
Social Security (Old-Age, Survivors, and Disability Insurance)

The Old-Age, Survivors, and Disability Insurance (OASDI) program provides monthly benefits to qualified retired and disabled workers and their dependents, and to survivors of insured workers. Eligibility and benefit amounts are determined by the worker's contributions to Social Security. Benefits are paid as an earned right to workers, their families, and their survivors. There is no means test to qualify for benefits.

At the end of December 2003, 47.0 million people were receiving benefits at a rate exceeding \$39 billion each month (more than \$470 billion annually). According to the latest Social Security Trustees Report, these cash benefits made up 4.3 percent of the nation's gross domestic product. During the same year, approximately 154 million employees and self-employed workers, along with employers, contributed \$533.5 billion to the OASDI trust funds—through which contributions are credited and benefits are paid.

Social Security benefits are essential to the economic well-being of millions of individuals. Social Security pays benefits to 90 percent of those 65 or older. It is the major source of income (providing 50 percent or more of total income) for 66 percent of the beneficiaries. It contributes 90 percent or more of income for one-third of the beneficiaries and is the only source of income for 22 percent of them.

Contributions and Trust Funds

A person contributes to Social Security through either payroll taxes or self-employment taxes under the Federal Insurance Contributions Act (FICA) or the Self-Employed Contributions Act (SECA). Employers match the employee contribution, while self-employed workers pay an amount equal to the combined employer-employee contributions. (Self-employed workers receive a special tax deduction to ease the impact of paying the higher rate.) There is a maximum yearly amount of earnings subject to OASDI taxes, \$87,900 in 2004. There is no upper limit on taxable earnings for Medicare Hospital Insurance. Employees whose contributions exceed the maximum taxable amount because they worked for more than one employer can receive refunds of excess FICA payments when they file their tax returns.

Taxes are allocated to the Old-Age (Retirement) and Survivors Insurance (OASI), the Disability Insurance (DI), and the Hospital Insurance (HI) Trust Funds. In addition to the taxes on covered earnings, OASI and DI trust fund revenues include interest on trust fund securities, income

from taxation of OASI and DI benefits, certain technical transfers, and gifts or bequests. By law, the OASI and DI trust funds may only be disbursed for

1. Monthly benefits for workers and their families.
2. Vocational rehabilitation services for disabled beneficiaries.
3. Administrative costs (currently less than 1 percent of expenditures).
4. The lump-sum death payment to eligible survivors.

Revenue received from FICA payments is transferred to the U.S. Treasury. FICA revenue in excess of outlays is used to purchase special interest-bearing Treasury bonds. These securities remain assets of the trust funds until needed to cover Social Security costs.

Structure and Organization

The OASDI program is administered by the Social Security Administration (SSA), which became an independent agency in 1995. The commissioner of Social Security serves a 6-year term following appointment by the president and confirmation by the Senate. A bipartisan Social Security Advisory Board serves to review existing laws and policies and commissions studies and issues recommendations intended to anticipate changing circumstances. The president appoints three of the seven board members, and Congress appoints the other four members.

The Social Security Administration is headquartered in Baltimore, Maryland. Major headquarter components include the National Computer Center that contains SSA's mainframe computers that drive our systems, much of the executive staff for policy, programs, and systems, as well as field support components. SSA's field structure is divided into 10 geographic regions containing more than 1,300 field installations in communities throughout the country. Office sizes range from large urban offices with 50 or more employees to remote resident stations staffed by one or two individuals. Each region is headed by a regional commissioner and staffed with specialists to handle regional administrative tasks and to assist field offices with operational issues. In addition, there are teleservice centers servicing all regions. Although physically located within the various regions, each teleservice center manages the public's Social Security business from throughout the nation using state-of-the-art communications systems. Seven program ser-

vice centers provide service and support for the field offices in some aspects of Social Security's workloads.

Tables 2.F1–2.F11 provide SSA administrative data on the agency's national workforce (**Tables 2.F1–2.F3**), claims workloads (**Tables 2.F4–2.F6**), delivery of services (**Table 2.F7**), and its hearings and appeals operations (**Tables 2.F8–2.F11**).

Program Changes

Program changes occur through legislation or (in areas where authority is delegated to the Commissioner) through regulation.

Changes are often implemented in phases and often entail recurring annual changes beyond the initial enactment date or year of first implementation. Rather recent changes with a significant and recurring impact are discussed below.

Elimination of Annual Earnings Test for Persons Reaching Full Retirement Age

Public Law 106-182, the Senior Citizen's Freedom to Work Act of 2000, enacted April 7, 2000, eliminated the earnings test beginning with the month a beneficiary attains full retirement age (FRA). Elimination of this earnings test is effective for taxable years ending after December 31, 1999.

The earnings limit that applies in the year of attainment of FRA is based on the limits previously established for persons at FRA through age 69—\$30,720 in 2003, and \$31,080 in 2004. Benefits are withheld at the rate of \$1 for every \$3 of earnings above these exempt amounts. In determining earnings for purposes of the annual earnings test under this legislation, only earnings before the month of attainment of FRA will be considered. The legislation also permits retired workers to earn delayed retirement credits for any months between the attainment of full retirement age and age 70 for which the worker requests that benefits not be paid.

Public Law 106-182 did not change the annual exempt amount for beneficiaries who are under FRA throughout the year, which continued to be pegged to increases in the average wage. This amount increased from \$11,520 in 2003 to \$11,640 in 2004. Withholding for beneficiaries subject to this earnings test is at \$1 for each \$2 of earnings over the exempt amounts. Proposed rules were published August 25, 2003.

Work Incentives Improvement Act

The Ticket to Work and Work Incentives Improvement Act, Public Law 106-170, was enacted on December 17, 1999. This legislation provides major enhancements to SSA's programs that assist disabled beneficiaries who attempt to return to work. It provides beneficiaries more choices in vocational rehabilitation and other support services and offers expanded health care for beneficiaries who are no longer eligible for cash benefits due to work. Effective October 1, 2000, the Act offers extended Medicare coverage to beneficiaries who return to work and offers buy-in for Medicaid coverage. Beginning January 1, 2001, former beneficiaries may have their benefits resumed if the benefits were terminated because of work, if their work activity ends within 5 years of the month their benefits stopped, and if they are still disabled.

The Ticket to Work program was phased in nationally over a 3-year period. During the first phase in 2002, SSA distributed tickets in the following 13 states: Arizona, Colorado, Delaware, Florida, Illinois, Iowa, Massachusetts, New York, Oklahoma, Oregon, South Carolina, Vermont, and Wisconsin.

During the second phase, in November 2002 through September 2003, SSA distributed tickets in the following 20 states: Alaska, Arkansas, Connecticut, Georgia, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, South Dakota, Tennessee, and Virginia and in the District of Columbia.

During the third phase, in November 2003 through September 2004, SSA is distributed tickets in the following 17 states: Alabama, California, Hawaii, Idaho, Maine, Maryland, Minnesota, Nebraska, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Washington, West Virginia, Wyoming, as well as in American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

Regulatory Increases in Substantial Gainful Activity and in Trial Work Period Amounts

Effective July 1, 1999, the Social Security Administration raised from \$500 to \$700 the amount of monthly earnings for a nonblind disabled individual to be considered engaging in substantial gainful activity (SGA). Effective January 1, 2001, the top SGA level was raised to \$740 per month, with the provision that ongoing SGA levels will be automatically adjusted annually on the basis of increases in the national average wage index. Effective January 1, 2004, the level is \$810 per month.

The SGA threshold is part of the definition of disability that requires an individual to be unable to engage in substantial gainful activity to be eligible for benefits. Earnings of more than the top SGA level will ordinarily demonstrate that an individual is engaged in SGA. Earnings of less than \$810 per month will ordinarily demonstrate that an individual is not engaged in SGA.

A different definition of SGA applies to blind persons receiving Social Security disability benefits. Increases in the SGA amount for blind individuals have long been pegged to increases in the national average wage index and thus were not affected by the 1999 or subsequent rule changes. The level for blind individuals increased from \$1,330 in 2003 to \$1,350 in 2004.

New rules also affect the trial work period (TWP). The TWP allows disability beneficiaries to test their ability to work for at least 9 months. During the TWP, beneficiaries may earn any amount and still receive full benefits. The monthly level at which earnings count toward the 9-month TWP was raised from \$200 to \$530 effective January 1, 2001, with future increases pegged to the national average wage index. The level is \$580 for 2004. After completion of 9 trial work months, the SGA level is used to determine whether earnings are substantial or not. If earnings fall below the SGA level, full benefits generally continue. If earnings are higher than the SGA level, cash benefits are usually suspended while medical benefits continue.

Table 2.A30 provides related historical data on disability program earnings guidelines, including reference to recent changes in thresholds for determining SGA.

Prohibitions on Payment of Title II Benefits to Persons Not Authorized to Work in the United States

The Social Security Protection Act (SSPA) of 2004, Public Law 108-203, was signed into law on March 2, 2004. Under section 211 of this legislation, certain noncitizen workers must meet additional requirements to be fully or currently insured and to establish entitlement to benefits based on the noncitizen's earnings. This law applies to Title II benefits and Medicare based on end-stage renal disease (ESRD).

Section 211 of the SSPA applies to a noncitizen worker whose Social Security number (SSN) was first assigned on or after January 1, 2004. A noncitizen worker must meet one of the following additional requirements to be fully or currently insured and to establish entitlement to any Title II benefit or end-stage renal disease (ESRD) Medicare based on the noncitizen worker's earnings:

1. The noncitizen worker must have been issued an SSN for work purposes at any time on or after January 1, 2004; or
2. The noncitizen worker must have been admitted to the United States at any time as a nonimmigrant visitor for business (B-1) or as an alien crewman (D-1 or D-2).

If a noncitizen worker whose SSN was originally assigned January 1, 2004, or later does not meet either of these additional requirements, then the worker is not fully or currently insured. This is true even if the noncitizen worker appears to have the required number of quarters of coverage (QCs) in accordance with the regular insured status provisions. Although this law applies directly to certain noncitizen workers, it also affects the entitlement of any person seeking a benefit on the record of a noncitizen who is subject to this law.

Coverage and Financing

In 2004, about 154 million persons will work in employment or self-employment covered under the OASDI program. In recent years, coverage has become nearly universal for work performed in the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Approximately 96 percent of the American workforce are covered by OASDI. Workers excluded from coverage fall into five major categories:

1. Civilian federal employees hired before January 1, 1984,
2. Railroad workers (who are covered under the railroad retirement system, which is coordinated with Social Security),
3. Certain employees of state and local governments who are covered under their employers' retirement systems,
4. Domestic workers and farm workers whose earnings do not meet certain minimum requirements (workers in industry and commerce are covered regardless of the amount of earnings), and
5. Persons with very low net earnings from self-employment, generally under \$400 annually.

Table 2.A1 outlines the history of coverage provisions and **Table 2.A2** provides a history of provisions regarding noncontributory wage credits, mostly for military service.

For most employees, taxes are withheld from wages beginning with the first dollar earned. The exceptions are domestic employees, election workers, and agricultural workers. In 2004, a domestic employee must earn \$1,400 from any single employer in a calendar year before FICA is withheld. Most election workers must earn \$1,200 in 2004 before FICA is withheld. Most agricultural workers wages are covered if the employer pays more than \$2,500 in total wages in a year or if the individual worker earns over \$150 in a year from a single employer.

Employees, their employers, and the self-employed each pay taxes on earnings in covered employment and self-employment up to an annual maximum taxable amount for OASDI. There is no upper limit on taxable earnings for Medicare Hospital Insurance (HI). The OASDI maximum taxable amount—\$87,900 in 2004—is updated automatically each year in relation to increases in the national average annual wage. The current FICA tax rate applicable to both employees and employers is 6.2 percent for OASDI (5.30 percent for OASI and 0.9 percent for DI) and 1.45 percent for HI.

