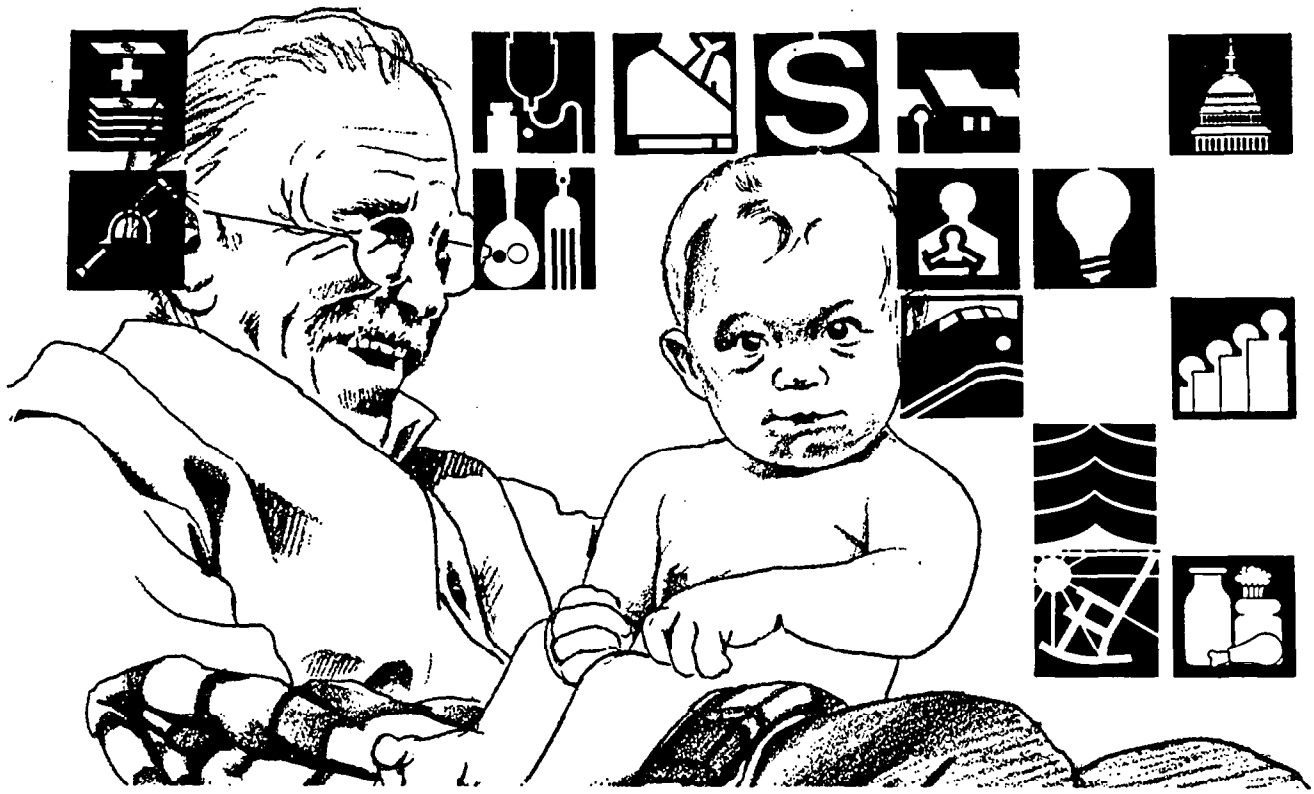


Social Security Programs in the United States

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

The term social security is popularly used in the United States to refer to the basic national social insurance program—old-age, survivors, disability, and health insurance. The term is used here in a broader sense to describe all types of social insurance, social assistance, and related programs.

Thus, this description provides the history and current program provisions of this country's social insurance systems: old-age, survivors, and disability insurance; Medicare; unemployment insurance; workers' compensation; and temporary disability insurance. It describes the major means-tested assistance programs—supplemental security income, aid to families with dependent children, Medicaid, and food stamps—as well as the smaller programs such as low-income home energy assistance, public housing, the school lunch program, and general assistance. Finally, it includes three programs for members of special groups: veterans, public employees, and railroad employees.

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

Nancy Miller of the Social Security Administration's Office of Legislative and Regulatory Policy is responsible for the chapter on the old-age, survivors, and disability insurance program. Wilmer Kerns of the Office of Research, Statistics, and International Policy (ORSIP) is responsible for the Medicare chapter, the section on means-tested programs, and the chapter on veterans' benefits. Daniel Price, of ORSIP, is author of the chapters on unemployment insurance, workers' compensation, and temporary disability insurance. And Ann Kallman Bixby, also of ORSIP, is responsible for the chapters on public employee programs and railroad retirement benefits.

Much appreciation is expressed to the many individuals and agencies who reviewed and checked the accuracy of the chapters relating to their particular interests.

Section I: Social Insurance Programs

By the mid-1920's, both the States and the Federal Government had begun to recognize that certain risks in an increasingly industrialized nation could best be met through the application of social insurance principles. In social insurance programs, certain risks—injury, disability, unemployment, old age, and death—are pooled; "premiums," or contributions, are paid either by employees and/or their 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 civilian employees of the Federal Government 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 universally dependent on factors beyond their individual control for their economic security. Previous methods utilized 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 nor 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 1935, President Franklin D. Roosevelt proposed to Congress long-range economic security legislation, embodying the recommendations of a specially created, Cabinet-level Committee on Economic Security. There followed the passage of the Social Security Act, signed into law on August 14, 1935.

This law established two social insurance programs on a national scale to help meet the risks of old age and unemployment: A Federal system of old-age benefits for retired workers who had been employed in 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, since the Great Depression 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. The first $3,000 of annual salary from one employer was considered as counting toward the total of annual wages on which benefits would be computed. This amount covered the total earnings of 90 percent of those in the labor force. While all wage and salary workers in commerce and industry were covered by the new program, many individuals were not covered, including the self-employed, agricultural and domestic service workers, casual laborers, employees of nonprofit organizations, and those subject to 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 addition of protection for a worker's dependents and survivors. In 1956, the scope of the program was broadened through the addition of disability insurance. Initially, benefits were provided for severely disabled workers aged 50 to 64 and for adults disabled before the age of 18 who were children of deceased or retired workers.

Unemployment compensation, which provided temporary cash payments to the involuntarily unemployed, was conceived by the Committee on Economic Security as the "front line of defense" from dependency resulting from 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.

By far the most important strengthening of the fabric of social insurance protection in recent years was the establishment of a comprehensive health insurance program, Medicare, in 1965. The 1965 Amendments to the Social Security Act set up a basic hospital insurance program for persons aged 65 or older, financed through a separate earnings tax and trust fund that provides protection against the costs of hospital and related care. The amendments also established a voluntary supplementary medical insurance (SMI) plan financed both through monthly premiums paid out of the current income of enrollees and through a matching Federal contribution from general revenues. SMI covers part of the cost of physician services and other related medical and health services not covered by the hospital plan. In 1972, the Medicare program was extended to disabled social security beneficiaries of any age under certain cirumstances and to most persons with chronic kidney disease.

Finally, in 1970, the black lung program was established by the Federal Coal Mine Health and Safety Act. Generally regarded as a specialized workers' compensation program, it provides monthly cash benefits to coal miners who are totally disabled because of black lung disease and to the survivors of miners who die from this disease.

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 and most important 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. Those who work in covered jobs pay social security taxes on their wages or earnings from self-employment that, along with taxes paid by employers at an equal rate, constitute the primary source of revenue to finance benefits and pay administrative expenses.

In 1985, about 123 million individuals were engaged in work covered by the social security program. At the end of 1984, about 36.4 million persons were receiving cash benefits totaling about $15 billion per month. These beneficiaries included 25.4 million retired workers and their family members, 7.2 million survivors of deceased workers, and 3.8 million disabled workers and their family members. Social security is an important source of retirement income for almost everyone; in 1982, two-thirds of the aged relied on their social security benefits for at least half 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 out of 5 workers are protected in the event they should become severely disabled.

Origins and Development of OASDI

Background. The social security program has been shaped by both long-standing traditions and changing economic and social conditions. It was created in 1935, at the height of the Great Depression. Because American society had changed from primarily agricultural to primarily industrial and urban, many families were devastated by the loss of cash wages that accompanied the widespread unemployment of that era. For vast numbers of the aged, and those nearing old age, the loss of savings brought with it the prospect of living their remaining years in destitution. During the worst years of the Depression, many old persons were literally penniless. In fact, less than 10 percent of the aged left estates large enough to be probated on 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 there were long waiting lists. As the Depression worsened, benefits to individuals were cut to enable States to spread limited funds among as many people as possible.

Meanwhile, both the States and the Federal Government had begun to recognize that workers in an increasingly industrialized country and their dependents could be effectively protected from certain economic risks through social insurance. In the United States, as in most industrialized countries throughout the world, social insurance began with workers' compensation (in effect in all but four States by 1929). President Franklin Roosevelt's Cabinet-level 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 were embodied in the Social Security Act, signed into law on August 14, 1935. The law also provided for Federal matching grants-in-aid to the States to help them give financial assistance to specified categories of the needy, the aged, the blind, and dependent children. It authorized Federal grants to the States for social services, public health, and vocational rehabilitation.

Major milestones in the development of OASDI. Under the 1935 law, workers in commerce and industry would earn retirement benefits through work in jobs covered by the system. Benefits were to be financed by a payroll tax paid by employees and their employers on wages up to $3,000 per year (the wage base). Monthly benefits would be payable at age 65 to workers with a specified amount of cumulative wages in covered jobs. The amount of benefits payable was generally related to the worker's average 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 were to be paid to the estates of workers who died before reaching age 65 or before receiving benefits equal to the total amount of taxes they had paid plus interest. Collection of taxes was scheduled to begin in 1937, but 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 approaching retirement age at that time and to their dependents. The 1939 law also established the concept of "quarter of coverage" as the basis for measuring whether an individual had worked long enough in covered employment to qualify for a benefit. Also, individuals who continued to work after age 65 could receive full benefits as long as their earnings did not exceed a specified amount. The 1939 amendments made monthly benefits first payable in 1940, instead of 1942 as originally planned. In addition to these changes in program benefits, the 1939 amendments altered program financing, creating the Old-Age and Survivors Insurance Trust Fund and establishing the concept of "pay-as-you-go" financing with a limited contingency reserve fund.

No major changes were made again in the program until 1950, when benefit levels were substantially increased; the wage base was also increased and a new schedule of gradually increasing tax rates was set forth in the law. Coverage was broadened to include many jobs that had been previously excluded, in some cases because experience was needed to work out ways to report the earnings and collect the taxes of persons in certain occupational groups. Among the groups covered by the 1950 amendments were regularly employed farm and household employees and self-employed persons other than farmers and professional people. Coverage was made available on a group voluntary basis to employees of State and local governments not under public employee retirement systems and to employees of nonprofit organizations.

In 1950, when coverage under the program was extended, the law was amended to allow a worker's average monthly earnings to be figured on the basis of his or her earnings after 1950. Similar consideration was given to the groups newly covered by the program in 1954 and 1956 (including members of the Armed Forces, most self-employed professional persons, and State and local employees under a retirement system under certain conditions) by providing that the 5 years of lowest earnings would be dropped from the computation of average earnings. So 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 disability insurance. Benefits were provided for disabled workers aged 50–64 suffering from severe disabilities of "long-continued and indefinite duration" and for adult disabled children (if disabled before adulthood) of deceased and retired workers. In 1958, the Act was further amended to provide benefits for dependents of disabled workers similar to those already provided for dependents of retired workers.

In 1960, the age-50 limitation for disability benefits was removed so that disability benefits could be payable at any age before 65 and a trial work provision was added to encourage beneficiaries to return to paid employment. The 1965 amendments modified the definition of disability so that a severely disabled person could qualify if his or her impairment was

expected to last at least 12 months. The 1967 amendments provided disability insurance benefits for certain disabled widows and widowers, starting at age 50.

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

By 1972, however, there was concern that beneficiaries continued to be vulnerable to substantial declines in purchasing power between benefit adjustments. In 1972, the Congress enacted a 20-percent benefit increase, which provided a real increase in the purchasing power of benefits, and provided for future automatic cost-of-living benefit increases equivalent to the increase in the Consumer Price Index. The wage base and the maximum amount a beneficiary could earn before experiencing a reduction in his or her benefits (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 continue to work beyond the full benefit retirement age.

The 1977 amendments made significant changes in the benefit computation provisions of the social security law. Under the 1972 amendments, benefits were—under prevailing and projected economic conditions—overadjusted for inflation; benefits at initial entitlement would reflect not only increases in wages during a person's working lifetime, but also a part of the increase in prices. Thus, for many workers retiring in the future, benefits could have exceeded their preretirement earnings by substantial amounts. The 1977 amendments replaced the technically flawed benefit formula with a new permanent benefit formula for those reaching age 62 in 1984 or later. (Transitional rules applied for those reaching age 62 during the period 1979–83.) Under the new rules, earnings for past periods were updated or "indexed" to take account of changes in average wages in the economy since they were earned. Cost-of-living adjustments would apply only after a person became eligible for benefits. Tax rates and the wage base were also adjusted to improve the program's financial stability.

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

In the late 1970's and early 1980's, benefit costs were driven up rapidly by unprecedented inflation while slow growth in wages and high unemployment held down payroll tax income to the system. This 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 the bipartisan Commission, the 1983 Amendments to the Social Security Act made a number of changes that improved program financing, including advancing tax rate increases already scheduled in prior law for employees and employers, permanent increases in self-employment tax rates, and inclusion of up to one-half of benefits in taxable income for certain upper-income beneficiaries (with resulting revenues appropriated to the OASI and DI trust funds). In addition, coverage was expanded to include Federal civilian employees hired after December 31, 1983, and all employees of nonprofit organizations (on a mandatory basis). To address the long-term outlook of the system, the Congress approved a gradual increase in the age of eligibility for full benefits from 65 to 66 by 2009 and to 67 by 2027. Actuarially reduced benefits will continue to be available at age 62, but with a greater reduction than under prior 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 whether a disability beneficiary's payments may be terminated because he or she is no longer disabled.

Program Principles

Throughout the development of the OASDI program certain basic principles have been adhered to.

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

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

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

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

Rights clearly defined in the law. Still another 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 provided in the law must be paid. If a claimant disagrees with the decision in his or her case, 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 additional employment, so that today the old-age, survivors, and disability insurance program approaches universal coverage. About 95 percent of the jobs in this country are covered under the program, compared with less than 60 percent when the program began in 1937. Except for special provisions applicable to only a few kinds of work, coverage is on a compulsory basis. The wide applicability and compulsory nature of the program are essential to its effectiveness in preventing dependency and want and in assuring the American worker and family of continuous protection during all phases of his or her working career.

Nearly all work performed by citizens and noncitizens, regardless of age or sex, is covered if performed within the United States (defined for social security purposes to include American Samoa, Guam, 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 respect to the worker's citizenship.

The majority of workers excluded from coverage fall into four major categories: (1) Federal civilian employees hired before January 1, 1984, (2) railroad workers (who are covered under the railroad retirement system, coordinated with social security), (3) employees of State and local governments not covered by a voluntary agreement, (4) household workers and farm workers who do not earn enough or work long enough to meet certain minimum requirements (workers in industry and commerce are covered regardless of regularity of employment or 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 21 by his or her parent or employment of one spouse by the other.

Employees of State and local governments are covered under agreements between the States and the Secretary of Health and Human Services. Each State decides what groups of eligible employees will be covered, subject to provisions in the Federal law that assure retirement system members a voice in any decisions to cover them under OASDI. Coverage of employment by States and their political subdivisions was made voluntary because of concerns that any Federal law levying a tax on the governmental functions of States and localities might be

unconstitutional.[1] At present, more than two-thirds of all State and local employees have been brought under coverage.

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 exemption is claimed on grounds of conscience or religious principles. Religious orders whose members have taken a vow of poverty may make an irrevocable election to cover their members as employees.

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

Gratuitous (noncontributory) wage credits of $160 a month are also provided to veterans, with certain restrictions, 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 Veterans' Administration) 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 the service is used for purposes of benefits paid by the uniformed services. The social security trust funds are reimbursed from Federal general revenues to finance benefits payable due to the noncontributory wage credits.

Eligibility for Cash Benefits

Insured status. To qualify for his or her own cash benefit payments and those for dependents or survivors, a worker must have demonstrated attachment to the labor force by a specified amount of work in covered employment or self-employment. The amount of covered work required is, generally speaking, related 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 in 1991 and later will need credit for 10 years of work in covered jobs to qualify for retirement benefits.

The period of time a person must have spent in covered work to be insured for benefits is measured in "quarters of coverage." A worker can be credited with up to four quarters of coverage per year, depending on his or her annual covered earnings. In 1986, a person is credited with one quarter of coverage for each $440 in covered earnings. This 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 quarters of coverage (acquired at any time after 1936) as the number of years elapsing between age 21 and age 62 or death or disability, whichever occurs first. For those who reached age 21 before 1951, the requirement is one quarter of coverage for each year between 1950 and retirement age, disability, or death.

If a worker dies before acquiring fully insured status, survivor benefits may be paid to his or her young widow(er) with children if he or she is "currently insured." An individual is currently insured with six quarters of coverage 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 5 of the 10 years before the onset of disability (or, in the case of workers who are disabled before age 31, one-half the time after age 21). Somewhat more liberal insured status requirements apply to workers who are blind.

The insured status requirements for each of the various cash benefits paid under the program are summarized in table 1.

Annual earnings test. The law provides that a beneficiary who has substantial earnings from work will have some or all cash benefits withheld, depending on the amount of his or her annual earnings. Benefits will also generally be withheld from a person receiving dependent's benefits 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. This is in line with the basic purpose of monthly benefits under the program—to replace some of the earnings from work that are lost by a worker and his or her family when he or she retires in old age, becomes disabled, or dies.

The amount a beneficiary can earn without having benefits reduced is increased automatically—in proportion to the rise in average earnings—whenever OASDI cash benefits are increased automatically. In 1986, a beneficiary under age 65 has his or her benefits reduced $1 for each $2 in annual earnings over $5,760; a beneficiary aged 65 to 69 may earn $7,800

[1] To date there has been no definitive court test of this issue.

