taxpayer's household for the whole year.

To meet the residency test, a child must live in the taxpayer's main home for more than 6 months during the year (12 months for a eligible foster child).

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

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

Table 12.—Earned income tax provisions in 1994 under the Omnibus Budget Reconciliation Act of 1993

Provision	Families with—		
	One child	Two or more children	No children
Creditable earnings.....	\$7,750	\$8,425	\$4,000
Credit rate percentage.....	26.3	30.0	7.65
Maximum credit.....	\$2,038	\$2,527	\$306
Threshold income.....	11,000	11,000	5,000
Phaseout percentage.....	15.98	17.68	7.65
Break-even income (credit reduced to 0).....	\$23,753	\$25,293	\$9,000

Poverty Guidelines

The Federal poverty guidelines are used to determine financial eligibility for assistance or services under certain Federal programs. For specific programs (not including public assistance 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 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 guidelines, which vary by family size, have been computed from the official poverty thresholds by increasing the weighted average poverty thresholds from the Bureau of the Census by the percentage change in the Consumer

Price Index for All Urban Consumers (CPI-U) from the second preceding year to the preceding year. For a family of four, the value is rounded to the next higher \$50; for family sizes above and below four, guidelines are computed by adding or subtracting equal dollar amounts derived from the average difference between poverty thresholds and rounding to the nearest multiple of \$20.

A set of poverty guidelines is estab-

lished for the contiguous 48 States and the District of Columbia; separate sets are established for Alaska and Hawaii. The guidelines become effective on the date they are published in the Federal Register (unless an office administering a program using the guidelines specifies a different effective date for that particular program) and remain in effect until the next set is issued. The poverty guidelines issued in February 1993 are shown in the table 13.

Table 13.—Federal poverty income guidelines, 1993^{1,2}

Size of family unit	Contiguous 48 States and District of Columbia	Alaska	Hawaii
1	\$6,970	\$8,700	\$8,040
2	9,430	11,780	10,860
3	11,890	14,860	13,680
4	14,350	17,940	16,500
5	16,810	21,020	19,320
6	19,270	24,100	22,140
7	21,730	27,180	24,960
8	24,190	30,260	27,780

¹ For family units with more than 8 members, add the following amount for each additional family member: \$2,460 in the 48 contiguous States and the District of Columbia, \$3,080 in Alaska, and \$2,820 in Hawaii.

² *Federal Register*, February 12, 1993, pp. 8287-8289.

Selected Publications for Further Reading

This monograph brings together information on the present status of the major social insurance, health care, and income support programs in the United States. Because of the technical and programmatic details of each program presented in this document the following list of selected publications relevant to the various programs may be useful. Unless otherwise noted, these publications are available through the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Overview

The 1993 Catalog of Federal Domestic Assistance is a government-wide

compendium of Federal programs, projects, services, and activities that provide assistance or benefits to the American public. It contains 1,308 assistance programs administered by 51 Federal agencies.

Social Insurance Programs

The Social Security Administration produces many consumer-oriented publications and fact sheets that provide information on the programs it administers and how to apply for benefits. These publications include:

Understanding Social Security—A brief overview of each of the Social Security programs.

Retirement—A guide to Social Security retirement benefits.

Disability—A guide to Social Security disability benefits.

Survivors—A guide to Social Security survivors benefits.

SSI—A guide to the SSI program.

Copies are available from any Social Security office or you can request copies by calling the toll-free telephone number 1-800-2345-SSA (1-800-234-5772) or contacting SSA's Public Information Center, P.O. Box 17743, Baltimore, Maryland 21235. These publications are also available in Spanish.

The Social Security Handbook, 1993

summarizes information about the Federal Old-Age, Survivors, Disability Insurance, Supplemental Security Income, Health Insurance, and Black Lung programs. It also contains brief descriptions of related programs. The purpose of the *Handbook* is to help people understand how these programs operate, who is entitled to benefits, and how to obtain these benefits.

The *Compilation of the Social Security Laws* (Volumes I and II) is a congressional committee print (WMCP:103-5 and 103-6) that reflects changes made in the Social Security Act based on enactment of major legislation through January 1, 1993.