See **Table 2.A3** for annual amounts of maximum taxable earnings and contribution rates. **Table 2.A4** shows historical annual maximum amounts of contributions by employees and self-employed persons.

A self-employed person pays the combined employee-employer rate of 12.4 percent for OASDI and 2.9 percent for HI under the Self-Employment Contributions Act (SECA). Two deduction provisions reduce the SECA and income tax liability of self-employed persons. The intent of these provisions is to treat the self-employed in much the same manner as employees and employers are treated for purposes of FICA and income taxes. The first provision allows a deduction from net earnings from self-employment equal to the amount of net earnings before the deduction multiplied by one-half the SECA tax rate. The effect of this deduction is intended to be analogous to the treatment of the FICA tax paid by the employer, which is disregarded as remuneration to the employee for FICA and income tax purposes. The second provision allows an income tax deduction equal to one-half of the amount of the SECA tax paid, which is designed to reflect the income tax deductibility of the employer's share of the FICA tax.

Table 2.A5 describes income tax credits for 1984–1989 intended to cushion the impact of increases in FICA and SECA taxes enacted in 1983. The SECA tax credits were replaced, effective 1990, by the deduction provisions described above. **Table 2.A6** outlines the history of provisions regarding appropriations from general revenues and interfund borrowing.

Insured Status

To become eligible for his or her benefit and benefits for family members or survivors, a worker must earn a minimum number of credits based on work in covered employment or self-employment. These credits are described as quarters of coverage. In 2004, a quarter of coverage (QC) is credited for each \$900 in annual covered earnings, up to a maximum of four QCs for the year. Earnings of \$3,600 or more in 2004 will give the worker four QCs regardless of when the money is actually earned or paid during the year. The amount of earnings required for a QC is adjusted automatically each year in proportion to increases in the average wage level.

Fully Insured

Eligibility for most types of benefits requires that the worker be fully insured. To be fully insured a worker must have a number of QCs at least EQUAL to the number of calendar years elapsing between age 21 (or 1950 if later) and the year in which he or she reaches age 62, becomes disabled, or dies—whichever occurs first. Under this requirement, workers who reach age 62 in 1991 or later need the maximum number of 40 QCs to be fully insured. For workers who become disabled or die before age 62, the number of QCs needed for fully insured status depends on their age at the time the worker becomes disabled or dies. A minimum of 6 QCs is required regardless of age.

In addition to earning the minimum number of credits based on work, if the worker is a noncitizen whose SSN was first assigned on or after January 1, 2004, he or she must meet one of the following additional requirements to become eligible for his or her benefit and benefits for family members or survivors:

1. The noncitizen worker must have been issued an SSN for work purposes at any time on or after January 1, 2004; or
2. The noncitizen worker must have been admitted to the United States at any time as a nonimmigrant visitor for business (B-1) or as an alien crewman (D-1 or D-2).

Currently Insured

If a worker dies before achieving fully insured status, benefits can still be paid to qualified survivors if the worker was "currently insured" at the time of death. Survivors benefits are potentially payable to a worker's children and to a widow(er) with the deceased worker's children in care.) To be currently insured, the worker must have earned 6 QCs in the 13 quarters ending with the

quarter of death (that is, 6 of the last 13 quarters, including the quarter in which death occurred).

Disability Insured

To qualify for disability benefits, a nonblind worker must have recent work activity as well as being fully insured. Under the test involving recent work experience, a nonblind worker who becomes age 31 or older must have earned at least 20 QCs among the 40 calendar quarters ending with the quarter in which the disability began. In general, workers disabled at ages 24 through 30 must have earned QCs in one-half of the calendar quarters elapsing between age 21 and the calendar quarter in which the disability began. Workers under age 24 need 6 QCs in the 12-quarter period ending with the quarter of disability onset. Workers who qualify for benefits based on blindness need only be fully insured. Special rules may apply if the worker had a prior period of disability.

Table 2.A7 summarizes the basic provisions concerning insured status.

International Agreements

The President is authorized to enter into international Social Security agreements (also called "totalization" agreements) to coordinate the U.S. Old-Age, Survivors, and Disability Insurance (OASDI) program with comparable programs of other countries. The United States currently has Social Security agreements in effect with 20 countries.

Social Security agreements and supplementary agreements, by effective dates

Australia	2002	Italy	1978, 1986
Austria	1991, 1997	Korea (South)	2001
Belgium	1984	Luxembourg	1993
Canada	1984, 1997	Netherlands	1990, 2003
Chile	2001	Norway	1984, 2003
Finland	1992	Portugal	1989
France	1988	Spain	1988
Germany	1979, 1988, 1996	Sweden	1987
Greece	1994	Switzerland	1980, 1989
Ireland	1993	United Kingdom	1985, 1997

International Social Security agreements have two main purposes. First, they eliminate dual Social Security coverage, the situation that occurs when a person from one

country works in another country and is required to pay Social Security taxes to both countries on the same earnings. Each agreement includes rules that assign a worker's coverage to only one country.

The second goal of the agreement is to help fill gaps in benefit protection for workers who have divided their careers between the United States and another country. Such workers may fail to qualify for Social Security benefits from one or both countries because they have not worked long enough to meet minimum eligibility requirements. Under an agreement, these workers and their family members may qualify for a partial U.S. benefit based on "totalized" (that is, combined) credits from both countries. Similarly, workers may qualify for partial benefits from the foreign country based on totalized credits.

Table 5.M1 shows the number of beneficiaries receiving totalization payments and their average benefits.

Benefit Computation and Automatic Adjustment Provisions

PIA Computation

The primary insurance amount (PIA) is the monthly benefit amount payable to the worker upon retirement at full retirement age or upon entitlement to disability benefits. The PIA is also the base figure from which monthly benefit amounts payable to the worker's family members or survivors are determined. The PIA is derived from the worker's annual taxable earnings, averaged over a period that encompasses most of the worker's adult years. Until the late 1970s, the average monthly wage (AMW) was the earnings measure generally used. For workers first eligible for benefits after 1978, average indexed monthly earnings (AIME) have replaced the AMW as the usually applicable earnings measure. The PIA computation based on AIME currently involves the following three steps:

1. Indexing of earnings. The worker's annual taxable earnings after 1950 are updated, or indexed, to reflect the general earnings level in the indexing year—the second calendar year before the year in which the worker is first eligible; that is, first reaches age 62, becomes disabled, or dies. Earnings in years after the indexing year are not indexed but instead are counted at their actual value. A worker's earnings for a given year are indexed by multiplying them by the following ratio (indexing factor): the average wage in the national economy for the indexing year,

divided by the corresponding average wage figure for the year to be indexed.

Table 2.A8 shows the indexing factors applicable to the earnings of workers who were first eligible from 1991 through 2004. **Table 2.A9** shows indexed earnings for workers first eligible from 1997 through 2004 who had maximum taxable earnings in each year after 1950. For a detailed description of an AIME computation, see Appendix D, "Computing a Retired-Worker Benefit."

2. Determining AIME. The period used to calculate AIME equals the number of full calendar years elapsing between age 21 (or 1950, if later) and the year of first eligibility, usually excluding the lowest 5 years. Workers disabled before age 47 have from zero to 4 excluded years from the computation. At an absolute minimum, 2 years are used to compute AIME. The actual years used in the computation (the "computation years") are the years of highest indexed earnings after 1950, including any years before age 22 or after age 61 as well as the year of disability or death. AIME is calculated as the sum of indexed earnings in the computation period, divided by the number of months in that period.

Table 2.A10 provides a historical outline of provisions related to AIME and AMW and describes variations in the number of dropout years.

Tables 2.A15 and **2.A16** describe AMW benefit computations based on the worker's nonindexed earnings after 1936 and 1950, respectively. (Very few persons currently being awarded benefits have PIAs computed under these old-start or new-start computation methods. These methods, particularly the new-start method shown in Table 2.A16, are more frequently applicable in earnings recomputations for workers who reached age 62 before 1979.)

3. Computing the PIA. The formula used to compute the PIA from AIME is weighted to provide a higher PIA-to-AIME ratio for workers with comparatively low earnings. The formula applies declining percentage conversion rates to three AIME brackets. For workers who reach age 62, become disabled, or die in 2004, the formula provides a PIA equal to the sum of
90 percent of the first \$612 of AIME, plus
32 percent of the next \$3,077 of AIME, plus
15 percent of AIME over \$3,689.

Beginning with the first year of eligibility, the PIA is increased by cost-of-living adjustments (COLAs).

Table 2.A11 shows the PIA formula and first applicable COLA for workers first eligible in 1979 or later.

The dollar amounts defining the AIME brackets are referred to as "bend points." These bend points (as described in Table 2.A11) are updated automatically each year in proportion to increases in the national average wage level. This automatic adjustment ensures that benefit levels for successive generations of eligible workers will keep up with rising earnings levels, thereby assuring consistent rates of earnings replacement from one generation of beneficiaries to the next.

The benefit formula applicable to a worker depends on the year of eligibility (or death) rather than on the year benefits are first received. Thus the PIA of a worker retiring at FRA in 2004 is calculated using the benefit formula that applies to all workers first eligible in 2000 (the "year of attainment" of age 62). The PIA derived from that formula is then increased by the COLAs effective for December 2001, 2002, and 2003 to obtain the PIA effective at FRA. Subsequent recomputations of the worker's benefit, including additional earnings not originally considered, delayed retirement credits, or additional COLA increases, all refer to the basic computation that originally applied, based on the year of attainment.

Beginning in 1981, benefits have been rounded to the next lower 10 cents at each step in the computation. The final benefit payment is rounded to the next lower dollar amount (if not already an even dollar). Before 1981, benefits were paid in 10-cent increments after rounding up to the next dime in each computation step.

A cost-of-living increase in benefits generally is established each year if the consumer price index for urban wage earners and clerical workers (CPI-W), prepared by the Department of Labor, indicates a percentage increase (after rounding) of at least 0.1 percent between two specified quarters. The arithmetical mean of the CPI-W for July, August, and September in the year of determination is compared with the arithmetical mean of the CPI-W for the later of (a) July, August, and September in the year in which the last effective cost-of-living increase was established or (b) the 3 months of the calendar quarter in which the effective month of the last general benefit increase occurred. The percentage increase in the CPI-W, rounded to the nearest 0.1 percent, represents the size of the increase in benefits, effective for December of the year in which the determination is made.

Under certain conditions, depending on the size of the combined OASDI trust funds relative to estimated disbursements, the applicability and size of a cost-of-living adjustment may be determined under an alternative method, called the "stabilizer provision." In no case, however, are benefits reduced below the level of benefits in the year of determination. Historically, this provision has never been triggered.

Table 2.A18 presents a history of provisions relating to the automatic adjustment of benefits, including a description of the stabilizer provision. In addition, the table includes a summary history and description of provisions relating to the annual automatic adjustment of (1) the maximum amount of taxable and creditable earnings, (2) the dollar amount needed to establish a quarter of coverage, (3) the bend points defining the AIME brackets in the PIA formula and the PIA brackets in the maximum family benefit formula, and (4) the exempt amounts under the earnings (retirement) test. All of these adjustments are linked to increases in the level of the national average annual wage, rather than to increases in the CPI. **Table 2.A19** illustrates the cumulative effect of statutory and automatic increases in benefits for workers who have been in benefit status over varying time periods.

Alternative PIA Computation Provisions

Special minimum PIA. Workers with low earnings but steady attachment to the workforce over most of their adult years may qualify for monthly benefits based on the special minimum PIA computation. This computation does not depend on the worker's average earnings, but on the number of coverage years—years in which the worker had earnings equal to or above a specified amount. The level of the special minimum PIA is the same for workers having the same number of coverage years, regardless of age or year of first eligibility. Increases in the special minimum PIA are linked to cost-of-living adjustments (COLAs).

See **Table 2.A12** for additional information on the special minimum PIA.