Table 1.—Benefits payble and insured status requirements under the OASDI program, January 1986

Retirement insurance benefits	
Monthly payments, equal to 100 percent of the primary insurance amount, are payable to:	*If worker is:*
A retired worker 65 or over [1]	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 [2]	Fully insured
Dependent child or grandchild under age 18, or age 19 if in school	Fully insured
Dependent 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 $138.50 are payable at age 72 to:	
A worker who reached age 65 (62 for women) before 1957	Transitionally insured
And monthly payments of $69.40 are payable at age 72 to a worker's:	
Spouse who reached age 72 before 1969	Transitionally insured
Survivor insurance benefits	
Monthly payments equal to 100 percent [3] of the primary insurance amount are payable to a worker's:	*If at death the worker is:*
Widow(er) or surviving divorced spouse aged 65 or older [4]	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
Dependent child or grandchild under age 18, or age 19 if in school	Either fully or currently insured
Dependent child or grandchild aged 18 or older who has been disabled since before age 22	Either fully or currently insured
Dependent parent aged 62 or older, when both parents are entitled	Fully insured
Lump-sum payment of $255 may be paid to a worker's:	
Widow(er) who was living with the worker at time of death; or, if none, to a person who was (or could have been) entitled to widow(er)'s, mother's or father's benefits for month of death; or, if none, to a person (or in equal shares to persons) who was (or could have been) entitled to a child's benefit for month of death	Either fully or currently insured
Monthly payments of $138.50 are payable at age 72 to a worker's:	
Widow(er) who reached age 72 before 1969	Transitionally insured
Disability insurance benefits	
Monthly payments equal to the amounts payable in retirement cases [5] are payable to:	*If worker is:*
A disabled worker under age 65 and his or her spouse and children [6]	Fully insured and has 20 quarters of coverage in the 40 calendar quarters ending with the quarter in which he became disabled [7]
A blind worker under age 65 and his or her spouse and children [6]	Fully insured
Special age-72 benefits	
Monthly payments of $138.50 are payable to:	*If the person meets:*
Certain persons who reached age 72 before 1972	Reduced requirements for insured status that apply only to this type of payment

[1] Reduced benefits are payable at age 62; benefit amount is permanently reduced by 5/9 of 1 percent for each month the benefit is paid before age 65 (or 20 percent over the full 3-year period). Benefit amount is increased by 1/4 of 1 percent for each month that no benefits are payable to a fully insured person between ages 65 and 70.

[2] 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).

[3] 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.

[4] 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.

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

[6] Same categories as in retirement cases.

[7] 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.

before his or her benefits are reduced. (Beginning in 1991, beneficiaries who have reached normal retirement age will have their benefits reduced $1 for each $3 in earnings exceeding the exempt amount.) Unreduced benefits are also payable to beneficiaries beginning with the month when they reach age 70, 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 dependents, in which the worker works more than 45 hours.

Disability requirement. Disability, for purposes of entitlement to monthly benefits, is defined as

"inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." The impairment must be so severe that the individual is 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 whether a specific job vacancy exists for that person, or whether he or she would be hired upon application for the work. The amount of earnings that ordinarily demonstrates substantial gainful activity is set forth in regulations. At present, earnings of $300 or more a month are presumed to represent substantial gainful activity, while earnings below $190 generally indicate the absence of substantial gainful activity. 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 a worker aged 55 or older who is blind. He or she is considered disabled if unable, because of blindness, to engage substantially in work requiring skills and abilities comparable to those required in the past occupation.

Monthly benefits (at a permanently reduced rate) are payable to disabled widows and disabled widowers at ages 50-59. The widow or widower must have become totally disabled within 7 years after the spouse's death or within 7 years after the end of entitlement to benefits as a mother or father or to widow's or widower's benefits based on a disability. The test of disability for disabled widows and widowers is more restrictive than that for disabled workers. Determinations of disability in the case of a widow or widower are made solely on the level of severity of the impairment (without regard to such factors as age, education, and work experience, which are considered in disabled-worker cases). The disabling impairment must be severe enough to prevent an individual from engaging in "any gainful activity" (as distinguished from "substantial gainful activity"). Benefits are also payable to a worker's adult children who have been disabled since before age 22, on the basis of the same definition of disability as applies to workers.

Determinations of disability are generally made on a reimbursable basis by State agencies (usually the State vocational rehabilitation agencies) under regulations established by the Secretary of Health and Human Services. A sample of decisions made by the State agencies is reviewed by the Social Security Administration to assure consistency and conformity with national policies. Applicants are referred to State vocational rehabilitation agencies for possible vocational rehabilitation services. Disability benefits are not payable to anyone who without good cause refuses vocational rehabilitation services made available to him or her. Payment may be made from the social security trust funds for the cost of providing vocational rehabilitation services to disability insurance beneficiaries who are successfully rehabilitated.

To further encourage a return to work, a disabled person who has not recovered but who returns to work is allowed a trial work period during which his or her benefits are continued, while he or she tests capacity to work. As a general rule, when a disabled person is working in a trial work period, only a month during which he or she is employed and earns more than $75 will count as a month of the trial work period. At the end of 9 months of trial work (not necessarily consecutive months) the case is reviewed to see whether the person is able to engage in substantial gainful activity. If he or she is not able to do substantial gainful work and has not medically improved, the benefits are continued. If he or she is able to engage in substantial gainful activity, the benefits are continued for a 3-month period of adjustment, so that the person receives a total of 12 benefit payments for months in which he or she works. In addition, as long as the beneficiary does not recover medically during the following 12-month period, the benefits will be reinstated for any month in which his or her earnings fall below the substantial gainful activity level. Beneficiaries who recover from their disabilities before they work 9 months, as well as beneficiaries who recover before they have tested their ability to work, get their benefits for 3 months more, including the month in which they recover.

The law includes numerous other provisions designed to encourage disability beneficiaries to return to work. These include the deduction of impairment-related work expenses from a person's earnings when determining whether he or she is engaging in substantial gainful activity, and the continuation of Medicare coverage for 36 months after cash benefits cease for workers who are engaging in substantial gainful activity but who have not medically recovered. A cap is set on the maximum family benefits payable in disability cases because of concern that some disabled workers might be discouraged from returning to work because benefits in some cases exceeded their predisability net earnings.

Payment of cash benefits abroad and totalization. Benefits are generally payable to U.S. citizens regardless of where they reside. Benefits cannot be paid to an alien who is outside the United States for more than 6 months unless that person meets one of several exceptions in the law. For example, an exception is provided (1) if nonpayment of benefits would be contrary to a treaty obligation of the United States, or

(2) if 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 for auxiliary or survivor benefits after 1984 generally must also have resided in the United States for 5 years and been related to the worker during that time. Benefits are not payable to an alien living in a country in which the Treasury Department has suspended payments.

Through international totalization agreements, the U.S. social security system is coordinated with the systems of certain other countries. Authorized under the 1977 amendments, these agreements benefit both workers and employers by eliminating dual coverage and contributions with respect to the same work under the social security systems of the countries that are parties to the agreement. 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 seven countries—Italy (1978), the Federal Republic of Germany (1979), Switzerland (1980), Belgium, Norway, and Canada (1984), and the United Kingdom (1985).

Types of Benefits

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

Monthly survivor benefits are payable to a widow or widower at age 60, or, if disabled, at age 50; to a widow or widower at any age if he or she has in his or her care 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, from age 18 to 19 if 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 benefit of $255 is also payable on the death of an insured worker to the spouse living with the worker at the time of death or eligible to receive benefits at that time based on his or her earnings record or, if there is no qualified spouse, to a child or children of the worker eligible for monthly survivor benefits.

Monthly disability benefits are payable to a disabled worker under age 65 after a waiting period of 5 full calendar months and terminate if he or she recovers or returns to substantial work despite the impairment. When the worker reaches age 65, he or she is transferred to the retirement rolls. Benefits for the 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 is based on his or her average covered earnings computed over the period of time he or she reasonably could have been expected to work in covered employment. The number of years in the averaging period is generally 5 less than the number of years after 1950 (or, if later, after age 21) up to the year in which the worker reaches age 62, becomes disabled, or dies. No less than 2 years can be used in the averaging period.

For persons who reached age 62, became disabled, or died before 1979, the actual dollar amount of covered earnings is used in the computation. For persons who reach age 62, become disabled, or die after 1978, the actual earnings are indexed—updated to reflect increases in average wage levels in the economy. After a worker's average monthly earnings or average indexed monthly earnings (AIME) have been determined, a benefit formula is applied to determine the worker's primary insurance amount (PIA), on which all social security benefits related to the worker's earnings are based. The benefit formula is weighted in favor of low earners since they have less margin for reduction in income than do high earners.

The maximum monthly benefit is generally payable only to workers who had earnings at or above the maximum amount that was counted for contribution and benefit purposes each year. For workers reaching age 62 in 1986, the maximum PIA is $788.20. Since 1981, there has been no statutory minimum benefit for newly eligible workers. The law does, however, provide a special minimum benefit intended to provide for long-term, low-paid workers a benefit that is higher than the regular benefit formula permits.

For persons turning age 62, dying, or becoming disabled in 1986, the benefit formula provides that the basic benefit amount, or PIA, is equal to:

90 percent of the first $297 of AIME, plus
32 percent of AIME between $298 and $1,790, plus
15 percent of AIME above $1,790.

The dollar amounts defining AIME brackets are adjusted annually based on changes in average earnings levels in the economy. As a result, initial benefit levels will generally keep pace with future increases in wages. For example, for all future years, initial social security retirement benefits are expected to replace a constant proportion (about 41 percent) of prior covered earnings for persons who worked a full worklife with earnings equal to the average in the economy and retired at the full-benefit retirement age. For persons who worked a full worklife and earned the Federal minimum wage, the replacement rate will be about 57 percent. And for persons who always earned the maximum subject to social security taxes, the replacement rate will be about 27 percent.

In general, after a worker's initial social security benefit has been determined, it is increased automatically each December (payable in the January checks) to reflect any increase in the cost of living, provided that the Consumer Price Index rose in the preceding year by at least 3 percent. (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. No benefit increase would be payable if the lower of these increased by less than 3 percent.)

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 full-benefit retirement age (currently age 65) is equal to the PIA. For workers who retire before age 65, the benefit is actuarially reduced to take account of the longer period over which they will receive benefits. 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 begins to receive benefits at age 60 receives 71 1/2 percent of the deceased spouse's basic benefit amount, as does 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 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 in worker's and spouse's benefits will be greater.

A worker who delays retirement past normal retirement age (now 65) has his or her benefits increased based on the delayed retirement credit. This credit, currently 3 percent of the PIA per year, takes account of benefits forgone by persons who continue to work past age 65. The delayed retirement credit will gradually rise from the current 3 percent per year to 8 percent per year between 1990 and 2009.

Auxiliary and survivor benefits 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 age 65 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 amount of monthly benefits that may be paid to a worker and his or her dependents or to survivors. The purpose of this provision is to assure 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 (for example, a wife or husband) who is eligible for a benefit based on his or her own earnings and who also may be eligible for a benefit as a dependent will draw his or her own benefit, plus any excess of the other benefit over his or her own—in effect, the larger of the two.

In addition, benefits may be reduced if a person's annual earnings from work or self-employment (or the earnings of the worker on whose record that person receives benefits) exceed an exempt amount. In 1986, beneficiaries aged 65 or older may earn up to $7,800; those under age 65 may earn up to $5,760. (The exempt amount increases automatically as wage levels rise.) A person's benefits are reduced $1 for each $2 in earnings over the annual exempt amount. 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. Auxiliary benefits are paid to the family members of a disability insurance beneficiary on the same basis as they are paid 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 families. Table 2 shows the number of individuals receiving benefits and the average benefit amounts for various benefit categories.

Program Financing

The plan of financing of the OASI and DI programs is that workers and their employers and self-employed persons pay taxes on earnings in covered jobs up to the annual taxable maximum ($42,000 in 1986; automatically adjusted as wages rise). These taxes (which comprise over 95 percent of

Table 2.—Number of persons receiving monthly benefits under OASDI, December, selected years, 1940-80, and September 1985, and average monthly amount, September 1985

Type of beneficiary	1940	1950	1960	1970	1975	1980	September 1985	Average amount, September 1985
All beneficiaries	222,488	3,477,243	14,844,589	26,228,629	32,084,511	35,618,840	36,875,442	$415.59
Retired workers	112,331	1,770,984	8,061,469	13,349,175	16,588,001	19,582,625	22,301,671	463.68
Disabled workers	...	...	455,371	1,492,948	2,488,774	2,861,253	2,647,127	469.51
Wives and husbands [1] of retired or disabled workers	29,749	508,350	2,345,983	2,951,552	3,320,310	3,480,212	3,369,046	228.59
Widows and widowers [2]	4,437	314,189	1,543,843	3,177,879	3,779,194	4,287,930	4,732,549	419.03
Widowed mothers and fathers [2]	20,499	169,438	401,358	523,136	581,845	562,798	371,298	321.52
Disabled widows and widowers [2]	...	...	...	49,281	109,511	126,659	106,219	305.93
Children [3]	56,648	699,703	2,000,451	4,122,305	4,972,008	4,609,813	3,304,347	250.70
Children of retired workers	6,410	46,241	268,168	545,708	642,564	642,445	455,906	191.13
Children of deceased workers	48,238	653,462	1,576,802	2,687,997	2,918,940	2,608,653	1,914,066	320.05
Children of disabled workers	...	...	155,481	888,600	1,410,504	1,358,715	934,375	137.71
Parents	824	14,579	36,114	28,729	21,444	14,796	9,708	366.07
Special age-72 beneficiaries [4]	...	...	...	533,624	223,424	92,754	33,477	134.07

[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 reached age 72 before 1972 and who are only under special insured provisions of the Social Security Act.

program revenue) are automatically deposited in two separate trust funds—the OASI trust fund and the DI trust fund. (The hospital insurance or HI portion of the Medicare program is also financed in this way, as described on page 20.)

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 holding the trust funds and for making periodic reports to Congress.

In addition to the social security taxes paid by employees, employers, and the self-employed, trust fund revenues include relatively small amounts transferred to the social security trust funds from the general fund: The Federal Government's employer social security taxes with respect to those Federal employees who are covered under social security (including payments for military service wage credits); interest on social security trust fund investments; and funds to pay for limited benefits to certain very old persons who qualify under special insured-status requirements. In addition, revenues arising from application of the income tax to up to half of the social security benefits of beneficiaries who have substantial amounts of other income are appropriated to the OASI and DI trust funds.[2]

Legislation enacted in 1981 and 1983 authorized certain borrowing of assets among the trust funds, with interest paid by the borrowing fund to the lending fund. The current borrowing authority, which permits borrowing among the OASI, DI, and HI trust funds under certain conditions, expires at the end of 1987. Repayments are to be made no later than the end of 1989.

Based on 75-year actuarial forecasts, a schedule of current and future tax rates designed to produce sufficient revenues, together with other revenues, to finance the program over the long range is set forth in the law. This schedule also specifies what portion of total revenues collected is to be allocated to each of the social security programs that are financed by payroll taxes. In 1986, tax rates for cash benefits are 5.7 percent each for the employee and employer and 11.4 percent for the self-employed. The Federal Disability Insurance Trust Fund is allocated a portion of these contributions: 0.5 percent each for the employee and employer and 1.0 percent for the self-employed. Current and future scheduled tax rates are shown in table 3. Table 4 summarizes the status of the OASI and DI trust funds during selected years.

Administration

The Secretary of Health and Human Services has the overall responsibility for administering all aspects of the OASDI program except (1) collection of social security contributions, which is performed by the Internal Revenue Service of the Department of the

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

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

Period	Total	OASDI	HI
	Percent of covered earnings for employee and employer each		
1986-87	7.15	5.7	1.45
1988-89	7.51	6.06	1.45
1990 and after	7.65	6.2	1.45
	Percent of covered earnings for the self-employed [2]		
1986-87	14.3	11.4	2.9
1988-89	15.02	12.12	2.9
1990 and after	15.3	12.4	2.9

[1] Tax rates apply to annual earnings up to $42,000 in 1986; this maximum taxable amount is subject to automatic adjustment as earnings levels rise.

[2] For 1986-89, credits (financed from general revenues) are provided to the self-employed against their social security tax liability; the amounts of these credits are equal to 2.0 percent of the annual self-employment income. After 1989, the tax credits will be replaced with special provisions designed to treat the self-employed in much the same manner as employees and employers are treated for social security and income-tax purposes.

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 done by the Secretary of the Treasury as Managing Trustee. The Social Security Administration, a constituent unit of the Department of Health and Human Services, headed by the Commissioner of Social Security, administers the OASDI program.

The law provides for the appointment of an Advisory Council on Social Security every 4 years to review the status of the OASDI and Medicare trust funds and to make recommendations with respect to 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, and also represent 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. Over the years, almost 300 million social security numbers have been issued; about 116 million persons had earnings credited to their records in 1983.

Employers withhold social security taxes from their employees' paychecks and forward these amounts, along with an equal employer tax, to the Internal

Table 4.—Status of the Old-Age and Survivors Insurance and Disability Insurance Trust Funds, by selected years, 1940-84

[In millions]

Year	Total receipts [1]	Expenditures				Total assets, end of year
		Total	Benefit payments	Net administrative expenses	Other expenditures [2]	
	Old-Age and Survivors Insurance Trust Fund					
1940	$368	$62	$35	$26	...	$2,031
1950	2,928	1,022	961	61	...	13,721
1955	6,167	5,079	4,968	119	-$7	21,663
1960	11,382	11,198	10,677	203	318	20,324
1965	16,610	17,501	16,737	328	436	18,235
1970	32,220	29,848	28,796	471	581	32,454
1975	59,605	60,395	58,509	896	991	36,987
1980	105,841	107,678	105,074	1,154	1,450	22,823
1981	125,361	126,695	123,795	1,307	1,593	21,490
1982	125,198	142,119	138,800	1,519	1,799	[3] 22,088
1983	150,584	152,999	149,214	1,534	2,251	[3] 19,672
1984	169,328	161,883	157,841	1,638	2,404	[3] 27,117
	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	3,067	164	28	5,614
1975	8,035	8,790	8,414	256	120	7,354
1980	13,871	15,872	15,437	368	66	3,629
1981	17,078	17,658	17,199	436	21	3,049
1982	22,715	17,992	17,338	590	64	[4] 2,691
1983	20,682	18,177	17,482	664	31	[4] 5,195
1984	[5] 17,309	18,546	17,897	626	23	[4] 3,959

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

[2] Includes expenditures for vocational rehabilitation services to disabled workers, childhood disability beneficiaries, and disabled widows and widowers as well as net transfers to (or from) the railroad retirement program.

[3] Includes $17.5 billion borrowed from the disability and health insurance trust funds under the interfund borrowing provisions of P.L. 97-123.