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 1993 edition contains more than 200 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, and other related income-maintenance and public assistance programs.

Black Lung Benefits (ERSA 91-94) is one of a series of fact sheets highlighting Department of Labor programs. Copies may be obtained from the U.S. Department of Labor, 200 Constitution Ave., NW., Room E-017, Washington, DC 20210.

Comparison of State Unemployment Insurance Laws reports the types of workers and employers who are covered under each State law, the method of financing the program, the benefits that are payable, the conditions to be met for payment, and the administrative organizations established to do the jobs. Copies may be obtained from U.S. Department of Labor, Office of Employment Statistics Administration, 200 Constitution Ave., NW., Room S-3522, Washington, DC 20210.

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 on offset provisions integrating workers' compensation and other program benefits, and on attorney fees. Copies may be obtained from U.S. Department of Labor, Employment Standards Administration, 200 Constitution Ave., NW., Washington, DC 20210.

The *1993 Analysis of Workers Compensation Laws* offers an overview of the important provisions of workers' compensation statutes and provides both a comparison and an understanding of the various laws. Sixteen detailed charts are presented to aid employers, employees, insurance firms, agents, brokers, attorneys, physicians, and others in locating specific provisions of the laws. Copies are for sale by the U.S. Chamber of Commerce, 1615 H Street, NW., Washington, DC 20062.

Social Security Programs Throughout the World, 1991 describes the major features of the social insurance programs of 146 countries and territories. The programs covered include old-age, invalidity, and death; sickness and maternity; work injury; unemployment; and family allowances. A Spanish edition is available that covers countries in the Western Hemisphere.

Five Decades of International Social Security Research is a 62-page index of comparative social security research reports and articles published by the Social Security Administration from 1937-90. The bibliography is indexed according to country and subject. The subjects include administration; financing; health; international agreements and organizations; old-age, survivors, and disability insurance; and private pensions. Copies may be obtained from the Social Security Administration, Program Analysis Staff, Suite 200, Van Ness Centre, 4301 Connecticut Ave., NW., Washington, DC 20008.

Health Care Programs

The *Health Care Financing Review* is published quarterly, with an annual Medicare/Medicaid Supplement, by the Health Care Financing Administration. The journal presents information on a broad range of health care financing and delivery issues.

The *1993 Data Compendium* contains historical, current, and projected data on Medicare enrollment and Medicaid recipients, expenditures, and utilization. Data pertaining to budget, administrative/operating costs, individual income, financing, and health care providers/suppliers are also included. Limited copies are available from the Health Care Financing Administration, Statistical Information Line (410) 597-5082.

The booklet *1993 Guide to Health Insurance for People with Medicare* discusses what Medicare pays and does not pay, the types of private health insurance to supplement Medicare, and describes 10 standard Medigap insurance plans.

The *Medicare 1993 Handbook* provides a comprehensive explanation of the Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) plans under the Medicare program. This *Handbook* is also available in Spanish. Copies may be obtained by writing to Medicare Publications, Health Care Financing Administration, 6325 Security Boulevard, Baltimore, Maryland 21207.

Programs for Special Groups

The *Railroad Retirement Handbook, 1993* describes the history, provisions, and financing of the retirement, disability, survivors, and health insurance programs, as well as the unemployment and sickness insurance program, provided under Federal law for railroad workers and their families. Copies may be obtained from the U.S. Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092.

The *Railroad Retirement Board, January 1993* presents an overview of

the responsibilities of the Board. It also contains the titles of publications pertaining to benefits payable by the Board that are available at any Railroad Retirement Board district office or its headquarters at 844 North Rush Street, Chicago, Illinois 60611-2092.

Annual Reports and Statistical Tables pertain to the administrative, financial, statistical, legal, and other aspects of the railroad retirement and unemployment insurance systems. Copies may be obtained from the Railroad Retirement Board at North Rush Street, Chicago, Illinois 60611-2092.

Federal Benefits for Veterans and Dependents, 1993 Edition gives a comprehensive summary of the Federal benefits available to veterans and their dependents. This publication also provides the addresses and telephone numbers of VA facilities.