Windfall Elimination Provision (WEP). The WEP affects persons who receive a pension based on noncovered work after 1956 and Social Security benefits. First eligibility for the noncovered pension and Social Security benefits must be after December 31, 1985, for WEP to apply. WEP reduces the Social Security PIA upon which OASDI benefits are based and affects all benefits paid on that record, except survivors. The WEP reduction ceases when entitlement to the pension payment ends, the wage earner dies, or the wage earner earns a total of 30 years

of substantial Social Security earnings. The WEP reduction amount is never more than one-half of the noncovered pension.

A WEP PIA is generally based on 40 percent of the first bend point instead of 90 percent as with the regular PIA:

Example: A retired worker with a noncovered pension of \$2,000 a month and less than 20 years of covered employment attains age 62 in 2004.

Normal PIA, based on AIME of \$800.

$$\$612 \times .90 = \$550.80$$

$$\$188 \times .32 = \$60.16$$

$$\text{PIA} = \$610.90$$

WEP PIA, based on AIME of \$800.

$$\$612 \times .40 = \$244.80$$

$$\$188 \times .32 = \$60.16$$

$$\text{PIA} = \$304.90$$

If a worker has more than 20 years of substantial covered earnings, the WEP PIA begins to increase. With the 21st year of substantial covered earnings, the first bend point percentage is increased by 5 percentage points. This rate of increase applies for each additional year of substantial covered earnings, through the 30th year of substantial earnings at which point WEP no longer applies. After 23 years of substantial coverage, for example, the first bend point percentage would be 55 percent. Thirty years of substantial earnings would yield a first bend point percentage of 90 percent (the normal percentage of the first bend point).

Examples of pensions subject to WEP are U.S. Civil Service Retirement System annuities, retirement benefits based on foreign earnings, and state and local pensions based on noncovered earnings.

Table 2.A11.1 provides more detail about the WEP computation and contains the amounts of substantial earnings for years after 1990. Substantial earnings for earlier years are listed in **Table 2.A12**.

Family maximum provisions. Monthly benefits payable to the worker and family members or to the worker's survivors are subject to a maximum family benefit amount. The family maximum level for retired-worker families or survivor families usually ranges from 150 percent to 188 percent of the worker's PIA. The maximum benefit for disabled-worker families is the smaller of (1) 85 percent of AIME (or 100 percent of PIA, if larger) or (2) 150 percent of the PIA.

Like the formula for determining the PIA, the maximum family benefit formula applicable to a worker depends on the year of first eligibility (that is, the year of attainment of age 62, onset of disability, or death). Once the worker's maximum family benefit amount for the year of first eligibility is determined, it is updated in line with the COLAs.

For information on family maximum provisions, as described here, see **Table 2.A13** (comparison of family maximums to the PIAs on which they are based) and **Table 2.A14** (disability family maximums). **Table 2.A17** shows the maximum family benefit amounts applicable in cases of first eligibility before 1979.

Benefit Types and Levels

Retired and Disabled Workers

The full retirement age (FRA) is the earliest age at which an unreduced retirement benefit is payable (sometimes referred to as the "normal retirement age"). The age for full retirement benefits is scheduled to rise gradually from age 65 to age 67, with the first incremental increase affecting workers who reached age 62 in the year 2000. Workers over age 62 who retire before FRA can receive reduced benefits. The monthly rate of reduction from the full retirement benefit (that is, the PIA) is 5/9 of 1 percent a month for the first 36 months immediately preceding FRA. The reduction rate is 5/12 of 1 percent a month for any additional months. The maximum overall reduction for early retirement will have risen from 20 percent to 30 percent for those workers who reach age 62 in 2022, when age 67 becomes the full retirement age.

If a disabled worker receives a reduced retirement benefit for months before disability entitlement, the disability benefit is reduced by the number of months for which he or she received the reduced benefit.

For workers who postpone their retirement beyond the full retirement age, benefits are increased for each month of nonpayment beyond that age up to age 70. This increase is called a "delayed retirement credit," and is potentially available for any or all months following attainment of the full retirement age (maximum of 60 months for persons who attained age 65 prior to 2003). The annual rate of increase for delayed retirement credits is 7 percent for workers who reach age 62 in 2002 and 7 1/2 percent for workers who reach age 62 in 2003 and 2004. The rate will rise to 8 percent for workers reaching age 62 in 2005 or later.

Spouses and Children of Workers

Spouses receive 50 percent of the worker's PIA (regardless of the worker's actual benefit amount), if the spouse has attained the full retirement age at entitlement to spousal benefits. The spouse of a retired or disabled worker can elect monthly benefits as early as age 62. These benefits are reduced at the rate of 25/36 of 1 percent a month for the first 36 months immediately preceding FRA and 5/12 of 1 percent for each additional month. The maximum overall reduction for early retirement will have risen from 25 percent to 35 percent by 2022, when age 67 becomes the full retirement age (FRA) for spouses attaining age 62 in that year.

Children of retired or disabled workers are also eligible to receive monthly benefits. The term "child" refers to a child under the age of 18, a child aged 18 to 19 attending elementary or secondary school full-time, or an adult child aged 18 or older who was disabled before age 22. In addition, young spouses (that is, those under the age of 62) who care for a worker's entitled child may also be eligible. For purposes of defining young spouses' benefits, the term "child" refers to a child under age 16 or to an adult child of the worker who was disabled before age 22. Children of retired or disabled workers can receive up to 50 percent of the worker's PIA, as can young spouses. (The benefit of a young spouse is not reduced for age.) Monthly benefits payable to the spouse and children of a retired or disabled worker are limited to a family maximum amount, as discussed earlier.

Benefits are payable to unmarried divorced spouses of retirement age who were married at least 10 years to the worker. A divorced spouse benefit is excluded from family maximum provisions. Divorced spouses aged 62 and older and divorced for 2 or more years (after marriage of 10 or more years) may be independently entitled on the record of the ex-spouse if the ex-spouse could be entitled if he or she applied.

Survivors Benefits

Widows and widowers of fully insured workers are eligible for unreduced benefits at full retirement age (FRA). As with retired workers and spouses, widow(er)s' FRA will gradually increase to age 67. Widows and widowers can elect reduced monthly benefits at age 60 or, if disabled, as early as age 50. Surviving divorced spouses can also receive benefits if married to the worker for at least 10 years and not remarried before age 60 (age 50 if disabled).

For survivors whose full benefit retirement age is 65, the monthly rate of reduction for the first 60 months immediately preceding FRA is 19/40 of 1 percent of the worker's PIA, with a maximum reduction of 28.5 percent

at age 60. For survivors whose full benefit retirement age is after 65, the amount of reduction for each month prior to FRA is adjusted accordingly to ensure that the maximum reduction at age 60 remains 28.5 percent of the worker's PIA.

Benefits for widows and widowers are increased if the deceased worker delayed retirement beyond the FRA. In these cases, the survivor benefits include any delayed retirement credits the deceased worker had earned. Conversely, if the worker had elected early retirement, widow(er)s' benefits are limited for widow(er)s first entitled to survivors benefits at age 62 or later. For these beneficiaries, the benefit is the higher of 82.5 percent of the worker's PIA or the amount the worker would be receiving if still alive. Disabled widow(er)s aged 50 to 60 receive the age 60 widow's rate (71.5 percent of PIA) regardless of their age at the time of entitlement.

Children of deceased workers and mothers and fathers under FRA are eligible to receive monthly benefits up to 75 percent of the worker's PIA if the worker died either fully or currently insured. Mothers and fathers must be caring for the worker's entitled child who is either under age 16 or disabled. A dependent parent aged 62 or older is eligible for monthly benefits equal to 82.5 percent of the worker's PIA. Each of two dependent parents can qualify for benefits equal to 75 percent of the deceased worker's PIA. Monthly benefits payable to survivors are reduced to conform to the family maximum benefit payable on the deceased worker's account. Benefits for a surviving divorced spouse, however, are disregarded when computing the maximum family benefit.

See **Table 2.A20** for more information on the increases in the full (or normal) retirement age for workers. **Table 2.A21** describes age-related reductions for dependent beneficiaries, as does **Table 2.A22** (widow(er)s). Additionally, **Tables 2.A23** and **2.A24** show the history of legislation relating to special monthly benefits payable to certain persons born before January 2, 1900. **Table 2.A25** summarizes the history of certain OASDI benefits other than monthly benefit payments. **Table 2.A26** presents illustrative monthly benefit amounts for selected beneficiary families, based on hypothetical earnings histories representing five different earnings levels. **Table 2.A27** shows minimum and maximum monthly benefits payable to retired workers retiring at age 62 in various years beginning with 1957 (the first full year benefits became available at age 62). **Table 2.A28** shows minimum and maximum monthly benefits payable to retired workers retiring at age 65 in various years beginning with 1940.

Provisions for Railroad Retirement Board Beneficiaries

The OASDI tables do not include a number of persons receiving Railroad Retirement benefits who would be eligible for Social Security benefits had they applied. The reason they have not applied is that receipt of a Social Security benefit would reduce their Railroad Retirement benefit by a like amount. The number of persons is not available but is estimated to be less than 100,000.

The Railroad Retirement Act of 1974, effective January 1, 1975, provided that the regular annuity for employees with 10 or more years of railroad service who retired after December 31, 1974, will consist of two components.

Public Law 107-90 (the 2001 amendments to the Railroad Retirement Act of 1974) effective January 1, 2002, revised the railroad service work requirement. The railroad service work requirement is 10 or more years of railroad service or, effective January 1, 2002, at least 5 years of railroad service after December 31, 1995. The two components are unchanged:

- Tier 1. A basic Social Security–level component equivalent to what would be paid under the Social Security Act on the basis of the employee's combined railroad and nonrailroad service, reduced by the amount of any monthly benefit under OASDI actually paid on the basis of nonrailroad work; and
- Tier 2. A "private pension"–component payable over and above the Social Security equivalent, calculated on the basis of the number of years of railroad service.

Effect of Current Earnings on Benefits

Beneficiaries under the full retirement age (FRA) with earnings in excess of certain exempt amounts may have all or part of their benefits withheld as a result of the annual earnings test (AET) provisions of the Social Security Act. For those at or above FRA, however, there have been recent changes to AET provisions. Amendments in 1996 eased the impact of AET provisions, while changes in 2000 removed the AET altogether for beneficiaries FRA or older. Public Law 104-121, enacted March 29, 1996, substantially raised the exempt amounts under the annual earnings test for persons who have reached full retirement age. These amounts are \$12,500 in 1996; \$13,500 in 1997; \$14,500 in 1998; \$15,500 in 1999; \$17,000 in 2000; \$25,000 in 2001; and \$30,000 in 2002. After 2002, the annual exempt amount is indexed to the growth in average wages. The indexed amount was \$30,720 in 2003 and \$31,080 in 2004. Benefits are withheld at the rate of \$1 in benefits for every \$3 of earnings

above the FRA exempt amount. Public Law 106-182, enacted April 7, 2000, eliminated the earnings test beginning with the month a beneficiary reaches FRA. In determining annual earnings for purposes of the annual earnings test, only earnings before the month of attainment of FRA will be counted.

Public Laws 104-121 and 106-182 did not change the annual exempt amount for beneficiaries who are under FRA throughout the year. This annual amount continues to be pegged to increases in average wages. The amount was \$11,520 in 2003 and \$11,640 in 2004. When the annual earnings limit affects working beneficiaries under FRA, benefits are withheld at the rate of \$1 for every \$2 of earnings above the exempt amount.

Individuals have the option to receive reduced benefits under a monthly earnings test if it is to their advantage to do so. This option is usually exercised in the first year of retirement, because in that year the monthly test permits payment for some months even if the annual earnings limit is greatly exceeded. Under the monthly test, beneficiaries receive a full monthly benefit for months in which they do not earn more than an amount equal to 1/12 of the annual earnings limit. The monthly earnings test is applied to the self-employed based on hours they work instead of monthly earnings. Generally, beneficiaries are eligible for the monthly earnings test in only one year.