[4] Excludes $5.1 billion lent to the Old-Age and Survivors Insurance Trust Fund under the interfund borrowing provisions of P.L. 97-123.

[5] Includes $2.8 billion representing income taxes paid on social security benefits under 1983 legislation.

Revenue Service on a regular schedule. Each January, employers file earnings reports with the Social Security Administration listing each employee by name and social security number and showing the wages paid to each employee during the year. SSA in turn shares this information with the Internal Revenue Service. Self-employed persons report their earnings for social security purposes and pay their social security contributions in connection with their income tax. Information from self-employment income reports is sent by the Internal Revenue Service to the Social Security Administration.

Reported earnings are posted to the worker's earnings record in the central office of the Social Security Administration in Baltimore, Maryland. When a worker or his or her family member applies for social security benefits, the worker's earnings record is used to determine the claimant's eligibility for benefits and the amount of any cash benefit payable. (The earnings credited to the worker's record are also used in determining entitlement to hospital insurance benefits.) Payment is certified to the Treasury Department by the Social Security Administration; the Treasury Department then mails out benefit checks or deposits the proper amounts directly in 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. Under the Systems Modernization Plan, begun in 1982, the Social Security Administration's computer systems are being updated and improved and put to new uses. For example, the Claims Modernization Project/Field Office Systems Enhancement now being pilot-tested envisions a claims process in which field office staff will be able to enter information directly into the system, to request any information in agency records needed to process the claim, and to produce a paper copy of the completed application for the claimant to sign.

The Social Security Administration headquarters, located in Baltimore, Maryland, consists of staff offices, a national computer center, disability operations, central records maintenance, and foreign claims operations. SSA also operates data operations centers 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, 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.

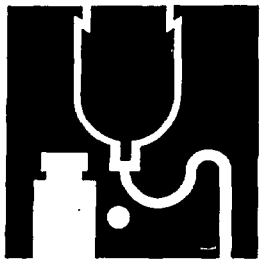
In addition, the Social Security Administration has a nationwide field network of more than 1,300 offices and 34 teleservice centers. Field operations are directed by the 10 Regional Commissioners and their staffs. The field installations are the main points of contact by the public with the Social Security Administration. 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 survivors 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 his or her entitlement to benefits. The appeals process consists of several levels of review. At each level, review must be requested in writing within certain time periods. First, the claimant may request reconsideration of the initial determination on his or her claim. If the claimant is dissatisfied with the reconsideration determination, he or she may request a hearing and appear in person before an administrative law judge from the Social Security Administration's Office of Hearings and Appeals. If the administrative law judge's decision does not satisfy the claimant, he or she may ask for a review by the Appeals Council. And, finally, the claimant may take his or her case to the Federal courts. The Social Security Administration's hearings and appeals process is administered through 135 hearing offices aligned under ten regional chief administrative law judges. The central office of the Office of Hearings and Appeals is located in Arlington, Virginia.

In calendar year 1984, the administrative expenses of the cash benefit program amounted to about 1.3 percent of benefit payments.

For More Information

Because this article is intended as a layman's guide to the social insurance, social assistance, and related protection available in this country, it provides only an overview of program provisions. For more details on individual programs, see "Sources of Information on Social Security Programs in the United States," on pages 60–61 of this issue.



Medicare: Health Insurance for the Aged and Disabled

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

Hospital Insurance Coverage

Individuals who are eligible for social security or railroad retirement benefits are eligible for hospital insurance (HI) when they attain age 65, whether they have claimed cash benefits or not. (If a person aged 65–69 is covered by an employer-sponsored health insurance plan as an employee or spouse, that plan becomes the primary payer and Medicare is secondary payer.) Hospital insurance provides basic protection against the costs of inpatient hospital services and related posthospital extended care. In addition, HI protection (and, optionally, SMI) is provided to disabled individuals (but not to their dependents) who have been entitled to disability insurance benefits or railroad retirement cash disability benefits for at least 24 months. Fully or currently insured workers and their dependents who have end-stage renal disease are also entitled to hospital insurance and can also enroll in the SMI program.

The 1972 amendments provided that persons who reach age 65 without qualifying for HI, under either the regular or a special transitional provision, may voluntarily enroll in the program by paying the full cost of coverage ($174 monthly, effective January 1, 1985; the amount is recalculated annually). States and other public employee groups may purchase hospital insurance protection on a group basis for their employees aged 65 or older at the same cost. Enrollment in the supplementary medical insurance program is required as a condition for "buying into" the HI program.

Approximately 26.9 million persons aged 65 or older and 2.9 million disabled beneficiaries under age 65 were protected by the HI program as of July 1984. HI benefit payments during 1984 amounted to $41.5 billion. HI payments accounted for about 50 percent of the personal health care expenditures for the aged in 1984.

Benefits provided. Under the hospital insurance plan, beneficiaries receive the following services:

- Inpatient hospital services for up to 90 days in each benefit period. A benefit period begins when the individual is admitted to a hospital and ends when the person has not received inpatient hospital or skilled-nursing facility services for 60 days. The patient pays a deductible amount, which is recalculated each year, plus a coinsurance payment equal to 25 percent of the deductible for the 61st through the 90th day of inpatient care. After the 90 days are exhausted, each beneficiary has a lifetime reserve of 60 days (91st day through the 150th day) of hospital care for optional use at a cost of 50 percent of the deductible per day. Covered hospital care includes all those services ordinarily furnished by a hospital to its inpatients: Semiprivate accommodations, operating room, laboratory procedures and X-rays, drugs and biologicals, nursing services (nopayments are made for private duty nursing), therapy services, and services of interns and residents-in-training. Inpatient services in a psychiatric hospital are subject to a lifetime limit of 190 hospital-days of care. Beneficiaries are charged a fee for the first 3 pints of blood furnished and not replaced.
- Certain posthospital, extended-care services are provided. If a patient who has been hospitalized at least 3 days requires a skilled level of nursing care but not hospital care, such services are covered in an institution or section of a hospital that qualifies as a skilled-nursing facility. Payment for up to 100 days of care in each benefit period is covered, but after the first 20 days patients must pay an amount equal to 12 1/2 percent of the hospital deductible per day for each of the remaining days used.
- Home health services—part time or intermittent skilled-nursing care, physical therapy, or speech therapy—also are provided. Unlimited home visits are covered if the beneficiary is homebound and if a physician determines that the individual needs home health care and sets up a home health plan of care. Medicare pays the reasonable cost of all covered home health visits. Durable medical equipment furnished as part of the home health plan is subject to 20-percent coinsurance (that is, the beneficiary must pay the first 20 percent of the cost).
- Hospice care covers terminally ill beneficiaries with a life expectancy of 6 months or less. The services are provided primarily in the beneficiary's home.

No service is covered as posthospital extended-care or posthospital home health services if such service would not be covered when furnished to a patient in a hospital. Special provisions are included for Christian Science sanatoriums and for payment for emergency services provided by nonparticipating hospitals.

Financing and administration. Hospital insurance is financed by a tax on earnings that is separate from that used to finance the social security cash benefits program but which is applied to the same maximum earnings base. (In 1986, annual earnings of up to $42,000 are subject to social security taxes.) This income is channeled into a separate HI trust fund, established on a basis similar to that of the Federal Old-Age, Survivors, and Disability Insurance Trust Funds. All hospital insurance benefits and administrative costs are paid from this trust fund. The HI contribution rate applies equally to employers and employees. It reached its scheduled permanent rate of 1.45 percent in 1986. Self-employed persons pay a rate that is double the employee rate.

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

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 whether hospitals, skilled-nursing facilities, home health agencies, hospices, and other suppliers of medical services meet the conditions for program participation. These standards include the requirements for medical and nursing staff, the physical environment in which care is provided, the maintenance of records, and the overall quality of care being provided. State agencies—usually health departments—apply the standards and also render consultative services to health care providers. Each participating provider must agree to limit beneficiary service charges to the applicable deductibles and coinsurance.

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

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

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

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

Supplementary Medical Insurance Coverage

Medical benefits supplementing those provided under the hospital insurance program are available to aged and disabled persons who are eligible for HI protection and to other categories of aged individuals. Some 29.5 million persons were enrolled in the SMI program as of July 1984. In 1984, the SMI program paid $19.5 billion in benefits.

Enrolled individuals pay a monthly premium of $15.50, which is deducted from their social security benefits, railroad retirement annuity, or Federal civil service retirement annuity. Enrollees who are not yet receiving their benefits are billed quarterly.

The premium rate is adjusted each year. Supplementary medical insurance costs not covered by premiums are financed from the Government's SMI general revenue fund. Aged persons receiving public assistance—cash payments or medical assistance—may be enrolled in the SMI program by their State assistance agency, which pays the premium for the individuals. All but a few States have agreements to "buy in" coverage for their welfare recipients.

Persons may terminate their enrollment in the SMI program at any time by filing a notice with the Social Security Administration. 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 penalty are available to employees or spouses who continue coverage under an employer health insurance plan from age 65 to age 70.) Enrollment may also be terminated for failure to pay the premium.

Benefits provided. The SMI program covers:

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

For most covered services, the beneficiary is liable for a $75 annual deductible and the first 20 percent of costs in addition to that deductible. Among services covered are home health services, ambulatory surgical center services, outpatient clinical laboratory services where the laboratory or physician submits the bill, and pneumococcal vaccine.

There is a special limitation on outpatient treatment by physicians of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year is limited to $250 or 50 percent of allowed charges, whichever is smaller. For services of physical therapists in independent practice, no more than $500 of charges per year can be reimbursed.

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

Payment for physicians' services and other services reimbursed on a charge basis is made in one of two ways. A beneficiary may file a claim for reimbursement based on an itemized bill, whether paid or unpaid, and receive payment for 80 percent of what have been determined to be reasonable charges above the deductible. In this case, the beneficiary is responsible for the total bill. Alternatively, the physician or supplier may accept an assignment and submit a claim directly for payment, agreeing to accept the carrier's determination for reasonable charges as the full fee for the services involved. The patient then pays no more than the deductible and 20 percent of the balance of the reasonable charge.

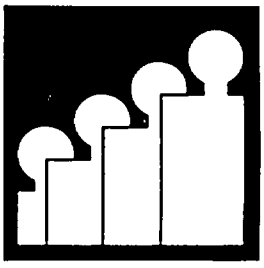
Physicians and suppliers may also voluntarily "participate" in Medicare and always accept assignment instead of making the decision each time a service is provided. A beneficiary who uses a participating physician or supplier is assured that he or she will not be responsible for more than the coinsurance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

The Medicare reasonable charge is the lowest of (1) the customary charge (generally the charge most frequently made) by each physician and supplier for each separate service or supply furnished to patients in the previous calendar year, (2) the prevailing charge (the amount that is high enough to cover the customary charges in 3 out of 4 bills submitted in the previous year for each service and supply) for each covered service and supply, or (3) the actual charge. Increases in prevailing charges for physicians' services are ordinarily limited from year to year by an economic index formula that relates physicians' fee increases to the actual increases in the cost of maintaining a practice and to rises in general earnings levels. From July 1984 through September 1985, charges were frozen at the level in effect during the 12 months that ended June 1984.

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

Financing and administration. Responsibility for administration of the SMI program, like the HI program, was transferred from the Social Security

Administration to the Health Care Financing Administration 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 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; and granting hearings to individuals with contested claims. Some institutional providers of services, such as home health agencies, hospital outpatient departments, and comprehensive outpatient rehabilitation centers, are served by HI intermediaries.



Unemployment Insurance*

Unemployment insurance programs are designed to provide benefits to regularly employed members of the labor force who become involuntarily unemployed and who are able and willing to accept suitable employment.

The first unemployment insurance law in the United States was established by Wisconsin in 1932 and 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.

By means of a tax offset, the Social Security Act provided an inducement to the States to enact unemployment insurance laws. A uniform national tax was imposed on the payrolls of industrial and commercial employers who in 20 or more weeks in a calendar year had eight or more workers. Employers who paid a tax to a State with an approved unemployment insurance law could credit (offset) up to 90 percent of the State tax against the national tax. Thus, employers in States without an unemployment insurance law would not have an advantage in competing with similar businesses in States with such a law because they would still be subject to the Federal payroll tax. Furthermore, their employees would not be eligible for benefits.

In addition, the Social Security Act authorized grants to States to meet the costs of administering the State systems. By July 1937, all 48 States, the then territories of Alaska and Hawaii, and the District of Columbia had passed unemployment insurance laws. Puerto Rico later adopted its own unemployment insurance program, which was incorporated into the Federal-State system in 1961. In a similar fashion, the program for workers in the Virgin Islands was added in 1978.

Federal law requires State unemployment insurance programs to meet certain requirements if employers are to get 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 the State laws be deposited in the unemployment trust fund in the U.S. Treasury. The fund is invested as a whole, but each State has a separate account to which its deposits and its share of interest on investments are credited. A State may withdraw money from its account in the trust fund at any time, but only to pay benefits.[3] Thus, unlike the situation in the majority of States having workers' compensation and temporary disability insurance laws, unemployment insurance benefits are paid exclusively through a public fund. No private plans can be substituted for the State plan.

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

*Statutory provisions as of September 2, 1984.

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

Coverage

About 93 million workers—or 97 percent of all wage and salary workers—were in jobs covered by unemployment insurance at the end of 1984. Coverage originally 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. Two Federal laws passed during the 1970's—the Employment Security Amendments of 1970 and the Unemployment Compensation Amendments of 1976—added substantially to the number and types of workers protected under the State programs.

Private employers in industry and commerce are subject to the law if they have one or more individuals employed at least 20 weeks during the current or preceding year or if they paid wages of $1,500 or more during any calendar quarter in the current or preceding year. Agricultural workers are covered on farms with a quarterly payroll of at least $20,000 with 10 or more employees in 20 weeks of the year. Domestic employees in private households are subject to FUTA if their employer pays wages of $1,000 or more in a calendar quarter. Excluded from coverage are workers employed by their families and the self-employed.

State and local government employees and employees of most nonprofit organizations are also exempt from FUTA. But as a result of the Federal legislation enacted in 1976, most employees in these groups now are required to be covered by State law as a condition for securing Federal approval of the State law. Under this form of coverage, local government and nonprofit employers have the option of making contributions as under FUTA, or of reimbursing the State for benefit expenditures actually made. Elected officials, legislators, members of the judiciary, and the State National Guard are still excluded, as are employees of nonprofit organizations that employ fewer than four workers in 20 weeks in the current or preceding calendar year.

Many States have extended coverage beyond that provided by Federal legislation. For example, 20 States have covered nonprofit organizations employing one or more workers (rather than four or more).

Federal civilian employees and ex-servicemen have been brought under the unemployment insurance system through special Federal legislation. The 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. However, Federal law prescribes certain eligibility requirements and a 13-week maximum duration for ex-servicemen's benefits. Railroad workers are covered by a separate unemployment insurance law enacted by Congress. This law is described in connection with the other benefit programs for persons employed in the railroad industry (see page 49).

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.[4] To be eligible for benefits, the workers must be ready, able, and willing to work and must be registered for work at a State public employment office. Workers who meet these eligibility conditions may still be denied benefits if they are found to be responsible for their own unemployment.

Work requirements. A worker's monetary benefit rights are based on his or her employment in covered work over a prior reference period, called the "base period," and these benefit rights remain fixed for a "benefit year." In most States, the base period is the first four quarters of the last five completed calendar quarters preceding the claim for unemployment benefits. As of September 1984, the base period used in nine States is 52 weeks closely preceding the claim. In one State, a uniform calendar-year base period established by law is used for all workers.

Seven States specify a flat minimum amount of earnings ranging from $600 to $2,047 in the base period to qualify. Thirteen States and Puerto Rico express their earnings requirements in terms of a multiple by which the individual will qualify (such as 30 times the weekly benefit amount). Most of these 21 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 other than the calendar quarter in which the claimant had the most wages. Eighteen States and the District of Columbia simply require base period wages totaling a specified multiple—commonly 1 1/2—of the claimant's high-quarter wages. Thirteen 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 there-

[4] Although the benefits are not means tested, they may be subject to Federal income taxes. Under the Revenue Act of 1978, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (P. L. 97-248), a taxpayer must include in gross income for Federal income tax purposes the lesser of the amount of unemployment benefits paid or half the excess of adjusted gross income plus unemployment benefits plus excludable disability income over $12,000 (for single taxpayers) or $18,000 (for married taxpayers filing jointly).

fore 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. In no State can a claimant who received benefits in one benefit year qualify for benefits in a second benefit year unless he or she has had intervening employment.

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

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. In addition, most States have special disqualification provisions that specifically restrict the benefit rights of students who are considered not available for work while attending school, and of individuals who quit their jobs for family reasons. Federal law also restricts 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 or 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, but, in nine States, all workers who are unemployed because of a labor dispute are subject to disqualification.

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

In 17 States, a worker also is disqualified for any benefits for a week in which he or she receives certain other forms of remuneration, such as wages in lieu of notice or dismissal payments, workers' compensation for temporary partial disability, back pay, or holiday pay. In 23 other States, such remuneration serves to reduce the weekly benefit; the claimant may receive as a benefit only the amount by which the benefit exceeds the other payment. All States but two and Puerto Rico permit simultaneous payment of unemployment benefits and supplemental unemployment benefits under collective-bargaining agreements.

Types and Amounts of Benefits

In 1984, an average of 2.1 million unemployed workers were receiving benefits each week under the State unemployment insurance programs. Their average weekly benefit was $123 and the average duration of benefits (regular program) throughout 1984 was 14.5 weeks.

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.

Thirty-seven laws use a formula that computes weekly benefits as a fraction of wages in one or more quarters of the base period. Most commonly, the fraction is taken of wages in the quarter during which wages were highest, as this quarter most nearly reflects full-time work. In 28 of these States and the District of Columbia, the same fraction is used at all benefit levels. The other laws use a weighted schedule, which gives a greater proportion of the high-quarter wages to lower-paid workers than to those earning more; in these areas, the minimum fraction varies

from 1/23 to 1/33 and the maximum from 1/17 (1/11 in Puerto Rico) to 1/24.

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

Each State establishes a ceiling on the weekly benefit amount and no worker may receive an amount larger than this ceiling. The maximum may be either a fixed dollar amount or a flexible amount. Under the latter arrangement, which has been adopted in 36 jurisdictions, the maximum is adjusted automatically in accordance with the weekly wages of covered employees. The maximum in these jurisdictions is expressed as a percentage of the statewide average weekly wage—from 48 percent to 70 percent. Such provisions remove the need for constantly amending the flat maximum statutory dollar amount as wage levels change.