Income Support Programs

An Overview of the AFDC Program, Fiscal Year 1992 presents State reported data on recipient characteristics, program and administrative costs; and a summary of AFDC legislative history. Copies may be obtained from the Administration for Children and Families, 370 L'Enfant Promenade, SW., Washington, DC 20477.

State Assistance Programs for SSI Recipients, January 1993 focuses on eligibility provisions and basic levels of assistance for individuals and couples who receive supplementary payments. Data are also presented on Federal-State administrative responsibilities for making payments, on State criteria for special need payments, and on Medicaid eligibility. Copies are available from the Social Security Administration, Office of Supplemental Security Income, 3-R-1 Operations Building, 6401 Security Boulevard, Baltimore, Maryland 21235.

Characteristics and Financial Circumstances of AFDC Recipients, FY 1991 presents data on the demographic and financial circumstances of families who received payments under the Aid to Families with Dependent Children pro-

gram. Data are presented for the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Copies may be obtained from the U.S. Department of Health and Human Services, Administration for Children and Families, 370 L'Enfant Promenade, SW., Washington, DC 20477.

Quarterly Public Assistance Statistics, Fiscal Year 1991 presents a comprehensive tabular presentation of AFDC State caseload data, AFDC and emergency assistance payments, AFDC applications and case discontinuances, requests for hearings in AFDC, and public assistance recipients by metropolitan statistical areas. Copies may be obtained from the U.S. Department of Health and Human Services, Administration for Children and Families, 370 L'Enfant Promenade, SW., Washington, DC, 20447.

Characteristics of Food Stamp Households, Summer 1992 describes the economic and demographic characteristics of food stamp households in 1992 and examines changes in their circumstances from the prior year. Copies may be obtained from the U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis and Evaluation, 3101 Park Center Drive, Alexandria, Virginia 22302.

Food Program Facts are brief narratives that explain each of the food assistance programs administered by the Food and Nutrition Service, U.S. Department of Agriculture. It also highlights the legislative history of the various programs. Copies may be obtained from the Food and Nutrition Service, U.S. Department of Agriculture, Public Information Staff/News Branch, 3101 Park Center Drive, Alexandria, Virginia 22302.

Low Income Home Energy Assistance Program, Report to Congress for Fiscal Year 1991 provides data on the States, tribes, and territories on their energy assistance programs, their usage of such programs, and other characteristics of low-income households and Low-Income Home Energy assisted households. Further information about the contents of this publication may be obtained from the U.S. Department of Health and Hu-

man Services, Administration for Children and Families, Office of Community Services, Division of Energy Assistance, 370 L'Enfant Promenade, SW., Washington, DC 20447.

Notes

¹See Andrew W. Dobelstein, *Politics, Economics, and Public Welfare*, Englewood Cliffs: Prentice-Hall, Inc., 1980, pp. 96-97.

²A 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.

³Unemployment benefits are subject to Federal income taxes. The benefit may be reduced if the worker is receiving certain types of income—pension, back pay, or workers' compensation for temporary partial disability.

⁴Beginning is 1990, the law allowed (a) a reduction in net self-employment earnings to which the OASDI and HI tax applies and (b) an income tax deduction of one-half the OASDI and HI taxes paid.

⁵Except for emergency services or services needed when outside the plan's service area.

⁶For a detailed examination of the provisions of the FERS programs, see Wilmer L. Kerns, "Federal Employees Retirement System Act of 1986," *Social Security Bulletin*, November 1986, pp. 5-10.

⁷Adapted from the *Railroad Retirement Handbook, 1993*, Railroad Retirement Board, 1993.

⁸Some States are conducting demonstration projects in which recipients receive and use cards resembling bank cards, instead of coupons, to purchase allowable foods at participating retail outlets.

⁹In some remote areas of Alaska, recipients may use food coupons to purchase hunting and fishing equipment (excluding equipment for transportation, clothing and shelter, firearms, ammunition, and other explosives), for procurement of food.

¹⁰Alternatives for tenant payments are the highest of the following: (1) 30 percent of monthly adjusted income; or (2) 10 percent of the gross monthly income; or (3) if the family receives welfare assistance, the portion of welfare assistance designated as the monthly housing cost for the family.

¹¹This change retains the relative amount of the maximum credit at the 1994 level.