Table 2.A29 provides historical detail on the retirement test.

Beneficiaries entitled on the basis of their own disability—disabled workers, disabled adult children, and disabled widow(er)s—are not subject to the earnings test. Substantial earnings by disabled beneficiaries, however, may indicate that they are able to do work that constitutes substantial gainful activity (SGA) and are therefore no longer disabled. Although other factors are considered, numerical earnings thresholds are used in a determination of SGA.

Table 2.A30 provides historical thresholds for determining substantial gainful activity (SGA).

Taxation of Benefits

Up to 85 percent of Social Security benefits may be subject to federal income tax depending on the beneficiary's income, marital status, and filing status. The definition of income for this provision is as follows: adjusted gross income (before Social Security or Railroad Retirement benefits are considered), plus tax-exempt interest income, with further modification of adjusted gross income in some cases involving certain tax provisions of limited applicability among the beneficiary population, plus one-half of Social Security and Tier 1 Railroad Retirement benefits.

For married beneficiaries filing jointly with adjusted gross income under \$32,000 a year, no Social Security benefits are subject to taxation. If adjusted gross income exceeds \$32,000 but is under \$44,000, the amount of benefits included in gross income is the lesser of one-half of benefits or one-half of income over \$32,000. If a couple's adjusted gross income exceeds \$44,000, the amount of benefits included in gross income is 85 percent of income over \$44,000 plus the lesser of \$6,000 or one-half of benefits. However, no more than 85 percent of benefits are subject to income tax. The income thresholds for single beneficiaries are \$25,000 and \$32,000.

If members of a married couple are filing separately, they do not have a minimum threshold if they lived together any time during the tax year. The amount of benefits included in gross income is the lesser of 85 percent of Social Security or Tier 1 Railroad Retirement benefits, or 85 percent of all income as defined above. Like all matters dealing with tax liability, taxation of Social Security benefits fall under the jurisdiction of the Internal Revenue Service.

Table 2.A31 shows the history of provisions related to taxation of Social Security benefits. **Table 2.A32** offers examples to illustrate when benefits are taxable and the amount subject to taxation.

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Supplemental Security Income

Program Overview

The Supplemental Security Income (SSI) program provides income support to persons aged 65 or older, blind or disabled adults, and blind or disabled children. Eligibility requirements and federal payment standards are nationally uniform. The 2004 federal SSI benefit rate for an individual living in his or her own household and with no other countable income is \$564 monthly; for a couple (with both husband and wife eligible), the SSI benefit rate is \$846 monthly.

Payments under SSI began in January 1974. It replaced the former federal-state adult assistance programs in the 50 states and the District of Columbia. Under SSI each eligible person is provided a monthly cash payment based on a statutory federal benefit rate. Since 1975, these rates have been increased by the same percentage, as the cost-of-living increases in OASDI benefits. If an individual or couple is living in another person's household and is receiving both food and shelter from the person in whose household they are living, the federal benefit rate is reduced by one-third. This is done instead of determining the actual dollar value of the in-kind support and maintenance.

For institutionalized persons, the eligibility requirements and payment standards depend on the type of institution. With some exceptions, inmates of public institutions are ineligible for SSI. For persons institutionalized for a complete calendar month, a maximum federal SSI payment of \$30 per month applies where (1) the institution receives a substantial part of the cost of the person's care from the Medicaid program, or (2) the institution receives payments from private health insurance on behalf of a recipient under age 18. Other eligible persons in institutions may receive up to the full federal benefit rate.

The federal payment is based on the individual's countable income. The first \$20 monthly in OASDI benefits or other earned or unearned income is not counted. Also excluded is \$65 monthly of earnings plus one-half of any earnings above \$65. For example, a person living in his or her own household, whose sole income is a \$200 monthly OASDI benefit, would receive \$384 in federal SSI payments:

$$\$564 - (\$200 - \$20) = (\$564 - \$180) = \$384.$$

A person whose income consists of \$500 in gross monthly earnings would receive \$356.50 in federal SSI payments:

$$((\$500 - \$85) / 2) = \$207.50 \text{ countable earnings}$$

$$\text{FBR } \$564 - \$207.50 = \$356.50 \text{ federal SSI}$$

Individuals generally are not eligible for SSI if they have resources in excess of \$2,000 (or \$3,000 for a couple). Certain resources are excluded, most commonly a home, an automobile, and household goods and personal effects of reasonable value. States have the option to supplement the federal SSI payment for all or selected categories of persons, regardless of previous state program eligibility.

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SSI: History Of Provisions

Basic Eligibility Requirements

1972 (Public Law 92-603, enacted October 30). An individual may qualify for payments on the basis of age, blindness, or disability.

Aged: Any person aged 65 or older.

Blind: Any person with 20/200 or less vision in the better eye with the use of correcting lenses, or with tunnel vision of 20 degrees or less. An individual transferred from a state Aid to the Blind (AB) program is eligible if he/she received such state aid in December 1973 and continues to meet the October 1972 state definition of blindness.

Disabled: Any person unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months. For a child under age 18, eligibility is based on disability of severity comparable with that of an adult. An individual transferred from a state Aid to the Permanently and Totally Disabled (APTD) program to SSI is also eligible if he/she received such state aid in December 1973 and continues to meet the October 1972 state definition of disability.

1973 (Public Law 93-233, enacted December 31). Only persons who had received APTD before July 1973 and were on the rolls in December 1973 may receive SSI on the basis of the state definition of disability; those who became eligible for state aid from July to

December 1973 must meet the federal definition of disability.

1980 (Public Law 96-265, enacted June 9). A disabled recipient who loses federal SSI eligibility because of earnings at the substantial gainful activity level may continue to receive a special benefit under section 1619 and retain eligibility for Medicaid under Title XIX of the Social Security Act. This special benefit status may continue as long as the recipient has the disabling impairment and meets all nondisability SSI eligibility criteria. States have the option of supplementing this special benefit.

This provision of the law was in effect from January 1, 1981, through December 31, 1983. Beginning in January 1984, under a 1-year demonstration project, this provision was continued for persons already eligible for either regular SSI payments or special monthly benefits.

1984 (Public Law 98-460, enacted October 9). The special benefit and Medicaid provisions of the 1980 legislation were extended through June 30, 1987 (retroactive to January 1, 1984).

1986 (Public Law 99-643, enacted November 10). The special benefit and Medicaid provisions of the 1980 amendments are made permanent. The provisions were amended effective July 1, 1987, with significant modifications to simplify administration and to allow free movement between regular SSI disability payments and either the special cash benefit or Medicaid eligibility under section 1619. The distinction between a disabled person eligible for regular SSI payments and one eligible for 1619(a) is that the latter has several months with gross earnings above the SGA level. Previously, section 1619(a) status required completion of a trial work period and the determination that the work was SGA.

1996 (Public Law 104-193, enacted August 22). For individuals under age 18, the “comparable severity” standard is eliminated and replaced with a requirement that a child be considered disabled if he/she has a medically determinable impairment that results in “marked and severe functional limitations,” and meets the existing statutory duration requirement. The law also eliminates references to “maladaptive behaviors” in the Listing of Impairments for children, and discontinues the use of individualized functional assessments for children.

SSI eligibility is prohibited for an individual in any month during which such an individual is a fugitive felon, fleeing prosecution, or violating state or federal conditions of probation or parole. In addition, SSI eligibility is prohibited for 10 years for those convicted of fraudulently claiming residence to obtain benefits simultaneously in two or more states.¹

Other Eligibility Provisions

Citizenship and Residence

1972 (Public Law 92-603, enacted October 30). The individual must reside within one of the 50 states or the District of Columbia and be a citizen or an alien lawfully admitted for permanent residence or permanently residing in the United States under color of law. Persons living outside the United States for an entire calendar month lose their eligibility for such a month.

1976 (Public Law 94-241, enacted March 24). Eligibility for SSI is extended to residents of the Northern Mariana Islands, effective January 9, 1978.

1980 (Public Law 96-265, enacted June 9). The income and resources of the immigration sponsors of aliens applying for SSI are considered in determining eligibility for and the amount of payment. After allowances for the needs of the sponsor and his/her family, the remainder is deemed available for the support of the alien applicant for a 3-year period after admission to the United States for permanent residence. This provision does not apply to those who become blind or disabled after admission, to refugees, or to persons granted political asylum. (See section “Deeming of Income and Resources” for subsequent changes to sponsor-to-alien deeming provisions.)

1989 (Public Law 101-239, enacted December 19). SSI eligibility is continued for a disabled or blind child who was receiving SSI benefits while living in the United States and is now living with a parent who is a member of the U.S. Armed Forces assigned to permanent duty ashore outside the United States, but not where the parent is stationed in Puerto Rico or the territories and possessions of the United States.

1993 (Public Law 103-66, enacted August 10). Above provision made applicable where the parent is a member of the U.S. Armed Forces and stationed in Puerto Rico or the territories and possessions of the United States.

1996 (Public Law 104-193, enacted August 22). Prohibits SSI eligibility for anyone who is not a U.S. citizen or national unless they are in a “qualified alien” category and meet one of certain exceptions such as lawful permanent residents who earn or can be credited with 40 qualifying quarters of earnings, certain refugee type categories eligible for up to 5 years of time-limited eligibility, or active duty U.S. military or veter-

1. This last provision was repealed in 1999 by Public Law 106-169 and replaced with a provision providing for nonpayment of benefits for up to 24 months for knowingly making false or misleading statements regarding material facts.

ans and their spouses and children. Extends eligibility for aliens receiving SSI as of August 22, 1996, (the enactment date of the law) for 1 year after the enactment date for those aliens found ineligible under the new standards.

(Public Law 104-208, enacted September 30). Amends Public Law 104-193 to add to the list of “qualified aliens” certain noncitizens (and their children) who have been battered or subjected to extreme cruelty by a spouse or parent or a member of the spouse’s or parent’s family living in the same household.

1997 (Public Law 105-18, enacted June 12). Extends eligibility for aliens receiving SSI as of August 22, 1996, until September 30, 1997, for those found ineligible under the new alien standards of Public Law 104-193.

(Public Law 105-33, enacted August 5). Further amends Public Law 104-193 to add Cuban and Haitian entrants, and the child of a parent who has been battered or subjected to extreme cruelty, to the list of qualified aliens. Provides that Cuban and Haitian entrants and Amerasian immigrants qualify for time-limited eligibility, and increases the time limit from 5 to 7 years for all time-limited categories. Additional exceptions are added for qualified aliens: (1) lawfully residing in the United States and receiving SSI benefits on August 22, 1996; and (2) lawfully residing in the United States on August 22, 1996, and meeting the definition of blind or disabled in the Social Security Act.

Certain noncitizen American Indians are excepted from the alien nonpayment provisions of Public Law 104-193.

Extends eligibility for “nonqualified aliens” receiving SSI as of August 22, 1996, until September 30, 1998.

1998 (Public Law 105-306, enacted October 28). Permanently extends eligibility of all remaining “nonqualified aliens” who were receiving SSI benefits when Public Law 104-193 was enacted on August 22, 1996.

2000 (Public Law 106-386, enacted October 28). Noncitizens, regardless of their immigration status, may be eligible for SSI to the same extent as refugees, if they are determined to be victims of “severe forms of trafficking in persons.”

2004 (Public Law 108-203, enacted March 2). Extends SSI eligibility to blind or disabled children who are U.S. citizens living with a parent assigned to permanent U.S. military duty outside of the United States and who were not receiving SSI benefits when living in the United States. Previously, only blind or dis-

abled children who received an SSI benefit for the month before the parent reported for permanent duty abroad were eligible. Effective April 2004 for applications filed after enactment.