The maximum weekly benefit for all States varies from $84 to $225 (excluding allowances for dependents provided by 14 jurisdictions); the median basic weekly maximum in September 1984 was $168. Because statutory increases in the maximum tend to lag behind the increase in wage levels, the maximums in States with fixed amounts often operate to curtail the benefit amounts of workers to below the 50-percent level. Minimum limits on benefits—usually ranging from $5 to $60 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

Table 5.—Selected benefit provisions under State unemployment insurance laws, September 1, 1984

State	Weekly benefit amount for total unemployment			Duration of benefits (weeks) [3]	
	Computation (fraction of high-quarter wages unless otherwise indicated) [1]	Minimum [2]	Maximum [2]	Minimum [4]	Maximum
Alabama	1/24	$22	$120	11+	26
Alaska	3.4-0.95% of annual wages, plus dependents' allowance	38-62	188-260	[3] 16	[3] 26
Arizona	1/25	40	115	12+	26
Arkansas	1/52 of two highest quarters, up to 66 2/3% of State average weekly wage	40	154	12	26
California	1/24-1/33	30	166	[3] 12+	[3] 26
Colorado	60% of 1/26 of claimant's two highest quarters up to 60% of State average weekly wage	25	206	7+-13	26
Connecticut	1/26 up to 60% of State average weekly wage plus dependents' allowance	15-22	168-252	[3] 26	[3] 26
Delaware	1/78 of three highest quarters, up to 63% of State average weekly wage	20	165	18	26
District of Columbia	1/23 plus dependents' allowance	26	[1] 206	17	26
Florida	1/2 of claimant's average weekly wage	10	150	10	26
Georgia	1/25	27	125	4	26
Hawaii	1/25 up to 66 2/3% of State average weekly wage	5	188	[3] 26	[3] 26
Idaho	1/26 up to 60% of State average weekly wage	45	173	10	26
Illinois	48% of claimant's average weekly wage up to 48% of State average weekly wage plus dependents' allowance	50	161-209	26	26
Indiana	4.3% plus dependents' allowance	40	84-141	9+	26
Iowa	1/19-1/23 up to 53% of State average weekly wage plus dependents' allowance	22-27	143-176	11+	26
Kansas	4.25% up to 60% of State average weekly wage [5]	40	163	10	26
Kentucky	1.185% of base period wages up to 55% of State average weekly wage	43	175	15	26
Louisiana	1/20-1/25 up to 66 2/3% of State average weekly wage [5]	10	205	12	26
Maine	1/22 up to 52% of State average weekly wage, plus dependents' allowance	22-27	133-208	7+-22	26
Maryland	1/24 plus dependents' allowance	25-28	[1] 175	26	26
Massachusetts	1/21-1/26 up to 57.5% of State average weekly wage, plus dependents' allowance	14-21	185-278	9+-30	30
Michigan	65% of claimant's weekly wage after tax earnings plus dependents' allowance [5]	54	197	15	26
Minnesota	[6]	52	198	11	26
Mississippi	1/26	30	115	13+	26
Missouri	4.5%	14	105	10	26
Montana	1/2 of claimant's average weekly wage up to 60% of State average weekly wage	42	171	8	26
Nebraska	1/17-1/24	12	120	17	26
Nevada	1/25 up to 50% of State average weekly wage	16	162	12	26
New Hampshire	1.8-1.2% of annual wages	26	141	26	26
New Jersey	60% of claimant's average weekly wage up to 56 2/3% of State average weekly wage plus dependents' allowance	20	[1] 193	15	26
New Mexico	1/26 up to 50% of State average weekly wage	29	145	19+	26
New York	67-50% of claimant's average weekly wage	40	180	26	26
North Carolina	1/52 of two highest quarters, up to 66 2/3% of State average weekly wage	15	166	13-26	26
North Dakota	1/52 of two highest quarters, up to 65% of State average weekly wage	60	185	12	26
Ohio	1/2 claimant's average weekly wage, plus dependents' allowance [5]	10	147-233	20	26
Oklahoma	1/25 up to 50-60% of State annual weekly wage [7]	16	197	[8] 20+	[8] 26
Oregon	1.25% of base-period wage up to 64% of State average weekly wage	47	204	7+	26
Pennsylvania	1/23-1/25 up to 66 2/3% of State average weekly wage, plus dependents' allowance	35-40	214-222	16	26

See footnotes at end of table.

Table 5.—Selected benefit provisions under State unemployment insurance laws, September 1, 1984—Continued

State	Weekly benefit amount for total unemployment			Duration of benefits (weeks) [3]	
	Computation (fraction of high-quarter wages unless otherwise indicated) [1]	Minimum [2]	Maximum [2]	Minimum [4]	Maximum
Puerto Rico	1/11-1/26 up to 50% of State average weekly wage	7	95	[3] 20	[3] 20
Rhode Island	55% of claimant's average weekly wage up to 60% of State average weekly wage, plus dependents' allowance	37-42	174-194	12	26
South Carolina	1/26 up to 66 2/3% of State average weekly wage	21	125	14	26
South Dakota	1/26 up to 62% of State average weekly wage [5]	28	129	18+	26
Tennessee	1/25-1/31 of average of two highest quarters	30	115	12	26
Texas	1/25 [9]	27	182	14+	26
Utah	1/26 up to 60% of State average weekly wage [5]	46	186	10	26
Vermont	1/2 of claimant's average weekly wage for highest 20 weeks up to 60% of State average weekly wage [5]	18	146	26	26
Virginia	1/25	54	150	12	26
Virgin Islands	1/23-1/25 up to 50% of State average weekly wage	15	130	26	26
Washington	1/25 of average of two highest quarters' wages up to 55% of State average weekly wage	51	185	16+-30	30
West Virginia	1.5-1.0% of annual wage up to 70% of State average weekly wage	18	225	28	28
Wisconsin	50% of claimant's average weekly wage up to 66 2/3% of State average weekly wage [5]	37	196	1-14+	26
Wyoming	1/25 up to 55% of State average weekly wage	34	183	12-26	26

[1] When States use a weighted high-quarter, annual wage, or average weekly wage formula, approximate fractions or percentages are figured at midpoint of lowest and highest normal wage brackets. When dependents' allowances are provided, the fraction applies to the basic benefit amount. In some States, variable amounts above maximum basic benefits are limited to claimants with specified number of dependents and earnings in excess of amounts applicable to maximum basic benefit. In the District of Columbia, Maryland, and New Jersey the maximum is the same with or without dependents' allowance.

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

[3] Benefits extended under State program when unemployment in State reaches specified levels: Alaska, California, by 50 percent; Connecticut, Hawaii, by 13 weeks. In Puerto Rico, benefits extended by 32 weeks in certain industries, occupations, or establishments when special unemployment situations exist. Benefits also may be extended during periods of high unemployment by 50 percent for up to 13 weeks under Federal-State extended unemployment compensation program.

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

[5] The minimum and maximum weekly benefit amounts are frozen indefinitely in Louisiana, South Dakota, and Wisconsin. The maximum weekly benefit amount is frozen until January 1986 in Ohio, and until June 1986 in Vermont.

[6] Sixty percent of first $85, 40 percent of next $85, 50 percent of balance of claimant's average weekly wage, up to 66 2/3 of State average wage.

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

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

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

Source: **Comparison of State Unemployment Insurance Laws**, Department of Labor, Washington, D.C., September 2, 1984.

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 age 16, 18, or 19 (and, generally, older if incapacitated), 10 include a nonworking spouse, and three consider other dependent relatives. The amount allowed per dependent varies considerably by State but generally is $10 or less per week, and, in the majority of States, the amount is the same for each dependent.

All laws have a limit on the total amount of dependents' allowances payable in any week. In four jurisdictions, the maximum weekly benefit is either the same with or without dependents or the dependents' allowances are payable only to those claimants with more than enough base period wages to get the basic maximum weekly benefit amount.

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

All but four jurisdictions provide a statutory maximum duration of 26 weeks of benefits in a benefit year. However, only 10 jurisdictions provide the same maximum for all claimants. The remaining 43 jurisdictions vary the duration of benefits through various formulas that relate potential duration to the amount of former earnings or employment—generally by limiting total benefits to a certain fraction of base period earnings or to a specified multiple of the weekly benefit amount, whichever is less. The minimum in the 43 jurisdictions ranges from as little as 1 week to as many as 20 weeks. Four States and Puerto Rico have their own State-financed programs for payment of extended benefits whenever unemployment reaches a specified level.

In 1970, a permanent Federal-State program of extended benefits was established for workers who exhaust their entitlement to regular State benefits during periods of high unemployment. The program is financed equally from Federal and State funds. Employment conditions in an individual State trigger extended benefits. This happens when the unemploy-

ment rate among insured workers in a State averages 5 percent or more over a 13-week period, and is at least 20 percent higher than the rate for the same period in the 2 preceding years. If the insured unemployment rate reaches 6 percent, a State may by law disregard the 20-percent requirement in initiating extended benefits. Once triggered, extended benefit provisions remain in effect for at least 13 weeks. When a State benefit period ends, extended benefits to individual workers also end, even if they have received less than their potential entitlement and are still unemployed. Further, once a State benefit period ends, another statewide period cannot begin for at least 13 weeks.

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

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

Financing

All employers who are covered by the Federal Unemployment Tax Act are charged a tax of 6.2 percent on the first $7,000 annually of each worker's covered wages, effective January 1985. However, employers do not pay the full amount because they may credit toward the Federal tax the payroll tax contributions that they pay toward a State unemployment insurance program established by an approved law. The credit may also include any savings on the State tax achieved under an approved experience-rating plan, as described below. On the other hand, the credit available to employers in a State may be reduced if the State has fallen behind on repayment of loans to the Federal Government. Many States obtained such loans when their reserves for paying benefits were depleted during periods of high unemployment. In October 1984, 21 States owed a total of $9.78 billion to the Federal Government.

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

All States finance unemployment benefits almost completely through employer contributions. There is no Federal tax on employees, and only three States collect employee contributions. In 1984, 30 jurisdictions had adopted tax bases higher than the $7,000 Federal base.

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

The provisions of experience rating systems vary widely among the States. In 42 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 1983, the estimated national average employer contribution rate actually paid was 2.8 percent of taxable payroll, or 1.4 percent of total wages in covered work. The average contribution rate varied widely by State, however. The percent of taxable payroll ranged from 0.8 to 4.8; that of total wages from 0.4 to 3.0. Nonprofit organizations and State and local governments have the option of reimbursing the State fund for unemployment insurance benefits attributable to service for them or of paying the regular State unemployment taxes on the same basis as other employers.

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

Administration

There are no Federal regulations concerning the form of the organization administering unemployment insurance or its place in the State government. Thirty 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. In all but four jurisdictions, advisory councils have been established; 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 more than 2,000 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, so that they 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.

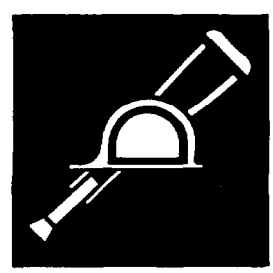
The Federal functions of the unemployment insurance program are chiefly the responsibility of the Employment and Training Administration's Unemployment Insurance Service in the U.S. Department of Labor. The Internal Revenue Service in the Treasury Department collects FUTA taxes, and the Treasury Department 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.

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

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

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

According to the 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, 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, was the first form of social insurance to develop widely in the United States. The Federal Government led the way with an act covering its civilian employees, passed in 1908 and re-enacted in 1916. Similar laws were enacted by 10 States in 1911; by 1920, all but six States had such laws. Today, 55 workers' compensation programs are in operation. Each of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands has its own workers' compensation program. In addition, two Federal workers' compensation programs cover Federal Government employees and longshoremen and

*Statutory provisions as of January 1, 1985.

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.

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 had the benefit of three common law defenses. These enabled the employer to block recovery if the employer could prove that the injury resulted from the normal risk of the work, that the negligence of a fellow worker was responsible, or that the injured worker was partly responsible. The enactment of workers' compensation laws introduced the principle 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 became limited because workers' compensation benefits became the exclusive remedy for work-related injuries.

Coverage

In 1983, State and Federal workers' compensation laws covered about 79 million employees, or 87 percent of the Nation's employed wage-and-salary labor force. No State's laws cover all jobs, except in New Hampshire. Among the most usual exemptions are domestic service, agricultural employment, and casual labor. However, 37 programs now have some coverage for agricultural workers and 25 programs have some coverage for domestic workers. Many laws also exempt employees of nonprofit, charitable, or religious institutions. Some States limit coverage to workers in hazardous occupations, variously defined.

In 14 States, employers having fewer than a specified number of employees are exempt from coverage (fewer than three employees in eight States, fewer than four in three States, and fewer than five in three States).

In addition, the coverage of State and local public employees differs widely from one State to another. Some laws provide broad coverage, specifying no exclusions or excluding only such groups as elective or appointed officials. Other laws limit coverage to employees of specified political subdivisions or to employees engaged in hazardous occupations. In a few States, coverage of government employees is entirely optional with the State, city, or other political subdivision.

Two other major groups outside the coverage of workers' compensation laws are railroad employees engaged in interstate commerce and seamen in the U.S. merchant marine. These workers are covered by Federal statutory provisions for employer liability that give the employee the right to maintain an action in negligence against the employer. The employer is barred from pleading the common law defense of fellow servant, contributory negligence, or assumption of risk.

The laws are compulsory for most of the private employment covered, requiring every employer within the scope of the law to comply with the provisions and pay the compensation specified, except in New Jersey, South Carolina, and Texas. In these three States, the laws 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 laws also vary regarding the methods used to assure that compensation will be paid when it is due. No State uses the general taxing power to finance workers' compensation. Employers in most jurisdictions are permitted to use commercial insurance companies to insure their liability against work accidents or to qualify as self-insurers by giving proof of financial ability to carry their own risk. In eight jurisdictions, however, commercial insurance is not allowed. In four of these areas, employers must insure with an exclusive State insurance fund, and in four others, they must either insure with an exclusive State insurance fund or self-insure. In 13 States a State fund is "competitive" with private insurance carriers. Federal employees are provided protection through a federally financed and operated system. Table 6 shows total workers' compensation benefits paid, including Federal black lung payments, by type of insurer for selected years. Also shown are the amounts for medical care and cash benefits, and benefits and employer costs related to covered payroll.

Eligibility for Benefits

The usual condition for entitlement to benefits is that the injury or death "arises out of and in the course of employment." Most programs exclude injuries due to the employee's intoxication, willful misconduct, or gross negligence.

Although at first virtually limited to injuries or diseases traceable to industrial "accidents," the scope of the laws 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

Table 6.—Benefits and costs under State and Federal workers' compensation programs, selected years, 1940-83 [1]

Year	Benefits paid during year (in millions)				Type of benefit		Percent of covered payroll [5]	
		Type of insurance						
	Total	Insurance losses paid by carriers [2]	State fund disbursements [3]	Employers' self-insurance payments [4]	Medical and hospital	Cash compensation	Cost of workers' compensation [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
1981.....	15,016	7,868	4,614	2,534	4,420	10,596	1.84	1.08
1982.....	16,263	8,647	4,738	2,879	4,860	11,403	1.73	1.15
1983.....	17,533	9,264	5,038	3,232	5,350	12,183	1.67	1.18

[1] Data include Alaska and Hawaii beginning with 1959.

[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 programs for Government employees, and, beginning in 1970, by the Federal black lung 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 revenue—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 by 5 percent to 10 percent to allow for administrative costs. Also includes benefits paid and administrative costs of Federal system for Federal employees.

State laws pay benefits only if the disability or death starts within a relatively short period after the last exposure to the disease (such as 1 year to 3 years) or if the claim is filed within a similar time after manifestation of the disease or after disability begins. Also, some States 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 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 laws. The supervisory authorities usually exercise control over such settlements to protect the best interest of the claimant. However, a lump-sum settlement may, in some cases, provide inadequate protection to disabled workers, especially where lump-sum agreements prevent payment of benefits in the future 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 employees 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 dependent children, especially in case of death.

All the laws, however, place dollar maximums on the weekly amounts payable to a disabled worker or to survivors, so that some beneficiaries (generally higher-paid workers) do not receive the amount indicated by these percentages. Particularly in a period of rising wages, the lag in enacting statutory increases in the weekly benefit ceiling may result in an injured worker receiving a benefit equal to less than a stated percentage of his or her wage. To avoid the periodic necessity for legislation to increase the maximum weekly benefit level, 45 jurisdictions have adopted flexible provisions for setting the limitation, based on automatic adjustments in relation to the average weekly wage of the jurisdiction.

Other provisions in workers' compensation laws, such as limits on the number of weeks for which compensation may be paid or on the aggregate amount that may be paid in a given case, as well as waiting period requirements, also operate to reduce the wage-replacement ratio specified in the laws.

Before paying benefits, all the laws require a waiting period ranging from 2 days to 7 days, with a 7-day waiting period being most common. However, workers whose disabilities last beyond a specified time—ranging from 3 days to 6 weeks—are paid

retroactively for the waiting period.

Temporary and permanent total disability. The great majority of compensation cases involve total disability for a temporary period, after which the employee will have recovered and be able to return to work. When the worker has been determined to be permanently and totally disabled for any type of gainful employment, permanent total disability benefits are payable. Both temporary and permanent total disability are usually compensated at the same rate. Table 7 shows the maximum percentage of wages used in computing temporary total disability benefits and the maximum period for which benefits are payable. It shows also the minimum and maximum payments per week, as well as the total maximum amounts when these are expressly stated in laws. For temporary disability, maximum weekly benefits (excluding dependents' allowances) range from $126 to $1,114 ($45 in Puerto Rico). The median State maximum in January 1985 was $292.

Most State laws pay temporary disability benefits for as long as the disability lasts and the condition has not been stablized to the point where no further improvement can result from medical treatment. But 17 States 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 laws provide for the payment of weekly benefits for life or the entire period of disability. A few other programs reduce the weekly benefit amount after a specified period, or they provide discretionary payments after a specified time. In the 11 States where permanent total disability benefits are limited as to duration, amount, or both, the periods range from 257 weeks to 600 weeks. Some laws provide additional payments for an attendant if one is required.