Other Benefits

1980 (Public Law 96-272, enacted June 17). SSI applicants and recipients are not required as a condition of eligibility to elect to receive Veterans Administration pensions under the Veterans and Survivors’ Pension Improvement Act of 1978 if the state of residence lacks a medically needy program under Title XIX.

Drug Addiction and Alcoholism (DA&A)

1972 (Public Law 92-603, enacted October 30). Any disabled individual who has been medically determined to be an alcoholic or drug addict must accept appropriate treatment, if available, in an approved facility and demonstrate compliance with conditions and requirements for treatment.

SSI payments are required to be made through a representative payee—another person or public or private agency designated by SSA to manage the recipient’s benefit on his/her behalf.

1994 (Public Law 103-296, enacted August 15). Any individual who is receiving SSI based on a disability where drug addiction or alcoholism is a contributing factor material to the finding of disability must comply with the DA&A treatment requirements. The individual must accept appropriate treatment when it is available and comply with the conditions and terms of treatment. Instances of noncompliance with the requirements result in progressively longer payment suspensions. Before payments can resume, the individual must demonstrate compliance for specific periods; 2 months, 3 months, and 6 months, respectively, for the first, second, third, and subsequent instances of noncompliance. An individual who is not in compliance with the DA&A treatment requirements for 12 consecutive months shall not be eligible for payments; however, this does not prevent such individuals from reapplying and again becoming eligible for payments.

SSI disability payments based on DA&A are also limited to a total of 36 benefit months (beginning March 1995) regardless of whether appropriate treatment is available. Months for which benefits are not due and received do not count towards the 36-month limit.

Payments based on DA&A must be made to a representative payee. Preference is required to be given to community based nonprofit social service agencies and federal, state, or local government agencies

in representative payee selection. These agencies when serving as payees for individuals receiving payments based on DA&A may retain the lesser of 10 percent of the monthly benefit or \$58 (indexed to the consumer price index [CPI]) as compensation for their services.

Establishment of one or more referral and monitoring agencies for each state is required.

1996 (Public Law 104-121, enacted March 29). An individual is not considered disabled if DA&A is a contributing factor material to a finding of disability.

Applies DA&A representative payee requirements enacted under Public Law 103-296 to disabled SSI recipients who have a DA&A condition and are incapable of managing their benefits. In addition, these recipients shall be referred to the appropriate state agency administering the state plan for substance abuse treatment.

Institutionalization

1972 (Public Law 92-603, enacted October 30). An individual who is an inmate of a public institution is ineligible for SSI payments unless the institution is a facility approved for Medicaid payments and is receiving such payments on behalf of the person. Under *regulations*, the Medicaid payment must represent more than 50 percent of the cost of services provided by the facility to the individual.

1976 (Public Law 94-566, enacted October 20). An inmate of a publicly operated community residence serving no more than 16 persons may, if otherwise eligible, receive SSI.

1983 (Public Law 98-21, enacted April 20). Payments may be made to persons who are residents of public emergency shelters for the homeless for a period of up to 3 months in any 12-month period.

1986 (Public Law 99-643, enacted November 10). Effective July 1, 1987, disabled or blind recipients who were receiving special SSI payments or had special SSI recipient status under section 1619 in the month preceding the first full month of institutionalization, may receive payments based on the full federal benefit rate for the initial 2 full months of institutionalization, if they reside in certain public medical, psychiatric, or Medicaid facilities or in private Medicaid facilities.

1987 (Public Law 100-203, enacted December 22). Effective January 1, 1988, payments may be made to persons who are residents of public emergency shelters for the homeless, for up to 6 months in a 9-month period.

Effective July 1, 1988, continued payment of SSI benefits for up to 3 months is permitted, at the rate that was applicable in the month prior to the first full month of institutionalization, for individuals whose expected institutional stay on admission is not likely to exceed 3 months, as certified by a physician, and for whom the receipt of benefits is necessary to maintain living arrangements to which they may return.

1996 (Public Law 104-193, enacted August 22). Effective December 1996, institutionalized children under age 18 whose private health insurance is making payments to the institution may receive no more than \$30 per month in federal SSI.

Vocational Rehabilitation and Treatment

1972 (Public Law 92-603, enacted October 30). Blind or disabled individuals receiving federal SSI benefits who are under age 65 must be referred to the state agency providing services under the Vocational Rehabilitation Act and must accept the services offered. States are reimbursed for the cost of services.

1976 (Public Law 94-566, enacted October 20). Blind or disabled children under age 16 must be referred to the state agency administering crippled children's services or to another agency designated by the state. States are reimbursed for the cost of services.

Of funds provided for these services, at least 90 percent must be used for children under age 6 or for those who have never attended public schools.

1980 (Public Law 96-265, enacted June 9). Disabled SSI recipients who medically recover while enrolled in approved vocational rehabilitation programs of state VR agencies may continue to receive benefits during their participation in such programs if the Commissioner of Social Security determines that continuation in the program will increase the probability that they leave the rolls permanently.

1981 (Public Law 97-35, enacted August 13). Funding no longer provided under Title XVI for medical, social, developmental, and rehabilitative services to disabled or blind children.

Reimbursement for the cost of rehabilitation services will only be made if the services result in the recipient's return to work for a continuous period of 9 months. The work must be at the substantial gainful activity earnings level.

1984 (Public Law 98-460, enacted October 9). Authorizes the reimbursement of states for the cost of VR services provided to individuals who (1) continue to receive benefits after medical recovery because they are participating in a state VR program or (2) refuse,

without good cause, to continue in or cooperate with the VR program in which they had been participating.

1987 (Public Law 100-203, enacted December 22).

Extends the provision for continuation of payments to disabled SSI recipients who have medically recovered while enrolled in an approved vocational rehabilitation program to include blind SSI recipients.

1990 (Public Law 101-508, enacted November 5). Reimbursement authorized for the cost of vocational rehabilitation services provided in months in which the individual was not receiving federal SSI payments, if

- SSI recipient status for Medicaid eligibility purposes was retained under work incentive provisions, or
- Benefits were in suspense² status (for a reason other than cessation of disability or blindness), or
- Federally administered state supplementation was received.

Extends benefit continuation provision to disabled SSI recipients who medically recover while participating in a nonstate VR program.

1999 (Public Law 106-170, enacted December 17).

Establishes a Ticket to Work and Self-Sufficiency program that will provide SSI (and OASDI) disability beneficiaries with a ticket that can be used to obtain vocational rehabilitation services, employment services, or other support services, from an employment network (EN) of their choice.

An EN chooses one of the two EN payment options at the time it submits an application to SSA to become an EN. The chosen payment system will apply to all beneficiaries served. An EN can elect to receive payment under the:

- Outcome payment system, under which it can receive payment for up to 60 outcome payment months; or
- Outcome-milestone payment system, under which it can receive payment for up to four milestones in addition to outcome payments. These milestones must occur before the EN enters the first month for which it is eligible for an outcome payment. Four milestone payments plus 60 months of reduced outcome payments equal 85 percent of the total that would be available if the EN chose the outcome payment system.

The four milestones are based on gross earnings exceeding the substantial gainful activity level for specified months. An outcome payment month is any

month in which SSA does not pay any federal disability cash benefits to a beneficiary because of work or earnings.

Also eliminates the requirement that blind or disabled SSI recipients aged 16 through 64 be referred to the state VR agency and accept the services offered.

Continuing Disability Reviews and Eligibility Redeterminations

1994 (Public Law 103-296, enacted August 15). During each of fiscal years 1996, 1997, and 1998, requires SSA to conduct continuing disability reviews (CDRs) on a minimum of 100,000 SSI recipients. In addition, during the same period, requires SSA to redetermine the SSI eligibility of at least one-third of all child SSI recipients who reach age 18 after April 1995 during the 1-year period following attainment of age 18. Redeterminations for persons turning age 18 could count toward the 100,000 CDR requirement.

1996 (Public Law 104-193, enacted August 22). Repeals the requirement that SSA redetermine the eligibility of at least one-third of all child SSI recipients who reach age 18 after April 1995 during the 1-year period following attainment of age 18.

Requires a CDR

- At least once every 3 years for SSI recipients under age 18 who are eligible by reason of an impairment that is likely to improve, and
- Not later than 12 months after birth for recipients whose low birth weight is a contributing factor material to the determination of their disability.

Requires eligibility redetermination for all child SSI recipients eligible for the month before the month in which they attain age 18.

Requires redetermination of eligibility for children considered disabled based on an individual functional assessment and/or consideration of maladaptive behavior.

Requires the representative payee of a child SSI recipient whose continuing eligibility is being reviewed to present evidence that the recipient is receiving treatment that is considered medically necessary and available for the condition which was the basis for providing SSI benefits.

1997 (Public Law 105-33, enacted August 5). Modifies provision of Public Law 104-193 to extend from 12 to 18 months the period for redetermining the disability of children under age 18 under the new childhood disability standard.

Modifies provision of Public Law 104-193 to permit SSA to schedule a CDR for a disabled child for whom

2. Recipients who have lost eligibility for SSI benefits for fewer than 13 consecutive months are in suspended payment status.

low birth weight is a contributing factor material to the determination of disability, at a date after the child's first birthday if the Commissioner determines the impairment is not expected to improve within 12 months of the child's birth.

Modifies provision of Public Law 104-193 to provide SSA the authority to make redeterminations of disabled childhood recipients who attain age 18, more than 1 year after the date such recipient attains age 18.

1999 (Public Law 106-170, enacted December 17). Prohibits the initiation of a CDR during the period that a recipient is "using a ticket" under the Ticket to Work program.

Deeming of Income and Resources

1972 (Public Law 92-603, enacted October 30). Deeming occurs when the income and resources of certain family members living in the same household with the SSI recipient are considered in determining the amount of the SSI payment. These family members are the ineligible spouse of an adult recipient and the ineligible parents of a child recipient under age 21.

After deduction of personal allocations for the spouse (or parents) and for ineligible children in the home, and after application of income exclusions, any remaining income of the spouse (or parents) is added to the income of the eligible person.

1980 (Public Law 96-265, enacted June 9). Children aged 18 or older are not subject to parental deeming.

Sponsor's income and resources deemed to an alien for 3 years.

1989 (Public Law 101-239, enacted December 19). Disabled children receiving home care services under state Medicaid programs, who are ineligible for SSI because of deeming of parental income, and who received SSI benefits limited to \$30 while in a medical treatment facility, may receive the \$30 monthly allowance that would be payable if the recipient were institutionalized.

1993 (Public Law 103-152, enacted November 24). Sponsor-to-alien deeming period extended from 3 years to 5 years, effective January 1, 1994, through September 30, 1996.

Considers an ineligible spouse or parent who is absent from the household because of active military service to be a member of the household for deeming purposes.

1996 (Public Law 104-193, enacted August 22). Deeming of income and resources from an immigration sponsor to a noncitizen continues until citizenship, with exceptions for those who earn, or can be cred-

ited with, 40 qualifying quarters of earnings. Effective for those whose sponsor signs a new legally enforceable affidavit of support.

(Public Law 104-208, enacted September 30). Amends Public Law 104-193 to add two exceptions to the sponsor-to-alien deeming:

- Provides that if the noncitizen is indigent and would be unable to obtain food and shelter without SSI benefits even after receiving support from the sponsor, then only the amount of income and resources actually provided by the sponsor will be counted for a 12-month period after a determination of indigence; and
- Provides that in certain cases, deeming would not apply for a 12-month period (with some options for extension) if the noncitizen (or his/her children) has been battered or subjected to extreme cruelty by family members.

1997 (Public Law 105-33, enacted August 5). Amends Public Law 104-208 to add an additional exception to sponsor-to-alien deeming when the parent of a noncitizen has been battered or subjected to extreme cruelty by family members.

Federal Benefit Payments

Federal Benefit Rates

Basic benefit standards are used in computing the amount of federal SSI payments. Benefit levels differ for individuals and couples living in households and for persons in Medicaid institutions. Individuals or couples living in their own households receive the full federal benefit. If an individual or couple is living in another person's household and receiving support and maintenance there, the federal benefit is reduced by one-third. The federal benefit rates for persons in households are increased annually to reflect increases in the cost of living. Legislation affecting the level of federal benefit rates since the inception of the SSI program are summarized in Table 2.B1.

Windfall Offset

1980 (Public Law 96-265, enacted June 9). Offset (by reduction of retroactive Social Security benefits) to prevent persons whose initial OASDI payment is retroactive from receiving more in total benefits than if they were paid the benefits when regularly due.

1984 (Public Law 98-617, enacted November 8). Offset provision expanded to allow for reduction of retroactive SSI benefits and to apply in cases of OASDI benefit reinstatement.

Proration of Benefit

1982 (Public Law 97-248, enacted September 3). Benefit for first month of eligibility to be prorated by the number of days in the month for which an application has been filed and there is eligibility.

1996 (Public Law 104-193, enacted August 22). Changes the effective date of an SSI application to the first day of the month following the date on which the application was filed or on which the individual first becomes eligible, whichever is later. This, in effect, eliminates prorated payments in initial claims.

Retrospective Monthly Accounting

1981 (Public Law 97-35, enacted August 13). Changes the method of computing the SSI benefit to one under which the benefit amount is computed on a monthly basis and is based on income and other characteristics in the previous (or second previous) month.

1984 (Public Law 98-369, enacted July 18). Changes the method of computing the SSI benefit to persons receiving Title II payments. The effect of the increased Title II income at the time of the cost-of-living increase is not delayed as it otherwise would be.

1987 (Public Law 100-203, enacted December 22). Provides an exception to retrospective monthly accounting so that amounts received under Aid to Families with Dependent Children (AFDC), foster care, refugee cash assistance, Cuban-Haitian entrant assistance, or general and child welfare assistance provided by the Bureau of Indian Affairs are counted only in the month received.

1993 (Public Law 103-66, enacted August 10). Changes the method of computing the SSI benefit to persons receiving the value of the one-third reduction. The effect of the increased value at the time of the cost-of-living increase is not delayed as it otherwise would be. Effective January 1995.

2004 (Public Law 108-203, enacted March 2). Eliminates triple counting of one-time, nonrecurring income by providing that this income will be counted only for the month that the income is received and not for any other month during the transition to retrospective monthly accounting during the first 3 months of an individual's SSI eligibility. Effective April 2005.

Uncashed Checks

1981 (Public Law 97-35, enacted August 13). States that have federally administered supplements to be credited their share of SSI checks that remain unnegotiated for 180 days.

1987 (Public Law 100-86, enacted August 10). SSI checks now unnegotiable after 1 year. States are credited their share of SSI checks after 1 year rather than 180 days.

Rounding of Payment Amounts

1982 (Public Law 97-248, enacted September 3). Cost-of-living adjustments in the federal SSI benefit and income eligibility levels are to be rounded to the next lower whole dollar, after the adjustment is calculated. Subsequent cost-of-living adjustments will be calculated on the previous year's benefit standard before rounding.

Penalties Resulting in Nonpayment of Benefits for False or Misleading Statements

1999 (Public Law 106-169, enacted December 14). Provides for the nonpayment of OASDI and SSI benefits (6, 12, and 24 months, respectively, for the first, second, and third or subsequent violations) for individuals found to have knowingly made a false or misleading statement of material fact for use in determining eligibility for benefits.

2004 (Public Law 108-203, enacted March 2). Expands the administrative sanction of nonpayment of benefits to situations where an individual has failed to disclose material information, if the person knew or should have known that such failure was misleading.

Authorizes federal courts to order a defendant convicted of defrauding Social Security, Special Veterans' Benefits, or SSI to make restitution to SSA. Restitution funds would be deposited to the trust funds or General Fund of the Treasury, as appropriate. Effective with respect to violations occurring on or after the date of enactment.

Exclusions from Income

General Exclusions

1972 (Public Law 92-603, enacted October 30). The first \$60 of earned or unearned income per calendar quarter for an individual or couple; the next \$195 and one-half the remainder of quarterly earned income. Unearned income includes Social Security benefits, other government or private pensions, veterans' benefits, and workers' compensation.

1981 (Public Law 97-35, enacted August 13). The first \$20 of earned or unearned income per month for an individual or couple; the next \$65 and one-half the remainder of monthly earned income. Unearned income includes Social Security benefits, other government or private pensions, veterans' benefits, and workers' compensation.

2000 (Public Law 106-554, enacted December 21). Earnings of persons defined as Social Security statutory employees are treated as self-employment income for SSI purposes.

Special Exclusions

1972 (Public Law 92-603, enacted October 30). Any amount of tax rebate issued to an individual by any public agency that is based on either real property or food purchase taxes.

Grants, scholarships, and fellowships used to pay tuition and fees at an educational institution.

Income required for achieving an approved self-support plan for blind or disabled persons.

Work expenses of blind persons.

For blind persons transferred from state programs to SSI, income exclusions equal to the maximum amount permitted as of October 1972 under the state programs.

Irregularly or infrequently received income totaling \$60 or less of unearned income and \$30 of earned income in a calendar quarter.

Payment for foster care of ineligible child residing in recipient's home through placement by a public or private nonprofit child care agency.

One-third of any payment received from an absent parent for the support of a child eligible for SSI.

Certain earnings of a blind or disabled child under age 22 regularly attending an educational institution.

State or local government cash payments based on need and designed to supplement SSI payments.

1976 (Public Law 94-331, enacted June 30). Disaster assistance from income for 9 months and application of one-third reduction for 6 months for certain victims of disasters occurring between January 1, 1976, and December 31, 1976.

(Public Law 94-566, enacted October 20). Any assistance based on need (including vendor payments) made to or on behalf of SSI recipients, which is paid and wholly funded by state or local governments.

The value of assistance provided under certain federal housing programs.

1977 (Public Law 95-113, enacted September 29). Food stamps, federally donated food, and the value of free or reduced price food for women and children under the Child Nutrition Act and National School Lunch Act.

(Public Law 95-171, enacted November 12). Provisions for exclusions for support and maintenance

under the Disaster Relief and Emergency Assistance Act of 1974 extended on a permanent basis. Effective January 1, 1978.

1980 (Public Law 96-222, enacted April 1). Earned income tax credit treated as earned income (temporarily excluded from 1975 through 1980).

(Public Law 96-265, enacted June 9). Remunerations received in sheltered workshops and work activity centers are considered earned income and qualify for earned income exclusions.

Impairment-related work expenses paid by the individual (including cost for attendant care, medical equipment, drugs, and services necessary to control an impairment) are deducted from earnings when determining if an individual is engaging in substantial gainful activity. Impairment-related work expenses are excluded in calculating income for benefit purposes if initial eligibility for benefits exists on the basis of countable income without applying this exclusion.

1981 (Public Law 97-35, enacted August 13). Modifies provision under which irregularly or infrequently received income is excluded to conform to change from quarterly to monthly accounting; amounts excludable: \$20 or less of unearned income and \$10 of earned income in a month.

1982 (Public Law 97-377, enacted December 21). From December 18, 1982, to September 30, 1983, certain home energy assistance payments are excluded if a state agency certified that they are based on need.

1983 (Public Law 97-424, enacted January 6). Support or maintenance assistance (including home energy assistance) provided in kind by a nonprofit organization or in cash or in kind by certain providers of home energy is excluded if the state determines that the assistance is based on need. Provision is applicable through September 1984.

Certain home energy assistance payments are excluded if a state agency certified that the assistance is based on need. Provision is applicable through June 1985.

1984 (Public Law 98-369, enacted July 18). The 1983 provisions for support and maintenance and home energy assistance continue to October 1, 1987.

1986 (Public Law 99-498, enacted October 17). Educational assistance used for educational expenses under the Higher Education Act of 1965 as amended.

1987 (Public Law 100-203, enacted December 22). The 1983 provisions for support and maintenance and home energy assistance made permanent.

Excludes death payments (for example, proceeds from life insurance) from SSI income determinations to the extent they were spent on last illness and burial.

Modifies the 1982 resource exclusion for burial funds to extend the exclusion to any burial fund of \$1,500 or less maintained separately from all other assets, thereby allowing interest to be excluded from income if retained in the fund.

1988 (Public Law 100-383, enacted August 10). Restitution payments made to Japanese internees and relocated Aleutians.

1989 (Public Law 101-239, enacted December 19). Interest on agreements representing the purchase of an excluded burial space.

Payments from the Agent Orange Settlement.

Value of a ticket for domestic travel received as a gift and not cashed.

1990 (Public Law 101-508, enacted November 5). Earned income tax credit (including the child health insurance portion).

Payments received from a state-administered fund established to aid victims of crime.

Impairment-related work expenses excluded from income in determining initial eligibility for benefits.

Payments received as state or local government relocation assistance.

Payments received under the Radiation Exposure Compensation Act.

Redefines as earned income, royalties earned in connection with any publication of the individual's work and honoraria received for services rendered (previously defined as unearned income).

1993 (Public Law 103-66, enacted August 10). Hostile fire pay to members of the uniformed services.

Payments received as state or local government relocation assistance made permanent.

1994 (Public Law 103-286, enacted August 1). Payments to victims of Nazi persecution.

1998 (Public Law 105-285, enacted October 27). Funds made available to an SSI recipient by a state or local government or a nonprofit organization as part of the Individual Development Account demonstration project.

(Public Law 105-306, enacted October 28). In-kind gifts to children with life-threatening conditions by tax-exempt organizations not converted to cash.

The first \$2,000 annually of cash gifts by tax-exempt organizations to, or for the benefit of, individuals under age 18 with life-threatening conditions.

(Public Law 105-369, enacted November 12). Payments made under the Ricky Ray Hemophilia Relief Fund Act of 1998.

2000 (Public Law 106-554, enacted December 21). Interest on funds deposited in an individual development account.

Any adjustments made to prior payments from other federal programs to account for the error in the computation of the consumer price index during 1999.

2001 (Public Law 107-16, enacted June 7). The refundable child tax credit is excluded in determining eligibility for means-tested programs, including SSI.

2004 (Public Law 108-203, enacted March 2). Changes the calculation of infrequent and irregular income from a monthly to a quarterly basis.

Excludes from the determination of an individual's income all interest and dividend income earned on countable resources. Effective July 2004.

Permits the student earned income exclusion to apply to any individual under age 22 who is a student. Thus, students under age 22 who are married or heads of households would be eligible for the exclusion. Effective April 2005.

Excludes from the determination of income any gift to an individual for use in paying tuition or educational fees, just as grants, scholarships, and fellowships for such use are currently excluded from the determination of income. Effective June 2004.

Resources

1972 (Public Law 92-603, enacted October 30). Countable resources limited to \$1,500 or less for an individual and to \$2,250 or less for a couple.

1984 (Public Law 98-369, enacted July 18). Limit on countable resources raised by \$100 a year for individuals and \$150 a year for couples, beginning in calendar year 1985 through 1989. The respective limits would become \$2,000 for an individual and \$3,000 for a couple in 1989 and thereafter.

1999 (Public Law 106-169, enacted December 14). Includes generally in the countable resources of an individual the assets of a trust that could be used for the benefit of the individual or spouse.

General Exclusions

1972 (Public Law 92-603, enacted October 30). A home of reasonable value—established *by regulation* as

not exceeding a fair-market value of \$25,000 (\$35,000 in Alaska and Hawaii).

Personal effects and household goods of reasonable value established by *regulation* as not exceeding a total market value of \$1,500.

An automobile of reasonable value—established by *regulation* as not exceeding a market value of \$1,200.

An automobile may be excluded, regardless of value, if the individual's household uses it for employment or medical treatment or if it is modified to be operated by or for transportation of a handicapped person.

Life insurance with face value of \$1,500 or less.

1976 (Public Law 94-569, enacted October 20). The recipient's home, regardless of value, is excluded from consideration in determining resources.