Injured persons who are compensated for temporary and/or permanent total disability receive additional benefits for dependents in nine States and under the Federal employee program. 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 will receive. In a few States, however, the additional allowances are limited by the fact that the same weekly maximum or the same aggregate maximum is payable whether or not there are dependents. In some States, the payments are higher for married persons than for single persons, and, in other States, the term dependents is defined to include spouses 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 the ensuing suffering and handicap and in part to recompense for the possibility of further reduction in earning capacity. The typical law recognizes two types of permanent partial disabilities: Specific or "schedule" injuries (for such clearly measurable matters as the loss of a part of the body) and general or "nonschedule" injuries (such as those caused by injury to the head, back, or nervous system).

Compensation for schedule injuries is generally at the same rate as for total disability, but it is subject to different (generally lower) dollar maximums in 21 jurisdictions. 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. In 41 laws, there are limitations on the maximum amounts and/or periods payable, ranging from 200 weeks to 1,000 weeks, and $10,000 to $75,000.

In the majority of laws, the compensation payable for permanent partial disability is in addition to that payable during the healing period or while the worker is temporarily disabled. In most laws, additional amounts are allowed for disfigurement. In some States, no benefits are payable for permanent partial disability due to occupational disease, or 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 of the laws provide weekly or monthly death payments for the duration of the spouse's unremarried lifetime (regardless of the spouse's age at the death of the worker) and, in all but two States, to children until age 16, 18, or later if the children are incapacitated. In nine States, however, the maximum amounts payable are limited, ranging from $45,000 to $250,000 ($16,500 in the Virgin Islands). Under the other 16 laws, payments are limited to a specific period, ranging from 231 weeks to 600 weeks (sometimes reduced by benefits paid to the deceased worker before his or her death).

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 in addition to periodic payments to survivors, subject to a specified maximum amount that ranges from $300 to $3,200. The maximum payment at the median is $1,800. Except for Oklahoma, States pay these amounts

Table 7.—Minimum and maximum benefits for temporary total disability under workers' compensation laws, January 1, 1985

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	$73 or worker's average weekly wage, if less.[2]	$194	66 2/3	300 weeks
Alaska	80% of spendable earnings	$110 or worker's spendable weekly wage, if less.	$1,114	200	...
Arizona	66 2/3	...	[3] $203.86	...	...
Arkansas	66 2/3	$15	$154	...	450 weeks or $69,300
California	66 2/3	$112	$224	...	...
Colorado	66 2/3	...	$315.98	80	...
Connecticut	66 2/3	$76.20 or 80% of worker's average, if less.[2]	[3] $381	100	...
Delaware	66 2/3	$77.22 or actual wage, if less.[2]	$231.64	66 2/3	...
District of Columbia	The lesser of 66 2/3 or 80% of spendable earnings	$103.31	$413.26	100	...
Florida	66 2/3	$20 or actual wage, if less.	$307	100	350 weeks
Georgia	66 2/3	$25 or actual wage, if less.	$135	...	...
Hawaii	66 2/3	$72.25 or worker's average wage, if less, but not lower than $38.[2]	$291	100	...
Idaho	[4] 60-90	[2] $130.05	$260 to $361.23[4]	90	After 52 weeks maximum weekly benefit is 60% of State average weekly wage.
Illinois	66 2/3	$100.90 to $124.30 or worker's average wage, if less.[4]	$491.65	133 1/3	...
Indiana	66 2/3	$50 or worker's average wage, if less.	$166	...	500 weeks or $83,000
Iowa	80% of worker's spendable earnings.	$101 or actual wage, if less.[2]	$580	200	...
Kansas	66 2/3	$25	$227	75	$75,000
Kentucky	66 2/3	[2] $60.96	$304.80	100	...
Louisiana	66 2/3	$66 or actual wage, if less.[2]	$248	75	...
Maine	66 2/3	$25	$447.92	166 2/3	...
Maryland	66 2/3	$50 or actual wage, if less.	$327	100	...
Massachusetts	66 2/3	$40 or worker's average wage, if less, but not less than $20 if normal working hours amount to 15 or more.	[3] $341.06	100	250 multiplied by State average weekly wage.
Michigan	80% of worker's spendable earnings	...	$358	90	...
Minnesota	66 2/3	$164.50 or actual wage, if less, but not less than $65.80.[2]	$329	100	...
Mississippi	66 2/3	$25	$126	...	450 weeks or $56,700
Missouri	66 2/3	$40	$222.73	70	400 weeks
Montana	66 2/3	...	$286	100	...
Nebraska	66 2/3	$49 or actual wage, if less.	$200	...	...
Nevada	66 2/3	...	$325.99	100	...
New Hampshire	66 2/3	$118 or actual wage, if less.[2]	$444	150	...
New Jersey	70	[2] 72	$269	75	400 weeks
New Mexico	66 2/3	$36 or actual wage, if less.	$298.63	100	600 weeks
New York	66 2/3	$30 or actual wage, if less.	$275	...	...

See footnotes at end of table.

Table 7.—Minimum and maximum benefits for temporary total disability under workers' compensation laws, January 1, 1985—Continued

State	Maximum percentage of wages	Payments per week		Percentage of State average weekly wage	Maximum duration of benefit [1]
		Minimum	Maximum		
North Carolina	66 2/3	$30	$280	100	...
North Dakota	66 2/3	$171 or employee's actual wage, if less.[2]	[3] $285	100	...
Ohio	72% for first 12 weeks; thereafter, 66 2/3	$118 or actual wage, if less.[2]	$354	100	...
Oklahoma	66 2/3	$30 or actual wage, if less.	$217	66 2/3	300 weeks
Oregon	66 2/3	$50 or 90% of actual wage, if less.	$324.13	100	...
Pennsylvania	66 2/3	[2] $112	$336	100	...
Puerto Rico	66 2/3	$10	$45	...	312 weeks
Rhode Island	66 2/3	...	[3] $292	100	...
South Carolina	66 2/3	$25	$287.02	100	500 weeks
South Dakota	66 2/3	$124 or worker's average wage, if less.[2]	$247	100	...
Tennessee	66 2/3	$15	$136	...	$54,400
Texas	66 2/3	[2] $35	$203	[5]	401 weeks
Utah	66 2/3	$45	[3] $310	100	312 weeks
Vermont	66 2/3	$139 or worker's average wage, if less.[2]	[3] $278	100	...
Virginia	66 2/3	$73.75 or employee's actual wage, if less.[2]	$295	100	500 weeks
Virgin Islands	66 2/3	$60 or employee's actual wage, if less.	$183	66 2/3	...
Washington	[4] 60–75	$42.69 to $81.23 [4]	$256.31	75% of State's monthly wage	...
West Virginia	70	[2] $107.10	$321.30	100	208 weeks
Wisconsin	66 2/3	$20	$321	100	...
Wyoming	66 2/3	$43.39	$347.71	100% of monthly wage	...
United States: Federal employees	[4] 66 2/3–75	$151.46 or actual wage, if less.[6]	$979.90	[6]	...
Longshore	66 2/3	$144.92 or worker's actual wage, if less.[2]	$579.66	200% of national average weekly wage	...

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

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

[3] Plus dependents' allowance. Arizona, $10 monthly for one or more dependents. Connecticut, $10 weekly per dependent child, not to exceed 50 percent of basic benefit or 75 percent of worker's wage. Massachusetts, $6 per dependent if weekly benefits are below $150 and 100 percent of wage. North Dakota, $5 per dependent child not to exceed worker's net wage. Rhode Island, $9 per dependent, not to exceed 80 percent of worker's wage. Utah, $5 for dependent spouse and per child up to 4, not to exceed State average wage. Vermont, $10 per dependent under age 21.

[4] According to number of dependents (and in Washington, marital status). Idaho, 7 percent ($20.23) of State average weekly wage for each dependent child up to 5.

[5] Maximum increased by 70 percent of increase in average weekly wage for manufacturing.

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

regardless of the availability of monthly survivor benefits. In a few States, a separate payment in addition to the funeral benefit is provided to cover the cost of the worker's final illness.

Medical benefits. All compensation acts require that medical aid be furnished to injured workers without delay, whether or not the injury entails work interruption. The care provided includes first-aid treatment, physician services, surgical and hospital services as needed, nursing, and all necessary medical drugs and supplies, appliances, and prosthetic devices.

Medical aid is also furnished without limit as to time or amount for accidental injuries (except that the Virgin Islands limits medical care to $16,000). A few laws pay only limited medical benefits in cases of occupational disease, dental care, or prostheses and appliances.

In more than half the jurisdictions, the employee has the right to make the original choice of physician. In some States the physician is chosen by the employee from a list prepared by the State agency or by the employer. The remaining acts give the

employer 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 stated period.

In practice, the employer's right to designate the physician may be passed on 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 most of the medical aid is provided by physicians in private practice on a fee-for-service basis, the acts 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 80 percent of a worker's former earnings. 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, 15 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.

In several States, 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, on the principle that the cost of work-related accidents is part of the expense of production. A few State laws contain provisions for nominal contributions by the covered employee for hospital and medical benefits.

The cost to an individual employer of protecting workers varies with the risk involved and is influenced primarily by such factors as the employer's industrial classification and the hazards of that industry, sometimes modified by experience rating. In industries characterized primarily by clerical operations, premium or "manual" rates may be less than 0.1 percent of payroll; in very hazardous occupations the rates may be as high as 20 percent or more. The premium rate an employer pays, 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 1982 the costs to employers of obtaining insurance or of self-insuring the risk of employment injury amounted to 1.7 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 1982, the jurisdictions were about evenly divided in the method used to defray administrative costs.

Administration

State workers' compensation laws in 26 jurisdictions are administered in the State's labor department or other agencies that administer general labor laws. In another 24 areas, the law is administered by an independent workers' compensation agency. Court administration exists in the other five States (with some limited administrative activities performed by an administrative unit). The Federal provisions are administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, except for part of the black lung program administered by the Social Security Administration, as discussed subsequently.

Generally, State administrative agencies are

expected to exercise supervisory, adjudicative, and enforcement powers so as to ensure prompt and continued payment of obligations and to secure compliance with the laws. 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 jurisdictions 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 there is a compensable claim. A claim for compensation must be filed with the administering agency for due notice to the employer or insurer. The deadline is commonly not longer than 1 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 laws, the employer or the carrier, on notification 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 what a worker should get. If the worker fails to receive this amount, the administrative agency can step in, investigate the matter, and correct any error. However, not many States have actively enforced these provisions because of lack of resources or for other reasons.

In some States, uncontested cases are settled by agreement between the employing firm and 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. In the five States where the act is administered through court procedure rather than a special agency, contested cases are adjudicated in the first instance by the courts.

Rehabilitation

All of the workers' compensation programs provide for physical rehabilitation care when needed. In addition, 46 of the workers' compensation laws contain special provisions for rehabilitation in the form of retraining, education, placement, and job guidance to help injured workers find suitable work. Fourteen jurisdictions directly operate rehabilitation facilities under the workers' compensation program to make available to injured workers the full services necessary to restore their ability to perform a job.

In most of the acts, special maintenance and other benefits are also provided to facilitate the vocational rehabilitation of the worker. Under some laws, maintenance benefits are provided through the extension of the period for which regular compensation is payable; under others, the maintenance benefits 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 the right 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 latest employer has to pay only for the last injury and the remainder of the award is paid from the second-injury fund.

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

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

The Black Lung Program

The black lung 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 program was established temporarily with the expectation that the States eventually would provide this protection to coal mine workers through their workers' compensation programs. The program was established under the administration of the Social Security Administration.

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

In addition to the cash benefits authorized under the original 1969 law, the black lung 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. As of the end of 1984, almost half a million 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, about 170,000 mine workers received medical care benefits through the Department of Labor in 1984. Besides those who actually mine the coal on the surface or underground, individuals disabled by black lung may be eligible for benefits if they processed or transported coal, constructed coal mines, or were owners or managers who had worked in the extraction of coal. Evidence of the existence of pneumoconiosis can be established by several means including definitive X-ray readings and presumptions based on the number of years of mining employment and the extent of disability.

The monthly benefit payable to a disabled miner is a flat amount equal to 37 1/2 percent of the monthly pay rate for a Federal Government employee in the first step of grade GS-2. As of January 1986, this amounted to $328.20. 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 $656.40. A widow or other surviving dependent (child, parent, brother, or sister) of a disabled miner who died also receives the basic benefit of $328.20. 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 the unemployment insurance or disability insurance program of a State on account of the miner's disability. Benefits paid to miners and dependents (except widows, wives, and children) are also subject to reduction on account of excess earnings computed as under the social security annual retirement test (a 50-cent reduction for each $1 of excess earnings). Black lung benefits administered by the Social Security Administration, which are paid from general revenues, are not considered workers' compensation payments for purposes of applying the workers' compensation offset provisions contained in the DI provisions.

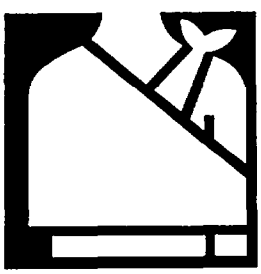
During calendar year 1984, total black lung benefit payments amounted to $1.7 billion, of which $1.0 billion was made through the part of the program administered by the Social Security Administration and $0.7 billion was made through the Department of Labor. Almost three-fifths of the payments were made to miners and their dependents, the remainder being paid to survivors. These payments include $121 million in medical benefits.

Financing and administration. The original part of the black lung program, Part B, administered by the Social Security Administration, 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 is 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 the claims that developed.

The present rates are intended to allow the program to cover current costs and to pay back loans that had to be advanced by the Government to the trust fund to pay benefits. Rates will revert to previous levels by the earlier of January 1, 1996, or after all principal and interest owed to the U.S. Treasury have been paid.



Temporary Disability Insurance, or Cash Sickness Insurance*

Five States, Puerto Rico, and the railroad industry have social insurance programs that partially compensate for the loss of wages caused by temporary nonoccupational disability or maternity.

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

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

It is estimated that, in 1982, about two-thirds of the Nation's wage-and-salary workers in private employment had some protection through these various voluntary and governmental group arrangements against loss of earnings caused by short-term nonoccupational disability. These workers received about $15.0 billion in wage-replacement benefits (including formal sick leave), of which $1.6 billion was paid under temporary disability insurance laws.

Coverage

Some 18 million employees, or about one-fourth of the country's wage-and-salary labor force in private industry, were covered in 1982 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, like the unemployment insurance programs in their jurisdictions, cover most commercial and industrial wage-and-salary workers in private employment if the employer has even one worker. Principal occupational groups excluded are domestic workers, family workers (parent, child, or spouse of the employer), government employees, and the self-employed. State and local government employees are included in Hawaii and hospital employees in Rhode Island; a similar program under another law covers State government employees in California. Agricultural workers are covered to varying degrees in California, Hawaii, New Jersey, and Puerto Rico but are not covered in the other jurisdictions. The California law permits self-employed individuals to elect coverage on a voluntary basis. Workers employed by railroads, railroad associations, and railroad unions are covered by temporary disability insurance under the national system included in the Railroad Unemployment Insurance Act.

The laws generally permit individuals who depend only on prayer or spiritual means for healing to elect not to be covered by the contribution and benefit provisions of the law. Other than for this type of minor exception, the laws make coverage against the risk of wage loss due to short-term nonoccupational disability mandatory for all employees subject to the

*Statutory provisions as of January 1, 1985.

law. However, the methods used for providing this protection vary. In Rhode Island, the coverage is provided through an exclusive, State-operated fund into which all contributions are paid and from which all benefits are disbursed. In addition, a covered employer may provide supplemental benefits in any manner he or she chooses. The State system takes no account of private cash sickness plans. The railroad program is also exclusively publicly operated in conjunction with its unemployment insurance provisions.

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

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

In 1982, private plans accounted for more than a fourth of the covered workers in New Jersey and about 6 percent in California. In contrast, private plans cover all workers in Hawaii, almost all in New York (95 percent), and 80 percent in Puerto Rico.

Eligibility for Benefits

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

Earnings or employment requirements. To limit benefits to individuals who have demonstrated a substantial attachment to the covered labor force, a claimant must have a prescribed amount of past employment or earnings to qualify for benefits. These requirements are similar to those under unemployment insurance but are less stringent in some cases. However, in most jurisdictions with private plans, the plans either insure workers immediately upon their employment or, in some cases, require a short probationary period of employment, usually from 1 month 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 or in cases where complications have resulted from an abortion.)

Disqualifying income. All the laws restrict payment of disability benefits when the claimant is also receiving workers' compensation payments. Further, New York does not pay benefits for employment-related disability, even if workers' compensation is not payable. The other jurisdictions do not pay for disabilities for which workers' compensation is payable. However, the statutes usually contain some exceptions to this rule—for example, if the workers' compensation is for partial disability or for previously incurred work disabilities. California and the railroad program will pay the difference if the temporary disability payment is larger than the workers' compensation benefit (and, in the case of the railroad program, if the temporary disability benefit is larger than benefits from certain other social insurance programs as well).

The laws differ with respect to the treatment of sick-leave payments. Rhode Island pays disability benefits in full even though the claimant draws wage continuation payments. New York deducts from the benefits any payment from the employer or from a fund contributed to by the employer, except for benefits paid pursuant to a collective bargaining

agreement. In California, New Jersey, and Puerto Rico, benefits plus paid sick leave for any week during disability may not exceed the individual's weekly earnings before his or her disablement. Railroad workers are not eligible for temporary disability benefits while they receive sick leave pay.

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

Types and Amounts of Benefits

In all seven temporary disability insurance systems, as with unemployment insurance in the United States, weekly benefit amounts are related to a claimant's previous earnings in covered employment. In general, the benefit amount for a week is intended to replace at least half the weekly wage loss for a limited time. All the laws, however, specify minimum and maximum amounts payable for a week. As of January 1, 1985, the maximum weekly amount ranged from $104 in Puerto Rico to $224 in California. In three States, the maximum is recomputed annually so that it will equal a specified percentage of the State's average weekly wage in covered employment: 66 2/3 percent in Hawaii, 53 percent in New Jersey, and 60 percent in Rhode Island, which also pays benefits to dependents.

The maximum duration of benefits payable per disability or per year is 26 weeks, except for a 39-week maximum in California. Hawaii, New York, Puerto Rico, and the railroad program provide for benefits of a uniform duration for all claimants who qualify. In the other States, the length of time that benefits will be paid varies, depending on the total amount of base period earnings (as under the unemployment insurance program) or length of covered employment.

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

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

In California, before a private plan can be substituted for the State plan, it must afford benefit rights greater than those under the State-operated plan. In Hawaii, New Jersey, and Puerto Rico, private plan benefits must be at least as favorable as those under the government plans. Hawaii permits deviation from statutory benefits if the aggregate benefits provided under the private plan are actuarially equal or better. In New York, adherence to precise statutory benefits is not required; the benefit package provided by private plans must be "actuarially equivalent" to the statutory formula and must meet certain minimum standards. Some features of a private plan can be inferior to the standards of the 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 will be paid, as long as benefits are not denied in any case in which they would have been paid under the statute. In fact, 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 than for State-operated plan coverage.

In 1982, the average payment for a week of disability ranged from $76 in Puerto Rico (publicly operated fund and private plans combined) to $225 in Hawaii (private plans). The average duration per period of disability was only 3.3 weeks in Hawaii but was 9.7 weeks in California.

In areas where private plan participation is permitted, special arrangements are needed to ensure continuity of coverage for a worker who changes employers or experiences periods of unemployment. In New York, the law requires that a worker be covered by a private plan for 4 weeks after termination of employment unless he or she is reemployed, in which case he or she will be covered by the new employer without a waiting period. Puerto Rico

requires that benefits under a private plan be payable for periods of disability that begin during unemployment or employment in uninsured work. In the other three States allowing private plans, the employer's responsibility for coverage lasts only 2 weeks after separation. After such coverage lapses, the worker may be eligible for continued disability benefits through the State fund. Special benefit and eligibility provisions are also in effect for disabled unemployed workers in Hawaii, New Jersey, and New York.

On the other hand, 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, there is no government contribution. The State-operated plan in Rhode Island is financed through an employee payroll tax of 1.2 percent on a worker's wage up to 70 percent of the State average annual wage in covered employment. Railroad employers pay a joint unemployment insurance-temporary disability insurance contribution on wages of up to $600 a month per employee. The contribution is the same for all employers but can vary each year from 0.5 percent to 8.0 percent, depending on the level of financial reserves in the system for the previous year.

Under the California State plan, employees pay a 0.6 percent payroll tax. Self-employed persons who have elected coverage contribute at a rate of 1.25 percent of wages, deemed to be $5,475 a quarter, without regard to actual self-employment earnings. In New Jersey, the State plan for employed workers is financed by a tax of 0.5 percent of covered wages up to $9,600 a year paid by employees and a corresponding tax of 0.5 percent for employers. However, the 0.5 percent employer tax rate may be modified to vary between 0.1 percent and 1.1 percent of covered payroll, depending on the experience of the employer with the disability risk and the level of reserves.

For benefits not exceeding the statutory benefits, New York employees may be required to contribute 0.5 percent of their wages up to a maximum of 60 cents per week; employers bear any additional cost 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 the programs in California, New Jersey, and Puerto Rico, workers covered by approved private plans are relieved from contributing to the government-operated fund; but when they are asked to contribute to the private plan they may not pay more than they otherwise would be required to pay for the State fund. When benefit costs exceed this amount, employers must pay the balance. In Hawaii and New York, higher contributions than specified in the law may be required of employees if the level of benefits provided bears a reasonable relationship to costs.

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

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

Administration

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

By the way of contrast, claims in New York and Hawaii are filed with and paid by the employer, the insurance carrier, or the union health and welfare

fund that is operating the private plan. The State agency limits its functions with respect to employed workers to exercising general supervision over private plans, to setting standards of performance, and to adjudicating disputed claims arising between claimants and carriers. A similar situation applies to claimants under private plans in California, New Jersey, and Puerto Rico.

All the laws require the claimant to be under the care of a physician (or, in California and Hawaii, the claimant may be in the care of an authorized religious 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 again be able to work.

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.

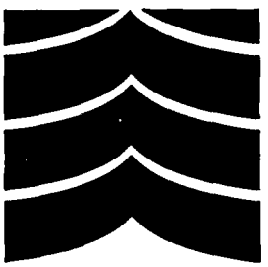
Section II: Programs for Special Groups

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. These veterans' benefits at first consisted mainly of compensation for the war disabled, widows' pensions, and land grants. Later, emphasis was placed on service pensions and domiciliary care. Following World War I, provisions were made for a full-scale system of hospital and medical care benefits.

Retirement programs for certain groups of government employees—mainly teachers, policemen, and firemen—date back to the 19th century. The teachers' pension plan of New Jersey, which was established in 1896, is probably the oldest statewide contributory retirement plan for government employees. By the early 1900's, a number of local governments had set up retirement plans for policemen and firemen, followed by plans for general municipal employees. New York State and New York City set up retirement systems for their employees in 1920, the same year that the civil service retirement system was initiated for Federal employees.

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



Veterans' Benefits

A wide array of programs and benefits is available to veterans of military service. Included are retirement annuities, periodic disability payments, educational assistance, hospitalization and medical care, survivor and dependency benefits, special loan programs, and hiring preference for certain jobs. Most of the veterans' programs are administered by the Veterans' Administration (VA), a Federal agency established in 1930 specifically to provide centralized administration of the various fragmented veterans' programs that had been established over the years.

The importance of veterans' benefit programs is illustrated by some selected benefit payment figures. During fiscal year 1984, total payments for benefits to veterans and their dependents, exclusive of career retirement and social security benefits, reached $24.1 billion. This amount included $13.9 billion for disability payments, $8.4 billion for medical programs, and $1.4 billion for educational programs.

Some 691,000 veterans were receiving pensions and about 673,000 widows were receiving survivor benefits in July 1985.

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 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 passed a pension program for veterans that was actually administered by Congress. As the number of military pensioners grew, administrative responsibility for the pension program was shifted from Congress to a succession of agencies.

The scope of veterans' programs, which had consisted of pensions to disabled veterans and to the widows and dependents of those who died on active duty, was broadened early in the 19th century with the advent of programs for domiciliary care and incidental medical and hospital care.

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

The final significant features of the veterans' benefit system were added during 1944 through the World War II GI bill. Major new features under this law included extensive educational benefits and a home loan program. Changes since World War II have, for the most part, extended existing benefit programs.

Cash Benefits

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

Compensation for service-connected disabilities. The disability compensation program pays monthly cash benefits to veterans who are disabled as a result of an injury or disease incurred or aggravated by active military duty, whether in wartime or peacetime. Individuals who were 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, which is rated by the percentage of normal function lost. Payments range from $66 a month for a 10-percent disability to $1,295 a month for total disability. In addition, specific rates of up to $3,697 a month are paid when eligible veterans suffer certain specific severe disabilities. Such cases are all decided on an individual basis. Veterans who have at least a 30-percent service-connected disability are entitled to an additional allowance for their dependents. The amount depends on the number of dependents and degree of disability.

Pensions for non-service-connected disabilities. Monthly cash benefits are provided to wartime veterans with limited income who are totally and permanently disabled (or aged 65 or older and not working) because of a condition not attributable to their military service. To qualify for these pensions, a veteran must have served in a designated war period that must include one or more of the following: the Mexican Border Period, World War I, World War II, the Korean conflict, or the Vietnam era. Generally, the period of service must have lasted at least 90 days and discharge or separation cannot have been dishonorable.

The maximum benefit effective December 1, 1984, ranges from $476 per month for a single veteran without a dependent spouse or child to $908 per month for a veteran who is in need of regular aid and attendance and who has one dependent. An additional $81 a month is payable for each additional dependent child. Benefits to veterans without dependents are reduced to $60 a month if they are receiving long-term domiciliary or medical care from the Veterans' Administration. Benefits are reduced by $1 for each $1 the beneficiary has in other income.

Benefits for survivors. The dependency and indemnity compensation program provides monthly cash benefits to the surviving spouse, children (who are younger than age 18, disabled, or students), and certain parents of service persons or veterans who die from an injury or disease incurred or aggravated by active duty or training, or from a disability otherwise compensable under laws administered by the Veterans' Administration.

Dependency and indemnity compensation payments are also made in cases of death due to a non-service-connected disability of at least 10 years duration or which 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.

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

The amount of the monthly benefit payable to a spouse depends on the last pay rate of the deceased service person or veteran, and it ranges from $476 to $1,305 a month. Amounts payable to eligible parents are lower, ranging from $5 to $266 a month depending on the parents' income, number of parents eligible, and parents' 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. The amount of this allowance is $143 a month for a spouse and $140 for a parent. Spouses who are not disabled enough to need the regular aid and attendance of another person, but whose physical condition confines them to the house, are entitled to an allowance of $70 a month in addition to their regular benefit. Death pensions were payable for service-connected deaths before 1957, but this program has little, if any, application for persons newly eligible for benefits.

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

The pension amount depends on the composition of the surviving family and the physical condition of the surviving spouse. Pensions range from $319 a month for a surviving spouse without dependent children to $609 a month for a surviving spouse in need of regular aid and attendance who has a dependent child. The pension is raised by $81 a month for each additional dependent child in a family.

Hospitalization and Other Medical Care

The Veterans' Administration 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 VA facilities according to priority groups. The highest priority for care is given to veterans who need treatment for a service-connected disability.

Hospital care. Eligible veterans are provided free hospital care and medical services.

Any veteran is eligible who is—

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

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

Care for dependents and survivors. The dependents and survivors of certain veterans may be eligible for medical care under the Civilian Health and Medical Program of the Veterans' Administration (CHAMPVA) when they are not eligible for medical care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or for Medicare. (CHAMPUS is the health insurance program for military retirees and their dependents. It is administered by the Department of Defense.)

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 VA facilities when space is available. Usually, however, the person with CHAMPVA coverage is treated at a community hospital of his or her choice: The Veterans' Administration pays for a part of the bill and the beneficiary is responsible for a

copayment under the CHAMPVA program.

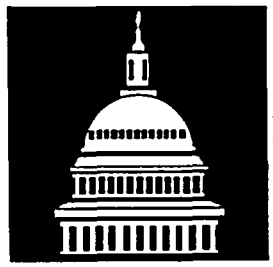
Nursing home care. Eligibility for admission to a Veterans' Administration nursing home is the same as for hospitalization in a VA facility. Admission is made according to priority groups, with the highest priority given to veterans who need nursing home care for a service-connected condition. The Veterans' Administration also contracts with community nursing homes to provide care at VA expense to certain veterans. Community nursing home care is usually limited to 6 months, and is available to veterans needing care for a service-connected disability or to veterans discharged from a VA hospital to the nursing home.

Outpatient medical treatment. Extensive outpatient medical treatment is available to veterans, including 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, who receive VA aid and attendance or housebound benefits, who are former prisoners of war, or who are 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 VA 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 VA facility.

Other medical benefits. Other Veterans' Administration 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; outpatient dental 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 VA may authorize hospital care or other medical services in the community at VA expense for certain veterans.

Educational Assistance

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



Public Employee Programs

The Federal Government, all 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, and workers' compensation benefits.

Federal Government

Civilian employees of the Federal Government receive various types of protection through employee benefit programs. They 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 civilian Federal employees was enacted in 1920. It covered about 330,000 persons and provided benefits to workers who retired because of age or disability after 15 years of service. In 1983, 2.7 million Federal workers were covered by the civil service retirement system.

The current law allows optional retirement (with full annuity) at age 55 with 30 years of service, at age 60 with 20 years of service, or at age 62 with 5 years of service. Workers with 20 years of service at age 50 and 25 years of service at any age are eligible for retirement benefits if involuntarily separated. Workers with 5 years of service may retire because of disability at any age, provided that they meet the criteria used to determine the existence of a disability.

Regular benefits are based on the average of a worker's 3 highest-salaried years. The formula is 1.5 percent of average salary for each of the person's first 5 years of service, 1.75 percent for each of the next 5, and 2.0 percent per year for any additional years. The formula thus provides long-service retirees with benefits equal to about two-thirds of their average earnings during their 3 highest-earnings years. Employees who retire because of disability are guaranteed a benefit of 40 percent of their average salary during their 3 highest-earning years, or an annuity based on projection of service to age 60, whichever is less. However, if a disabled annuitant's regular retirement benefit is larger than the guarantee, he or she receives the larger amount, but not more than 80

percent of average salary. In 1983, 1.4 million retired and disabled annuitants received $18.0 billion in civil service retirement benefits.

The spouse of an employee who dies before retirement receives a benefit amounting to 55 percent of the disability formula. The minimum amount payable is 55 percent of the smaller of (1) 40 percent of the deceased employee's "high-3" average pay (or 22 percent of his or her recent earnings), or (2) the regular annuity obtained after increasing the employee's service by the period between the date of death and the date when he or she would have reached age 60. Child survivors usually receive flat monthly payments.

A retired worker may elect to receive reduced annuities in order to provide survivor benefits to his or her spouse at death. These benefits are equal to 55 percent of the unreduced annuity. In 1983, 503,000 survivor annuitants received $2.6 billion in civil service benefits.

Cost-of-living adjustments generally are made in retirement benefits annually, based on changes in the Consumer Price Index. The civil service retirement system is financed partially by joint employer-employee contributions and partially by general revenues. Federal workers contribute 7 percent of their salary and the Federal Government assumes the balance of the cost, including unfunded liabilities.

Employees who leave the Federal Government before completing 5 years of service, or who die before completing 18 months of service, are entitled to a refund of their contributions to the system. Those who leave after 5 years of service have the option of receiving a refund or leaving the contributions in the fund and drawing a pension at age 62.

Full-time, permanent Federal employment before January 1, 1984, was not covered by the social security program. However, Federal civilian employees who were not covered under a Federal retirement system—primarily part-time or temporary employees—have been covered by social security since 1950. All Federal civilian employees were covered under the hospital insurance program (Part A of Medicare) beginning January 1, 1983.

Under legislation enacted in 1983, social security coverage was extended to all Federal civilian employees hired after December 31, 1983, including those with previous periods of Federal service if they had a break in service lasting more than 365 days. Coverage was also extended to some current employees—that is, Members of Congress, the President and Vice President, Federal judges, and most executive-level political appointees.

The Office of Personnel Management administers programs that provide group life and health insurance to Federal employees and annuitants. These programs are optional and are funded by joint contributions from the worker and the employing agency. The Government pays one-third of the cost of basic life insurance and an average of 60 percent of the cost of health benefits. Life insurance coverage is made available under an insurance industry contract; health insurance is provided under contracts with private carriers, service benefit plans, and health maintenance organizations.

Workers receive 13 days of paid sick leave each year. Sick leave may be accumulated without limit and may be credited toward length of service at retirement. The Federal Employees Compensation Act (the workers' compensation program that covers Federal employees) provides protection in the event of job-related injury, illness, or death. Unemployment insurance for Federal workers is paid for by Government contributions to the Federal-State unemployment insurance system. The States where workers are employed administer the program and determine the amount and duration of benefits, as they do for other workers.

Armed Forces

Since 1957, all members of the U.S. Armed Forces have been covered by the social security program. Those with 20 years or more of service are also eligible for retirement benefits under the military retirement system. Military retirement pay is equal to 2.5 percent of final basic pay (high 3 years of basic pay for those entering the Armed Forces after September 8, 1980) for each year of service. As in the civil service system, a retiree may elect to receive reduced retirement pay in order to provide an annuity to his or her surviving spouse. The amount of a spouse's pension is a proportion (up to 55 percent) of the retired service member's full retired pay at the time of death. The benefit is reduced when the spouse is eligible for certain social security benefits.

Military pensions and annuities generally are increased annually to keep pace with the cost of living. During 1983, 1.4 million retired service members and their survivors received $16.1 billion in military retirement benefits.

The Department of Defense helps provide medical care for active duty personnel, retirees, and all 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 CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). This program shares with the members the cost of care provided by 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 benefits on the same basis as other workers in their State.

State and Local Government

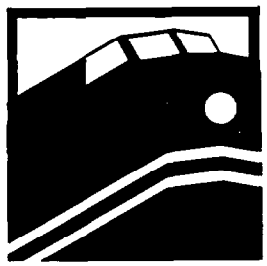
The majority of State and local government employees are covered by retirement systems maintained by States or localities. The provisions of the plans vary from one jurisdiction to another. However, nearly all require contributions from their employees and nearly all guarantee benefits at least equal to the amount of those contributions.

Most State and local plans permit retirement because of disability as well as age and provide for early retirement, but at a reduced benefit. It is usual for high-risk employees, such as policemen or firefighters, to be eligible for retirement on length of service alone, regardless of age. Other employees normally must meet age as well as years of service requirements. In 1982, State and local government retirement systems paid $16.6 billion in benefits to 2.9 million persons; 2.4 million of these persons received benefits based on age and service.

Benefits under State and local retirement systems are usually calculated on a 3- to 5-year average salary, and a 1.5 percent or 2.0 percent multiplier for each year of service. The multiplier is lower in those plans where employees are covered by social security and where benefits are integrated with the social security program. Although relatively few systems provide survivor benefits per se, retiring employees are commonly given the option of electing a smaller annuity for themselves to provide one for a surviving spouse.

When the social security program was enacted in 1935, State and local government employees were not included. However, legislation was enacted in 1950 and later to provide employees of State and local governments with coverage by social security at the employer's option under certain conditions. The coverage of State and local government employment has gradually expanded. In 1954, 3.4 million employees entered the social security system when the option of coverage was extended to all employees (except policemen and firefighters) even if they were already covered by a pension plan. By 1981, 10.1 million State and local government employees were in employment covered under the program. This figure represented about 68 percent of all workers whose major job was in State or local government at that time.

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



Railroad Retirement*

The Great Depression led to movements for retirement plans on a national basis because few workers were covered under any type of retirement plan. While the social security system was in the planning stage, railroad workers sought a separate industrywide pension system to cover their employment. As a result, legislation was enacted in 1934, 1935, and 1937 to establish a railroad retirement system separate from the social security system. Like social security, the railroad retirement system provides monthly benefits to retired and disabled workers and to their dependents and survivors.

The number of workers covered under the railroad retirement system continues to decline. In 1939, the system covered 1.2 million employees; by 1983, the number had dropped to 0.4 million. Some 982,000 beneficiaries were on the rolls at the end of fiscal year 1983, of whom 440,000 were employee annuitants and 232,000 were spouse annuitants.

The specific benefit provisions of the program have changed several times since 1937, as the shrinking of the system caused various financial problems. The present provisions were established by the Railroad Retirement Act of 1974, and were amended by legislation in 1981 and 1983. The basic requirement for a regular employee retirement annuity is 120 months (10 years) of creditable railroad service. A railroad worker is protected under the old-age, survivors, disability, and health insurance (OASDHI) provisions of the Social Security Act until he or she has 10 years of creditable railroad service.

Railroad retirement annuities are calculated under a two-tier formula. The first tier is equivalent to a social security benefit and is based on railroad retirement credits and any nonrailroad social security credits an employee has acquired. The second tier is based on railroad service credits only and is equivalent to the benefits payable under other industrial pension plans.