1977 (Public Law 95-171, enacted November 12). Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 for 9 months following receipt.

1979. Reasonable value for an automobile increased by *regulation* to \$4,500 of current-market value; personal goods and household effects increased to \$2,000 of equity value.

1982 (Public Law 97-248, enacted September 3). The value, within prescribed limits, of a burial space for the recipient, spouse, and immediate family is excluded. In addition, \$1,500 each (less the value of already excluded life insurance and any amount in an irrevocable burial arrangement) may be set aside for the burial of the recipient and spouse.

1984 (Public Law 98-369, enacted July 18). The unspent portion of any retroactive Title II or Title XVI payment is excluded for 6 months following its receipt, and the individual must be given written notice of the time limit on the exclusion.

1985. *Regulations* permit exclusion, regardless of value, of an automobile needed for essential transportation or modified for a handicapped person. The \$4,500 current market value limit applies only if no automobile could be excluded based on the nature of its use.

1987 (Public Law 100-203, enacted December 22). Provides for suspension of the 1980 transfer of assets provision, in any month that it is determined that undue hardship would result.

Real property that cannot be sold for the following reasons: it is jointly owned; its sale would cause the other owner(s) undue hardship because of loss of housing; its sale is barred by a legal impediment; or the owner's reasonable efforts to sell have been unsuccessful.

Temporarily extends the 1984 exclusion of retroactive Title II and Title XVI benefits from 6 months to 9 months (the longer exclusion applies to benefits paid in fiscal years 1988 and 1989).

1988 (Public Law 100-707, enacted November 23). Removes the time limit for exclusion of disaster assistance.

2004 (Public Law 108-203, enacted March 2). Increases to 9 months and makes uniform the time period for excluding from resources amounts attributable to payments of past-due Social Security and SSI benefits and earned income and child tax credits. Effective for such payments received on or after the date of enactment.

Special Exclusions

1972 (Public Law 92-603, enacted October 30). Assets of a blind or disabled individual that are necessary to an approved plan of self-support.

Tools and other property essential to self-support (PESS), within reasonable limits. Shares of nonnegotiable stock in regional or village corporations held by natives of Alaska.

For persons transferred from state programs to SSI, resource exclusions equal to the maximum amount permitted as of October 1972 under the state program.

1988 (Public Law 100-383, enacted August 10). Restitution payments made to Japanese internees and relocated Aleutians.

1989 (Public Law 101-239, enacted December 19). Specifies that no limitation can be placed on property essential to self-support used in a trade or business, or by an individual as an employee (including the tools of a tradesperson and the machinery and livestock of a farmer).

Payments from the Agent Orange Settlement.

1990 (Public Law 101-508, enacted November 5). Earned income tax credit excluded for the month following the month the credit is received.

Payments received from a state-administered fund established to aid victims of crime excluded for a 9-month period. Individual not required to file for such benefits.

Payments received as state or local government relocation assistance excluded for a 9-month period. (The provision expired 3 years after its effective date.)

Payments received under the Radiation Exposure Compensation Act.

1993 (Public Law 103-66, enacted August 10). Makes permanent the 9-month exclusion of payments received as state or local government relocation assistance.

1994 (Public Law 103-286, enacted August 1). Payments to victims of Nazi persecution.

1996 (Public Law 104-193, enacted August 22). Dedicated financial institution accounts required to be established for large past-due benefits for disabled individuals under age 18 with a representative payee.

1998 (Public Law 105-285, enacted October 27). Funds made available to an SSI recipient by a state or local government or a nonprofit organization as part of the Individual Development Account demonstration project.

(Public Law 105-306, enacted October 28). In-kind gifts to children with life-threatening conditions by tax-exempt organizations not converted to cash.

The first \$2,000 annually of cash gifts by tax-exempt organizations to, or for the benefit of, individuals under age 18 with life-threatening conditions.

(Public Law 105-369, enacted November 12). Payments made under the Ricky Ray Hemophilia Relief Fund Act of 1998.

2000 (Public Law 106-554, enacted December 21). Funds deposited by an individual in an individual development account and the interest on those funds.

2001 (Public Law 107-16, enacted June 7). The refundable child tax credit in the month of receipt and in the following month.

2004 (Public Law 108-203, enacted March 2). Excludes grants, scholarships, fellowships, or gifts to be used for tuition or educational fees from an individual's countable resources for 9 months after the month of receipt.

Transfer-of-Assets Penalties

1980 (Public Law 96-611, enacted December 28). Assets transferred for less than fair market value for the purpose of establishing eligibility for benefits under the Social Security Act are counted as resources for 24 months after transfer.

1988 (Public Law 100-360, enacted July 1). Removes the transfer-of-assets penalty for transfers made July 1, 1988, or later.

1999 (Public Law 106-169, enacted December 14). Provides a penalty under the SSI program for the disposal of resources at less than fair market value. The penalty is a loss of benefits for up to 36 months. A

formula is provided to determine the number of months.

Presumptive and Emergency Payments and Interim Assistance Reimbursement

Presumptive Payments

1972 (Public Law 92-603, enacted October 30). A person applying on the basis of disability who meets all other criteria of eligibility, and is likely to be disabled, may receive payments for 3 months pending the disability determination.

1976 (Public Law 94-569, enacted October 20). Presumptive payment provision was extended to persons applying on the basis of blindness.

1990 (Public Law 101-508, enacted November 5). Extends the period for receipt of payments to 6 months.

Emergency Advance Payments

1972 (Public Law 92-603, enacted October 30). Any applicant who can be presumed to meet the criteria of eligibility, but has not yet been determined eligible, and who is faced with a financial emergency may receive an immediate cash advance of up to \$100.

1987 (Public Law 100-203, enacted December 22). Increases the maximum emergency advance payment amount to the maximum amount of the regular federal SSI monthly benefit rate plus, if any, the federally administered state supplementary payment.

1996 (Public Law 104-193, enacted August 22). Applicants who have a financial emergency may receive an emergency advance payment in the month of application, which, effective with this law, is always before the first month of eligibility. These advance payments are recouped by proportional reductions in the recipient's first 6 months of SSI benefits.

Interim Assistance Reimbursement

1974 (Public Law 93-368, enacted August 7). SSA may enter into agreements with the states to repay them directly for assistance payments made to an SSI applicant while his/her claim is being adjudicated. The repayment is made from the first check due to the individual. This legislation expires June 30, 1976.

1976 (Public Law 94-365, enacted July 14). The authority to repay the state for interim assistance is made permanent.

1987 (Public Law 100-203, enacted December 22). Extends interim assistance reimbursement to situations in which payments are made by states or political subdivisions to persons whose SSI payments

were suspended or terminated and who subsequently are found to be eligible for such benefits. Also clarifies that the payment from which the interim assistance reimbursement is paid must be the first payment of benefits relating to the interim period.

Medicaid Eligibility

1972 (Public Law 92-603, enacted October 30). States can provide Medicaid coverage to all recipients of SSI payments. Alternatively, they can limit coverage by applying more restrictive criteria from the state Medicaid plan in effect on January 1, 1972.

States can accept SSA determination of eligibility or make their own determination.

1976 (Public Law 94-566, enacted October 20). Preserves the Medicaid eligibility of recipients who become ineligible for cash SSI payments due to the cost-of-living increases in Social Security benefits.

1980 (Public Law 96-265, enacted June 9). Blind or disabled recipients under age 65 no longer eligible for either regular or special SSI payments because of their earnings may retain SSI recipient status for Medicaid eligibility purposes under the following conditions: (1) they continue to have the disabling impairment, (2) they meet all nondisability eligibility criteria except for earned income, (3) they would be seriously inhibited from continuing employment without Medicaid services, and (4) their earnings are insufficient to provide a reasonable equivalent of SSI payments and Medicaid.

In states that do not provide Medicaid coverage categorically to all SSI recipients, qualification for Medicaid benefits depends on the state's specific eligibility and program requirements.

The Medicaid provision of the 1980 legislation was in effect from January 1, 1981, through December 31, 1983. Under a 1-year demonstration project, beginning January 1, 1984, this provision was continued for persons already eligible for regular or special SSI payments or for retention of Medicaid eligibility.

1984 (Public Law 98-460, enacted October 9). Medicaid provision of 1980 legislation extended through June 30, 1987 (retroactive to January 1, 1984).

1986 (Public Law 99-272, enacted April 7). Restores Medicaid eligibility for some disabled widow(er)s who became ineligible for SSI when their Title II benefits increased in 1984 because of a change in the Social Security disabled widow(er)s benefits reduction factor.

1986 (Public Law 99-643, enacted November 10). The SSI recipient status for Medicaid eligibility provision of the 1980 amendments is made permanent.

Effective July 1, 1987, certain expenses are excluded from earnings when determining sufficiency of earnings to establish SSI recipient status eligibility for Medicaid purposes:

- Impairment-related work expenses of disabled persons,
- Work expenses of blind persons,
- Income required for achieving an approved self-support plan, and
- The value of publicly funded attendant care services.

Effective July 1, 1987, preserves the Medicaid eligibility of recipients who become ineligible for SSI payments because of entitlement to, or an increase in, Social Security disabled adult child benefits on or after the effective date.

Effective July 1, 1987, requires all states to provide Medicaid coverage for recipients in special SSI status (either receiving special SSI payments or in the special recipient status described for 1980) if they received Medicaid coverage the month before special SSI status.

1987 (Public Law 100-203, enacted December 22).

Effective July 1, 1988, restores or preserves the Medicaid eligibility of persons aged 60 or older who are eligible for Social Security benefits as widows or widowers (but not eligible for Medicare) and who become ineligible for SSI payments or state supplementation because of the receipt of old-age or survivors insurance benefits under Social Security.

1990 (Public Law 101-508, enacted November 5). Age limit for retention of SSI recipient status for Medicaid eligibility purposes (1980 and subsequent work incentive provisions, above) is eliminated.

Preserves the Medicaid eligibility of SSI recipients who become ineligible for payments when they become entitled to Social Security disabled widow(er)s benefits following the revised definition used for their disability.

1997 (Public Law 105-33, enacted August 5). Requires states to continue Medicaid coverage for disabled children who were receiving SSI payments as of August 22, 1996, and would have continued to be eligible for such payments except that their eligibility terminated because they did not meet the revised SSI childhood disability standard established under Public Law 104-193.

State Supplementation

1972 (Public Law 92-603, enacted October 30). States are given the option of providing supplementary pay-

ments both to recipients transferred from the state program and to those newly eligible for SSI.

States may either administer the payments themselves or have the Social Security Administration make payments on their behalf. When state supplementary payments are federally administered, the Social Security Administration makes eligibility and payment determinations for the state and assumes administrative costs.

“Hold harmless” protection, which limits a state’s fiscal liability to its share of expenditures for Old-Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled for calendar year 1972, is provided to states electing federal administration of their supplementary plans. This provision applies only to supplementary payments that do not, on the average, exceed a state’s “adjusted payment level.” (The adjusted payment level is the average of the payments that individuals with no other income received in January 1972; it may include the bonus value of food stamps. Adjustments are provided for payments that had been below state standards.)

1973 (Public Law 93-66, enacted July 9). Provides for mandatory state supplementation as assurance against reduction of income for persons who received state assistance in December 1973 and were transferred to SSI. These supplementary payments must equal the difference between (1) the amount of the state assistance payment that the individual received in December 1973 plus other income and (2) the individual’s federal SSI payment plus other income.

1976 (Public Law 94-585, enacted October 21). After June 30, 1977, when the federal SSI payment level is increased by a cost-of-living increase, such an increase will be excluded in calculating the “hold harmless” amount.

Requires states to maintain state supplementation payments at the level of December 1976 (“maintenance of payments”) or to continue to pay in supplements the same total annual amounts (“maintenance of expenditures”) when the federal SSI payment level is increased and thereby pass through any increases in federal benefits without reducing state supplements.