*Adapted from the **Informational Conference Handbook, January 1984**, Railroad Retirement Board, 1984.

The Medicare program provides hospital insurance and related medical care insurance to railroad workers on the same basis as for persons covered by the OASDHI program.

Types of Benefits

Employee annuities. Employees with 30 or more years of creditable service may receive full annuities at age 62 and annuities that have been reduced for early retirement as early as age 60. Employees with 10–29 years of service may receive full annuities at age 65 and may retire as early as age 62 with a benefit reduction.

Annuities based on total disability are payable at any age to workers who are permanently disabled for all regular work and have at least 10 years of creditable railroad service. Annuities based on occupational disability (the worker is permanently disabled for his or her regular railroad occupation) are payable at age 60, if an employee has at least 10 years of railroad service, or at any age, if the employee has at least 20 years of service. A current connection [5] with the railroad industry also is required for an annuity based on occupational rather than total disability. Five months must elapse after the onset of disability before payment of the annuity can begin.

Vested dual benefits. A disabled or a retired employee who qualified for both railroad retirement and social security benefits before 1975, and who meets certain vesting requirements, can receive an annuity amount in addition to Tier I and Tier II benefits. Generally, the employee must have been fully qualified for both pensions as of December 31, 1974, and have had a current connection with the railroad industry.

Supplemental annuities. Supplemental annuities are payable to railroad employees who were awarded regular retirement annuities. To qualify, an employee must be at least aged 65 with 25–29 years of creditable service (aged 60 with 30 or more years of creditable service) and have a current connection with the railroad industry. Neither a regular annuity nor a supplemental annuity can be paid until the employee stops working for a railroad or the last nonrailroad employer he or she had before retirement.

Spouse and survivor annuities. If a retired employee is at least aged 62 with 10–29 years of service, his or her spouse is eligible for an annuity at age 62. Early retirement reductions of up to 25 percent are applied to the spouse's annuity if the spouse retires before age 65.

[5] For a current connection, an employee must have worked for a railroad for at least 12 of the months in the 2 1/2 years (30 months) immediately preceding retirement.

If a retired employee is aged 60 or older and has at least 30 years of service, his or her spouse is eligible for an annuity at age 60. Early retirement reductions are applied to the spouse's annuity if the employee retires before age 62.

A wife of an employee who qualified for a regular annuity is eligible for a wife's annuity at any age if she is caring for the employee's child who is under age 16 or who became disabled before age 22. If the spouse is the husband of a railroad employee, his annuity is, in effect, equal to what social security would pay in the same situation and is therefore generally less than the amount of the spouse's annuity otherwise payable.

A spouse's annuity is not payable for any month in which the employee's annuity is not payable or for any month in which the spouse returns to work.

Under a special minimum-guaranty provision, families of railroad workers will not receive less in monthly benefits than they would have gotten if railroad earnings were covered by social security laws only. This provision covers situations in which one or more members of a family are eligible for a type of social security benefit that is not provided under the Railroad Retirement Act.

For example, under the Social Security Act, children's benefits are provided when an employee is disabled, retired, or deceased. The Railroad Retirement Act provides children's benefits only if the employee is deceased. Therefore, if a retired railroad employee has children who would otherwise be eligible for a benefit under social security, the employee's annuity will be increased to reflect what social security would pay the family, unless the annuity is already more than that amount.

Annuities are payable to widows and widowers, children, and certain other dependents. A lump-sum benefit is payable to the estate of the deceased railroad employee only if there are no survivors immediately eligible for monthly benefits. Eligibility for survivor benefits depends on whether or not the employee was insured under the Railroad Retirement Act at the time of death. An insured employee is one with at least 10 years of railroad service and a current connection with the railroad industry. If a deceased employee was not so insured, survivor benefits are payable under social security and jurisdiction is transferred to the Social Security Administration.

Survivor annuities, like retirement annuities, consist of Tier I and Tier II components. The Tier I component of a widow's or widower's annuity may be reduced if the person is receiving a Federal, State, or local government pension. A survivor annuity is not payable for any month in which the survivor works for a railroad or railroad union.

Amount of Benefits

The total amount of Tier I and Tier II railroad retirement benefits payable to an employee and spouse at the time the employee's annuity begins is limited to the larger of $1,200 a month or an individual family maximum based on the highest 2 years of taxable earnings in the 10-year period ending with the year the employee's annuity begins. This maximum applies only at the time of the initial award and benefits are subsequently increased to reflect increases in the cost of living, regardless of whether or not a maximum limitation applies at the time of the initial award. The maximum increases every year as the amount of creditable earnings rises.

For employees first entitled to a railroad retirement annuity and a Federal, State, or local government pension after 1985, the Tier I amount will be reduced if the employee is also receiving a public pension based, in part or in whole, on employment not covered by social security. The reduction will be phased in over a 5-year period, but the resulting Tier I amount cannot be reduced by more than 50 percent of the public pension.

The Tier I and vested dual benefit components of employee and spouse retirement annuities may also be subject to certain other limitations based on any earnings outside the railroad industry, although no reduction is made for any earnings in months after the annuitant reaches age 70. (In 1986, annual earnings of up to $7,800 for those aged 65–69 and $5,760 for those under age 65 will be exempt from work deductions.)

If an employee is receiving a disability annuity, the Tier I portion may, under certain circumstances, be reduced for receipt of workers' compensation or public disability benefits. Certain work restrictions also can affect payment, depending on the amount of earnings. The annuity is not payable for any month in which the annuitant earns more than $200. Withheld payments will be restored if earnings for the year are less than $2,500.

After retirement, the Tier I portion of both employee and spouse annuities is increased for higher living costs at the same time, and by the same percentage, as social security benefits. These automatic increases, normally payable on January 1, can be triggered when the Consumer Price Index rises by 3 percent or more between the third calendar quarter of the year and the corresponding quarter of the previous year.

The Tier II portion of retired employee and spouse annuities is normally increased annually by 32.5 percent of the Tier I cost-of-living increase rate.[6] Tier II cost-of-living increases are generally payable at the same time as Tier I cost-of-living increases.

[6] Remedial financial legislation in effect precluded Tier II railroad retirement cost-of-living increases in January 1984 and limited payment of January 1985 increases to partial amounts.

Financing and Administration

The financial interchange between the railroad retirement and social security systems is intended to put the social security trust funds in the same position they would have been in had railroad employment been covered under the Social Security Act since 1937. All computations under the financial interchange are performed according to social security law. Therefore, the amount of benefits payable under the Railroad Retirement Act has no effect on the results. Estimates are made both of the social security benefits that would be paid to railroad beneficiaries and of the taxes railroad workers would pay if they were covered by social security. The net of these calculations is paid by the social security trust funds to the Railroad Retirement Account.

Since 1975, if a retired or disabled railroad retirement annuitant is also awarded social security benefits, the Social Security Administration determines the amount due, but the payment is made by the Railroad Retirement Board in a combined monthly benefit check.

The amount of the employee's Tier I benefit portion is reduced by the amount of the social security benefit because the Tier I portion is based on combined railroad retirement 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 principles of social security law, under which the beneficiary, in effect, receives only the higher of any two benefits to which he or she is entitled.

By law, railroad retirement Tier I taxes are coordinated with social security taxes and increased automatically when social security taxes rise. In 1985, the tax on employees and employers each was 7.05 percent on the first $39,600 of earnings. In addition, both employees and employers paid Tier II taxes to finance railroad retirement benefit payments over and above social security levels. The employee tax ratio was 3.5 percent and the employer ratio was 13.75 percent on the first $29,700 in earnings.

Beginning with taxable year 1984, regular railroad retirement and survivor benefits are subject to Federal income tax in the same manner as social security benefits. Also beginning with taxable year 1984, Tier II benefits and vested dual benefit payments are subject to Federal income tax under the same rules as those for private pensions; such benefits are subject to income tax to the extent that they exceed the

contributions made by the employee.

The Railroad Retirement Board is an independent agency in the executive branch of the U.S. Government and is administered by three members appointed by the President with the advice and consent of the Senate. By law, one member is appointed upon the recommendation of railroad labor organizations, the second one upon recommendation of railroad employers, and the third member, the chairman, is independent of employees and employers and represents the public interest. The terms of office are 5 years and are arranged to expire in different calendar years.

Unemployment Insurance and Sickness Benefits

The railroad unemployment insurance system, like the railroad retirement system, was established in the 1930's. Federal-State unemployment programs, established under the Social Security Act in 1935, 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, but in different States, received different treatment and different benefit amounts when they became unemployed. Employees 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 National Security Commission, which reported on the nationwide State plans for unemployment insurance, recommended that railroad workers 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, effective July 1, 1939. The Act established a system of benefits for unemployed railroad workers, financed entirely by railroad employers and administered by the Railroad Retirement Board.

In 1946, Congress extended the railroad unemployment insurance program to include temporary cash sickness and special maternity benefits. This program is financed by the contributions of railroad employers only, based on the taxable earnings of their employees. The taxable earnings base is the first $600 of each employee's monthly earnings.

Section III: Means-Tested Programs

Means-tested programs, also called public assistance, provide direct cash support for needy people. To be eligible for means-tested 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, as was 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 so 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.

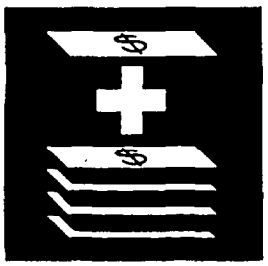
The Social Security Act of 1935 established two categorical Federal-State grant programs:

- **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 raised on an ad hoc basis over the years. In 1950, eligibility was extended to the permanently and totally disabled. In 1972, the programs of old-age assistance, aid to the permanently and totally disabled, and aid to the blind were replaced by the supplemental security income (SSI) program. This program guarantees a minimum monthly benefit to needy aged, blind, and disabled persons who meet federally established eligibility

criteria. Most States supplement the Federal benefits.

- **Aid to dependent children.** The ADC 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. The most significant of these are Medicaid, which provides reimbursement for medical expenses, and food stamps, which provides coupons that may be used to purchase food. In addition, various Federal and Federal-State programs provide energy assistance to low-income families, housing assistance, and food and nutritional services. General assistance may also be available at the State or local level.



Supplemental Security Income

In 1972, Congress replaced the categorical Federal-State programs for the needy aged, blind, and disabled with the Federal supplemental security income (SSI) program. The creation of this unified program brought to an end the disarray of eligibility requirements and benefit levels embodied in the assistance programs that had been administered at the State and local levels.

Under the SSI program, eligibility requirements were made uniform, both with respect to the means (financial) test required to qualify for benefits, and the definitional requirements such as age of eligibility and medical conditions of disability and blindness. Federal benefit payments under SSI were also made uniform so that qualified individuals are guaranteed the same minimum amount regardless of where they live. The SSI program also established uniform amounts of income that are disregarded when determining the eligibility of an individual or couple.

Coverage and Eligibility

SSI provides monthly cash payments to any aged, blind, or disabled person whose countable income is less than $4,032 per year, as of January 1, 1986. To qualify as an aged person, an individual must be at least 65 years old.

The qualifying standards for payments based on disability under SSI are the same as those used for the social security disability insurance program. That is, an individual is considered to be disabled if he or she is "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of 12 months." Those who received assistance under their State program of aid to the permanently and totally disabled in December 1973 and for at least 1 month before July 1973 were automatically eligible for SSI, as long as they continued to meet that definition of disability. For a child under age 18, the disability must be of comparable severity to that of an adult.

An individual is considered to be blind if he or she has a central visual acuity of 20/200 or less in the better eye with the use of correcting lenses or with tunnel vision of 20 degrees or less. Blind recipients who were transferred to the SSI rolls may continue to meet the less strict State standards of October 1972. Such persons are considered blind for purposes of the SSI program so long as they continue to meet that State definition.

Benefit Amounts

For the year beginning January 1, 1986, a maximum Federal monthly SSI payment of $336 is payable to eligible individuals living in their own household. 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 $504. In addition, as discussed subsequently, the Federal payments are supplemented by all but two of the States.

Federal payments are adjusted automatically to reflect social security cost-of-living increases. Under the SSI law, States may not reduce their supplemental payments to offset any increase in the Federal amount. This assures recipients that they will receive the full amount of the automatic increases in their payments. In September 1985, 3.8 million persons were receiving Federal SSI payments averaging $202 per month (table 8).

Factors Affecting Benefits

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

Table 8.—Number of persons receiving federally and State-administered SSI payments and average monthly benefit amount, by reason for eligibility and type of payment, June 1985

Type of payment	Total	Aged	Blind	Disabled
	Number of persons (in thousands)			
Total	4,166	1,553	82	2,530
Federally administered:				
Federal SSI payments	3,763	1,338	73	2,351
Federal SSI payments only	2,460	927	44	1,479
Federal SSI and federally administered State supplements	1,303	401	30	872
State supplements:				
Federally administered State supplements only	336	183	8	145
State-administered State supplements	67	31	...	34
	Average monthly benefit amount			
Total	$230	$168	$277	$266
Federal SSI payments	202	142	229	236
Federally administered State supplements	104	102	147	103
State-administered State supplements	95	89	112	102

are in public institutions and who have more than half the cost of their care paid for by the Medicaid program receive an SSI payment of $25 per month while they are in the institution. However, those in public institutions not covered by Medicaid are ineligible for SSI unless the institution is a publicly operated community residence with no more than 16 residents.

SSI payments generally are reduced if the recipients have other income. However, the first $20 of income per month, whether earned or unearned, is disregarded. Any additional unearned income obtained by recipients during the month—most often a social security benefit—reduces SSI payments dollar for dollar. The SSI law requires recipients to apply for any other benefits to which they may be entitled, such as social security, unemployment insurance, or workers' compensation.

Earned income of SSI recipients receives a somewhat less stringent treatment to encourage recipients to work. In addition to the initial $20 a month disregarded, the first $65 of earned income in any month is also excluded from countable income. Thereafter, SSI payments are reduced by $1 for every $2 earned.

Income from a number of other sources is excluded when determining payment amounts. These sources include income from scholarships, certain earnings of students, work expenses of blind persons, impairment-related work expenses of the disabled, and income from child foster care payments. Income necessary for an approved plan of self-support for blind and disabled recipients is also disregarded. Irregular and infrequent income is not counted as long as it does not exceed $20 per month if unearned or $10 a month if earned.

The amount of assets a person may hold and be eligible for SSI is limited. In most cases the limits are $1,700 for an individual and $2,550 for a couple. In 1987–89, the limit on countable resources will be raised by $100 each year for individuals and $150 each year for couples. The limit in 1989 and thereafter will be $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 and an automobile with a current market value of up to $4,500. A recipient may hold a life insurance policy with a face value of up to $1,500. Special exclusions are applicable to the resources necessary for an approved plan of self-support for blind and disabled recipients. The value of a burial space for a recipient, spouse, and immediate family member is excluded. There also is a provision for the exclusion of funds set aside for burial.

State Supplementation

The SSI legislation provides that anyone who received assistance under the former State assistance programs before January 1, 1974 (the date of SSI's implementation) may not receive lower benefits under the new program. States in which the previous assistance levels were higher than the Federal SSI payment are 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 newly awarded or converted from the State assistance rolls.

A State may administer its supplemental payments itself or choose to have the Federal Government do so. When a State chooses Federal administration, the Social Security Administration (SSA) maintains that State's payment records, and issues the Federal payment and the State supplement in one check. SSA assumes the cost of administering these supplements and is reimbursed by the State only for the amount of the supplementary payments. However, if a State chooses to administer its own payments, it processes applications and makes eligibility determinations separately from the Federal Government. As of January 1986, 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 category (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. States may also differentiate between geographic regions, though 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. Some States rely on individual determination of need; others provide a supplement to all persons who qualify for supplemental security income. In December 1984, 1.9 million persons were receiving State supplements averaging $97. Of the 1.9 million, 1.6 million were receiving federally administered supplements and 331,000 were receiving State-administered supplements.

Administration

Federal SSI payments and the administrative costs of federally administered State supplements are financed from the Federal Government's general revenue fund. Total obligations for fiscal year 1985 were $11.2 billion, of which $8.6 billion was for benefit payments. In addition, in calendar year 1984 federally administered State supplements totaled $1.8 billion and State-administered State supplements, $0.3 billion. Applications for SSI payments are taken at SSA district offices. There the supporting documentation is examined, and the district office staff determines whether the applicant meets the program criteria on age, income, and assets. The aged applicant has any claim for social security benefits processed by the district office. When disability or blindness is involved, medical determinations of eligibility are made by the State disability determination agencies. The district offices may also make emergency payments of up to $100 to eligible applicants who are in severe financial difficulty.

Computation of benefit amounts is made at SSA's central office in Baltimore, Maryland, 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. Every State in the Union now operates such a program, known as aid to families with dependent children (AFDC). The program aids children in families where need is brought about by the incapacity, death, continued absence, or (in some States) 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 such a way as to provide a higher percentage of Federal matching to States with lower per capita incomes and a lower percentage to States with higher per capita incomes. The Federal Government also pays a certain percentage of the costs related to program administration and training and the costs for acquiring and implementing statewide management information systems. Federal administration is the responsibility of the Social Security Administration. To qualify for grants, the States must comply with the Federal guidelines set forth in title IV, part A of the Social Security Act. The most important of these are the following:

- Anyone wishing to make application for AFDC will be given the 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 administered by a single State agency.
- Prompt notice and opportunity must be provided for a fair hearing to anyone whose application is denied or whose payment is reduced or terminated.

In addition, the State must participate financially in its AFDC program, based on the grant formula for the State's share, and must submit for the Federal Government's approval a plan for administering the program. It is illegal for a State to exclude anyone from participating in the program solely on the basis of age, citizenship, or residency requirements. Within these broad guidelines, the States may choose whom they will assist, how the assistance will be given, and how much it will be. There is great variation among the States in their choice on these matters.

The most variable factor is the needs standard, which is the dollar amount a State determines to be essential to meet a minimum standard of living in that

State for a family of specified size. On January 1, 1985, the monthly needs standard for an AFDC family of three was $474 in New York, $286 in Mississippi, and $421 in Colorado.

In computing its needs standard, a State takes into account allowances for food, clothing, shelter, utilities, and other necessities. The family's need is theoretically equal to the difference between the determined needs standard for a family of a given size and the actual resources available to the family. However, the States are not required to provide the full amount of this difference. States have statutory and administrative ceilings on the amount that may be paid, which may result in assistance payments below the needs standard. Payment standards are adjusted periodically by the States, based on their fiscal abilities. In December 1984, average payments ranged from $91.47 per family or $31.26 per recipient in Mississippi to $578.45 per family or $231.27 per individual in Alaska. The average benefit nationwide was $335.40 per family or $114.72 per recipient.

Payments usually are made directly to AFDC recipients. However, individuals who are physically or mentally incapable of managing their own funds, or who request it, may have their payments go to a representative payee on their behalf. The most common applications are for rent and utility payments made directly to a landlord or a utility company.

Eligibility

In December 1984, 3.7 million families—10.7 million children and their parents—received $1.2 billion in AFDC payments in the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

The eligibility requirements for AFDC are set by the States based on the provisions of the Social Security Act. In all States, the children to be assisted must be needy and deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent. They must be living in the home of a parent, or with both parents if one of them is incapacitated. Some 23 States, the District of Columbia, and Guam have unemployed parent programs, which permit children to receive payments if the principal wage earner in the family is present but unemployed. To qualify, children generally must 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.

A State may at its option provide assistance to a pregnant woman with no other eligible children during the last 4 months of pregnancy. Pregnant women are exempted from the requirement for work registration or training beginning from 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. However, aliens are not eligible until 3 years after they enter the United States. Until then, aliens are considered to have the income and resources of their private sponsors. Aliens who are sponsored by public or private agencies also are ineligible for 3 years, unless the agency or organization ceases to exist or has become unable to meet the alien's need.

Federal law requires States to calculate the amount of a stepparent's income that will be available to any child in the household receiving AFDC. The same laws apply to stepparents that apply to natural or adoptive parents—that is, the stepparent must be deceased, disabled, or unemployed in States with an unemployed parent program for a payment to be made.

The need, income, and resources of parents, legal guardians, and siblings (except SSI recipients) living in the same assistance unit as the dependent child must be taken into account. An assistance unit includes those persons in a household whose need and income are considered when determining the amount of assistance. Effective on October 1, 1984, the income of the parents or legal guardians of a minor parent must also be counted if all parties are living in the same household.

Other conditions for eligibility, of a financial nature, may be imposed on recipients, and these vary from State to State. For example, some States impose liens on the real property of recipients.

Eligibility is limited to those families that have gross income at or below 185 percent of the State standard of need. To encourage recipients toward self-support, Federal law disregards some earned income in determining the amount of the AFDC payment. A monthly amount of $30 plus one-third of income may be disregarded for a period of up to 4 months. An additional $30 may be disregarded for up to 8 months. The first $75 of earned income from full- or part-time employment is also disregarded as a work expense deduction for both applicants and recipients. Earned income is the amount of gross income rather than take-home pay. All other income is considered in determining the AFDC payment.

Assets held by AFDC applicants are considered in determining eligibility. States must set a limit of $1,000 or less on the equity value of the resources that an assistance unit may own. States must count the equity value for all resources except the value of a home owned and occupied by the assistance unit, the

equity value of a car worth up to $1,500, and, at State option, the value of basic essential items, such as clothing and furniture of limited value.

AFDC recipients who are classified as employable must register for work or training under the work incentive program (WIN). States may require participation in one of the federally sponsored work programs such as community work experience (CWEP), work supplementation (WSP), employment search or WIN demonstrations. Employable recipients work a specified number of hours as a condition for eligibility for aid, or accept employment in lieu of an AFDC payment. States may subsidize jobs in the public and private sector and receive Federal matching funds. Many States have imposed additional work requirements as a condition for providing AFDC financial assistance.

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

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

States collect child support payments and past due amounts through a number of methods, including (1) the withholding of Federal and State tax refunds, (2) withholding unemployment compensation, (3) imposing liens on property, (4) establishing security and bonding conditions, (5) assignment of wages, and (6) notifying credit bureaus about overdue child support payments.

Administration and Financing

The cost of AFDC is shared by Federal, State, and local governments. Since 1958, the formulas have been designed to provide higher Federal matching rates to States with more limited resources than to other States. This is done by 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, varying among the programs, limits the amount of payments to be shared and the ratio of Federal sharing. The States may make higher payments by using State and/or local money.

Under the regular matching formula for AFDC, the Federal share is 5/6 of the first $18 of the average monthly payment per recipient, plus a proportion of the amount over $18, with a maximum of $32 per recipient subject to Federal participation. The proportion applied to the average amount above the first $18 varies between 50 percent and 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 with a maximum payment of $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 reimbursement. This provides for Federal matching, again varying with the State's per capita income, of from 50 percent to 83 percent of the aggregate amount spent for cash payments and medical assistance to recipients. All but a few States use this more generous formula for calculating reimbursement.

Generally, most service costs and other administrative expenses incurred under public assistance programs are shared equally by the Federal Government and the States. However, the Federal share can be increased to 75 percent of the cost of providing rehabilitation and other social services and staff training in States that provide certain self-care and self-support services.

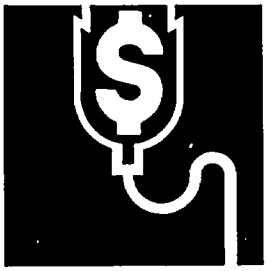
Under the work incentive program, 90 percent of State agency expenditures for employment support services, vocational rehabilitation, and medical services are reimbursed by the Federal Government.

The Social Security Administration administers Federal participation in the AFDC program and 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.



Medicaid

All States except Arizona participate in the medical assistance program commonly known as Medicaid (title XIX of the Social Security Act). The program provides Federal matching funds to States to help them provide for the cost of medical care and services for low-income persons through direct payment to suppliers of the care and services.

The Medicaid program has it roots in the 1950 Amendments to the Social Security Act, which provided Federal reimbursement to States for the States' payments to providers of medical care to recipients of old-age assistance. However, any such payments were limited to the maximum individual old-age assistance amount for which Federal sharing was available. In 1956, a separate State maximum was introduced for State payments to medical providers or vendors. In 1960, assistance for the costs of medical expenses was extended to the aged who were deemed "medically needy"—that is, to those whose incomes were high enough that they were ineligible for old-age assistance but too low to meet their medical expenses. In 1962, the Federal grants for medical expenses applicable to the aged were extended also to recipients of aid to the blind and aid to the permanently and totally disabled.

Coverage

To be eligible for Federal funds, a State Medicaid program must cover all persons who receive assistance under the AFDC program. Most SSI recipients also are covered. States have three options for covering the aged, blind, and disabled. They may include (1) all SSI recipients, (2) all SSI recipients who have undergone a separate State determination for Medicaid, or (3) the aged, blind, and disabled who meet eligibility standards more restrictive than those for SSI. In any case, States must protect the Medicaid eligibility of those individuals who were eligible for Medicaid before the implementation of SSI, and they must cover anyone who receives a mandatory State SSI supplement. The States also must include poor pregnant women.

A State may also elect to provide coverage to those known as "medically needy only." Individuals who are considered medically needy under a State Medicaid program must either (1) have income that is generally no more than 133 1/3 percent of the AFDC cash payment for a family of similar size or (2) have incurred medical expenses at least equal to the difference between their income and the applicable income standard. Thirty-one States have a medically needy program.

In all, 21.4 million aged, blind, or disabled persons and persons in poor families with children received Medicaid benefits in fiscal year 1984. These recipients included:

Total	21,365,000
Aged 65 or older	3,165,000
Blind	80,000
Permanently and totally disabled	2,870,000
Dependent children younger than age 21	9,771,000
Adults in families with dependent children	5,598,000
Other	1,185,000

Basic Program Features

The Medicaid program complements the Medicare program. Medicaid may pay the premiums for supplementary medical insurance (SMI) and the deductible and coinsurance costs of hospital insurance (HI) and SMI for the indigent aged. Medicaid also covers some medical services—the most important being long-term nursing home care—that the Medicare program does not cover.

The services provided under the Medicaid program to cash assistance recipients must include at least the following:

- Inpatient and outpatient hospital services.
- Rural health clinic services.
- Laboratory and X-ray services.
- Skilled-nursing care for adults.
- Home health services for any individual entitled to skilled-nursing care.
- Certain screening, diagnostic, and treatment services for children.
- Family planning services and supplies.
- Nurse/midwife services.

Provision for other services is optional and States may require the payment of nominal deductible and coinsurance amounts for their use. A common optional service is care in intermediate care facilities, which provide more than room and board but less than skilled-nursing care.

For the medically needy, however, a State may choose the services that it will provide; it need not include all the services listed above. Nominal premium payments or fees may be imposed on any service offered to the medically needy. Since 1972, Medicaid institutions have been required to implement the utilization review practices that govern Medicare institutions. The same State agency must certify facili-

ties for participation under both programs. The agency must also establish a plan for statewide review of the quality and appropriateness of the services offered. A single definition and set of standards must be used in evaluating skilled-nursing care facilities under the two programs. Finally, each State must control utilization of institutional services, and conduct professional, independent audits. The penalty for failure to comply with these regulations is a reduction in the Federal matching funds that the State receives from the Federal Government.

Financing and Administration

The Medicaid program is administered jointly by the States and the Health Care Financing Administration. Federal costs totaled $21.7 billion in fiscal year 1985 and were financed by the Government's general revenue fund. State costs in that year totaled $17.8 billion.

As indicated above, States may choose to have their Medicaid costs reimbursed at a rate between 50 percent and 83 percent of actual expenditures, with AFDC reimbursement figured separately under a different formula, or have reimbursement for both programs calculated under the Medicaid formula. The fraction of actual expenditures reimbursed depends on the State's per capita income, with wealthier States having a smaller share of their costs reimbursed. On average, States receive reimbursement for 55 percent of their Medicaid costs from the Federal Government.

Most administrative costs are matched at 50 percent for all States. Family planning and Indian health services are matched at 90 percent and 100 percent, respectively. Administrative expenditures for the development and operation of approved Medicaid management information systems are reimbursed at 90 percent and 75 percent, respectively. And costs of certain medical professionals used to administer the program are matched at 75 percent.

Each State designs and administers its own program under guidelines set and reviewed by the Health Care Financing Administration.

Food Stamps

Under the food stamp program, single persons and those living in households meeting nationwide standards for income and assets may receive coupons redeemable for food at most retail food stores. The monthly amount of coupons that a household receives is determined by household size and income. This amount is updated to account for food price increases. As of November 1, 1984, an eligible four-person household with no income received $264 monthly in food stamps. Households with income receive the difference between what has been determined to be the cost of a nutritionally adequate diet and 30 percent of their income, after certain allowable deductions.

Initiated on a pilot basis in 1961, the food stamp program was formally established by the Food Stamp Act of 1964, with counties in 22 States participating. Originally, participants purchased food stamps. The difference between their face value and the purchase price was known as the bonus value. In 1971, the program was significantly expanded. Virtually all States were required to participate and eligibility criteria and payment levels were federally established. Legislation in 1973 expanded the categories of persons eligible and provided for semiannual adjustment of the stamp's value.

In 1977, the purchase requirement was eliminated and households began receiving the bonus value of the food stamps. Also beginning in 1977, and again in 1980, 1981, and 1982, amendments were enacted to constrain the costs being incurred under the food stamp program.

Basic Program Features

To qualify for the program, a household must have less than $1,500 in disposable assets ($3,000 if one member is aged 60 or older and the household has at least two persons) and gross income below 130 percent of the Office of Management and Budget poverty guidelines for the household size. (In 1984, the guideline figure for a four-person family was $10,200.) Households with a person aged 60 or older or a disabled person receiving either supplemental security income or social security disabled-worker benefits may have gross income exceeding 130 percent of the poverty guidelines. One- and two-person households that meet the applicable standard receive at least $10 a month in food stamps. Even those receiving other Federal assistance payments must meet these requirements to receive food stamps. The monthly deductions from income are:

- Eighteen percent of earned income.
- A standard deduction — $95, as of October 1, 1984.
- The amount paid for child care while the child's caretaker is working or looking for work, up to $134 a month, as of October 1, 1984.

- Any medical expenses for an aged or disabled person, as defined above, after subtracting $35. If more than one person in the household is aged or disabled, $35 is subtracted before deducting combined medical expenses.
- An excess shelter deduction, which is total shelter costs including utilities minus 50 percent of income after all the above deductions have been subtracted and limited to $134 minus child care expenses, as of October 1, 1984. Households with an aged or disabled person do not have a limit on this deduction.

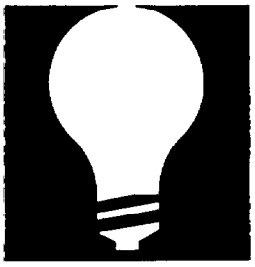
Households are certified to receive food stamps for varying lengths of time, depending on their income sources and individual circumstances. Recertification is required at least annually. Households whose sole income is from SSI payments or social security benefits are certified for a 1-year period. Moreover, households must report income or expense changes of $25 or more or other changes in circumstances that would affect eligibility. Families with income or food loss resulting from natural disasters such as tornadoes or floods may be eligible for food stamps for up to 1 month if they meet the special disaster income and asset limits.

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

An estimated 20.9 million persons received food stamps during 1984. The average monthly value per person of the food stamps was $42.77 and the total value of food stamps issued during the year was $10.7 billion.

Financing and Administration

The food stamp program is in effect in the 50 States, the District of Columbia, and the Virgin Islands. (In July 1982, Puerto Rico received a block grant for nutrition assistance and ceased to be part of the food stamp program.) It 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 themselves. Administrative costs are shared by the Federal and State governments.



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. LIHEAP is administered at the Federal level by the Department of Health and Human Services (HHS). The Department of HHS has administered energy assistance programs since fiscal year 1980.

For fiscal year 1984, a total of $2.075 billion was appropriated by Congress for low-income home energy assistance. For fiscal years 1985 and 1986, the respective appropriations were $2.1 billion and $2.275 billion.

The estimated number of households receiving home energy assistance in fiscal year 1984, by type of assistance, was as follows:

Heating	6,517,000
Cooling	536,000
Energy crisis intervention	1,098,000
Winter	1,078,000
Summer	20,000
Low-cost energy weatherization/energy-related repair	216,000

An unduplicated total of households assisted cannot be derived from these estimates because the same household may be included under more than one type of energy assistance.

Eligible households may receive funds for heating and cooling costs, and for weather-related and supply-shortage emergencies. The States may allocate up to 15 percent of the funds to be used for low-cost residential weatherization or other energy-related home repairs.

To receive grants, 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 title XXVI with similar and related programs.
- Provide 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.
- When designating local agencies to carry out the purposes of the program, give consideration to agencies that have managed the program before.
- Ensure that energy suppliers receiving benefits directly on behalf of eligible households will not treat assisted households differently than 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 upon with reasonable promptness.

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 AFDC, supplemental security income, food stamps, or means-tested veterans' benefits. States are permitted to set more restrictive criteria as well.

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

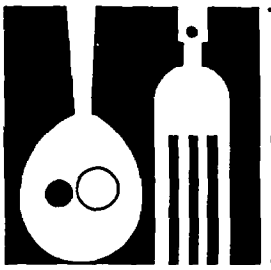
Earlier energy assistance programs in fiscal years 1977–79 were administered by the Community Services Administration and were focused on crisis assistance to households facing immediate hardships. These programs were funded at lower levels—$200 million annually.

Public or Other Subsidized Housing

Numerous programs are designed to remedy the unsafe and unsanitary housing conditions and the acute shortage of decent, safe, and sanitary dwellings for low-income families. Several Federal, State, and local agencies administer these programs. Some are funded by the Department of Agriculture (for rural families) or largely by State and local agencies, but most are administered by the Department of Housing and Urban Development (HUD). Among the most important HUD rental housing programs are low-rent public housing under sections 8, 236, and 101 (rent supplements) of various U.S. housing acts.

Low-rent public housing projects are owned, managed, and administered by a local housing authority. Partial financing may be provided by the State or HUD. Participation in public housing is determined by two factors—program eligibility and the availability of housing. Income standards for initial and continuing occupancy vary by local housing authority, although the limits are constrained by Federal guidelines. Rental charges, which in turn define net benefits, are set by a Federal statute not to exceed 30 percent of adjusted monthly money income. A recipient household can be either a family or two or more related persons or an individual who is handicapped, elderly, or displaced by urban renewal or a natural disaster. Other HUD programs provide similar types of housing assistance to low-income families and individuals.

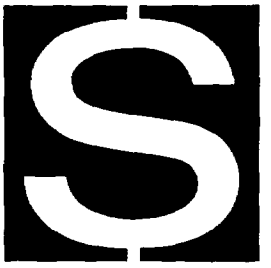
Two of the more common types of programs in which Federal, State, and local funds are used to subsidize private sector rental housing are rent supplement and interest reductions plans. Under a rent supplement plan (for example, sections 8 and 101), the difference between the "fair market" rent and the rent charged to the tenant is paid to the owner by a government agency. Under an interest reduction program (for example, section 236), the amount of interest paid on the mortgage by the owner is reduced so that subsequent savings can be passed along to low-income tenants in the form of lower rent charges.



School Lunches

The national school lunch program is designed to help safeguard the health and well-being of the Nation's children by assisting the States in providing an adequate supply of food for all children at a moderate cost. Additional assistance is provided for children determined by local school officials to be unable to pay the full established price for lunches. Like the food stamp program, the national school lunch program is 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 students eating lunches prepared at participating schools pay less than the total cost of the lunches. Some students pay the full established price for lunch (which, itself, is subsidized), while others pay a reduced price for lunch, and still others receive a free lunch. Until January 1981, children were eligible for free school lunches if their household's income was below 125 percent of the poverty guidelines or for reduced-price lunches if their household's income was between 125 percent and 195 percent of the poverty guidelines. The term "income" excluded certain Federal benefits and specified hardship expenses. Effective January 1,1981, the hardship exclusion was replaced by a standard deduction. Beginning August 13, 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 130 percent for free lunches and to 185 percent for reduced-price lunches.



General Assistance

General assistance may be furnished by State or local authorities to needy persons who do not qualify for the major welfare programs or whose assistance payments are too small to meet their basic needs. General assistance is available in 36 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. In January 1983, 1.3 million persons received general assistance. General assistance is often the last resort for unemployed persons who are ineligible for AFDC or unemployment insurance benefits, or who have exhausted their unemployment benefits. However, about one-third of the States refuse to provide general assistance to households containing an employable person except in specific emergency situations, such as fire or flood.

The eligibility requirements and payment levels of the general assistance programs vary from State to State, and often within the States. Payments are usually lower and of shorter duration than those of the major assistance programs. They may consist of vendor payments as well as cash assistance.

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