1982 (Public Law 97-248, enacted September 3). Begins a 3-year phase out of “hold harmless” protection. Effective with fiscal year 1985, Wisconsin and Hawaii (the only remaining “hold harmless” states) assumed the full cost of their supplementary payments.

1983 (Public Law 98-21, enacted April 20). Federal pass-through law is adjusted (1) by substituting the state supplementary payment levels in effect in

March 1983 for those in effect in December 1976 as the levels that states must maintain in complying with the pass-through requirements, and (2) with regard to the \$20 (individual) and \$30 (couple) increase in the federal SSI standard in July 1983, by requiring states to pass through only as much as would have been required if the SSI cost-of-living adjustment had been made in July 1983.

1987 (Public Law 100-203, enacted December 22). Provides for federal administration of state supplements to residents of medical institutions.

Provides for required pass through of \$5 increase in federal rate for persons whose care in institutions is paid in substantial part by Medicaid.

1993 (Public Law 103-66, enacted August 10). Requires states to pay fees for federal administration of their state supplementation payments. The fees are \$1.67 for each monthly supplementary payment in fiscal year 1994, \$3.33 in fiscal year 1995, and \$5.00 in fiscal year 1996. Fees for subsequent fiscal years will be \$5.00 or another amount determined by the commissioner to be appropriate. The commissioner may charge the states additional fees for services they request that are beyond the level customarily provided in administering state supplementary payments.

1997 (Public Law 105-33, enacted August 5). Revises the schedule of per-payment fees for federal administration of state supplementation for fiscal years 1998 (\$6.20) through 2002 (\$8.50) and provides a formula for determining the fee beyond fiscal year 2002.

1999 (Public Law 106-170, enacted December 17). A state that has an agreement with SSA to administer its supplementation payments must remit both payments and fees prior to the SSI payment date.

2000 (Public Law 106-554, enacted December 21). Changes the effective date of above provision from 2009 to 2001.

Overpayment Recovery

1984 (Public Law 98-369, enacted July 18). Limits the rate of recovering overpayments from monthly payments to the lesser of (1) the monthly payment or (2) 10 percent of a recipient’s monthly income. Permits a higher or lower adjustment at the request of the recipient subject to the agreement of the Commissioner. The limit does not apply if fraud, willful misrepresentation, or concealment of material information was involved on the part of the recipient or spouse in connection with the overpayment.

Waives recovery of certain overpayments due to amount of excess resources of \$50 or less.

Provides temporary authority for the recovery of overpayments from tax refunds.

1988 (Public Law 100-485, enacted October 13). Grants permanent authority to recover overpayments from tax refunds.

1998 (Public Law 105-306, enacted October 28). Authorizes SSA to collect SSI overpayments by offsetting Social Security benefits, with a maximum monthly offset of no more than 10 percent of the Social Security benefit.

1999 (Public Law 106-169, enacted December 14). Makes representative payees liable for an SSI overpayment caused by a payment made to a recipient who has died, and requires SSA to establish an overpayment control record under the representative payee's Social Security number.

Requires SSA to recover SSI overpayments from SSI lump-sum amounts by withholding at least 50 percent of the lump-sum payment or the amount of the overpayment, whichever is less.

Extends all of the debt collection authorities currently available for the collection of overpayments under the OASDI program to the SSI program.

2001 (Public Law 107-16, enacted June 7). Subjects one-time tax refund payments provided under this Act to overpayment recovery under tax refund offset provisions.

2004 (Public Law 108-203, enacted March 2). Provides for recovery of overpayment of SSI benefits by withholding from OASDI and Special Veterans' Benefits up to 100 percent of any underpayment of benefits and 10 percent of ongoing monthly benefits.

Also provides for recovery of overpayment of OASDI or Special Veterans' Benefits by withholding from SSI up to 100 percent of any underpayment of benefits but limits any recovery from SSI benefits to the lesser of 100 percent of the monthly benefit or 10 percent of the individual's total monthly income.

Effective with respect to overpayments that are outstanding at the time of enactment.

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Medicare

The following are brief summaries of complex subjects. They should be used only as overviews and general guides to the Medicare and Medicaid programs. The views expressed herein do not necessarily reflect the policies or legal positions of the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services (DHHS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.¹

Overview

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled," is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons aged 65 and over. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise noncovered aged persons who elect to pay a premium for Medicare coverage. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (Public Law 106-554) allowed persons with Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) to waive the 24-month waiting period.

Medicare has traditionally consisted of two parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), also known as Part B. A third part of Medicare, sometimes known as Part C, is the Medicare Advantage program, which was established as the Medicare+Choice program by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33) and subsequently renamed and modified by the Medicare Prescription Drug, Improvement, and Modernization

Act (MMA) of 2003 (Public Law 108-173). The Medicare Advantage program expands beneficiaries' options for participation in private-sector health care plans.

The MMA also established a fourth part of Medicare: a new prescription drug benefit, also known as Part D, beginning in 2004. Part D activities are handled within the SMI trust fund but in an account separate from Part B. It should thus be noted that the traditional treatment of "SMI" and "Part B" as synonymous is no longer accurate, since SMI now consists of Parts B and D. The purpose of the two separate accounts within the SMI trust fund is to ensure that funds from one part are not used to finance the other.

When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2004, almost 42 million are enrolled in either Part A or Part B or both parts of the Medicare program, and about 5 million of them have chosen to participate in a Medicare Advantage plan.

Coverage

Part A is generally provided automatically and free of premiums to persons aged 65 and over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in federal, state, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are entitled to Part A benefits. Part A coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly premium for their coverage. In 2003, Part A provided protection against the costs of hospital and specific other medical care to about 41 million people (35 million aged and 6 million disabled enrollees). Part A benefit payments totaled \$152.1 billion in 2003.

The following health care services are covered under Part A:

- Inpatient hospital care coverage includes costs of a semiprivate room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-

1. These summaries were prepared by Earl Dirk Hoffman Jr., Barbara S. Klees, and Catherine A. Curtis, Office of the Actuary, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244. The authors wish to express their gratitude to Mary Onnis Waid, who originated these summaries and diligently prepared them for many years before her retirement.

term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required of beneficiaries who are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).

- Skilled nursing facility (SNF) care is covered by Part A only if it follows within 30 days (generally) of a hospitalization of 3 days or more and is certified as medically necessary. Covered services are similar to those for inpatient hospital but also include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (described later), with a copayment required for days 21 through 100. Part A does not cover nursing facility care if the patient does not require skilled nursing or skilled rehabilitation services.
- Home health agency (HHA) care is covered by Parts A and B. The BBA transferred from Part A to Part B those home health services furnished on or after January 1, 1998, that are unassociated with a hospital or SNF stay. Part A will continue to cover the first 100 visits following a 3-day hospital stay or a SNF stay; Part B covers any visits thereafter. Home health care under Parts A and B has no copayment and no deductible.

HHA care, including care provided by a home health aide, may be furnished part-time by an HHA in the residence of a homebound beneficiary, if intermittent or part-time skilled nursing or certain other therapy or rehabilitation care or both is necessary. Certain medical supplies and durable medical equipment (DME) may also be provided, though beneficiaries must pay a 20 percent coinsurance for DME, as required under Part B of Medicare. There must be a plan of treatment and periodical review by a physician. Full-time nursing care, food, blood, and drugs are not provided as HHA services.

- Hospice care is a service provided to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program but does pay small coinsurance amounts for drugs and inpatient respite care.

An important Part A component is the benefit period, which starts when the beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by Part A during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61 through 90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, the beneficiary can elect to use days of Medicare coverage from a nonrenewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care. Copayments are also required for such additional days.

All citizens (and certain legal aliens) aged 65 and over, and all disabled persons entitled to coverage under Part A, are eligible to enroll in Part B on a voluntary basis by payment of a monthly premium. Almost all persons entitled to Part A choose to enroll in Part B. In 2003, Part B provided protection against the costs of physician and other medical services to about 38 million people (33 million aged and 5 million disabled). Part B benefits totaled \$123.8 billion in 2003.

Part B covers the following services and supplies:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists; also covered are the services provided by these Medicare-approved practitioners who are not physicians: certified registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or SNF), physician assistants, and nurse practitioners and clinical nurse specialists in collaboration with a physician;
- Services in an emergency room or outpatient clinic, including same-day surgery, and ambulance services;
- Home health care not covered under Part A;
- Laboratory tests, X-rays, and other diagnostic radiology services, as well as certain preventive care screening tests;
- Ambulatory surgical center services in a Medicare-approved facility;
- Most physical and occupational therapy and speech pathology services;
- Comprehensive outpatient rehabilitation facility services, and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it;

- Radiation therapy; renal (kidney) dialysis and transplants; heart, lung, heart-lung, liver, pancreas, and bone marrow transplants; and, as of April 2001, intestinal transplants;
- Approved DME for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, and casts; and
- Drugs and biologicals that cannot be self-administered, such as hepatitis B vaccines and immunosuppressive drugs (certain self-administered anticancer drugs are covered).

To be covered, all services must be either medically necessary or one of several prescribed preventive benefits. Part B services are generally subject to a deductible and coinsurance (see next section). Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical, speech, or occupational therapy services performed in settings other than hospitals), and higher cost-sharing requirements (such as those for outpatient treatments for mental illness).

Medicare Advantage (Part C) is an expanded set of options for the delivery of health care. Although all Medicare beneficiaries can receive their benefits through the original fee-for-service program, most beneficiaries enrolled in Parts A and B can choose to participate in a Medicare Advantage plan instead. Organizations that seek to contract as Medicare Advantage plans must meet specific organizational, financial, and other requirements. Following are the primary Medicare Advantage plans:

- Coordinated care plans, which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law; and
- Private, unrestricted fee-for-service plans, which allow beneficiaries to select certain private providers. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk nor does it vary payment rates based on utilization.

These Medicare Advantage plans are required to provide at least the current Medicare benefit package, excluding hospice services. Plans may offer additional covered services and are required to do so (or return excess payments) if plan costs are lower than the Medicare payments received by the plan.

Beginning in 2006, a new regional Medicare Advantage plan program will be established that allows regional coordinated care plans to participate in the Medicare Advantage program. Between 10 and 50 regions will be established, and plans wishing to participate must serve an entire region. There are provisions to encourage plan participation, and a fund will be established that can be used to encourage plan entry and limit plan withdrawals.

For individuals entitled to Part A or enrolled in Part B (except those entitled to Medicaid drug coverage), the new Part D initially provides access to prescription drug discount cards, at a cost of no more than \$30 annually. For low-income beneficiaries, Part D initially provides transitional financial assistance (of up to \$600 per year) for purchasing prescription drugs, plus a subsidized enrollment fee for the discount cards. This temporary plan, which began in mid-2004, will be phased out in 2006.

Beginning in 2006, Part D will provide subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of a premium, to individuals entitled to Part A or enrolled in Part B, with premium and cost-sharing subsidies for low-income enrollees. Beneficiaries may enroll in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage plan that offers Part D coverage. (Late enrollment penalties may apply under certain circumstances.)

Part D coverage includes most prescription drugs and biologicals approved by the Food and Drug Administration (FDA). (The specific drugs currently covered in Parts A and B will remain covered.) Part D coverage can consist of either standard coverage (defined later) or an alternative design that provides the same actuarial value. (However, the specific actuarial equivalence test leaves very little flexibility for plans to design alternative coverage.) For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.

To encourage employer and union plans to continue to offer prescription drug coverage to Medicare retirees, Part D also provides for certain subsidies to those plans that meet specific criteria.

It should be noted that some health care services are not covered by Medicare. Noncovered services include long-term nursing care, custodial care, and certain other health care needs, such as dentures and dental care, eyeglasses, and hearing aids. These services are not a part of the Medicare program, unless they are a part of a private health plan under the Medicare Advantage program.

Program Financing, Beneficiary Liabilities, and Provider Payments

All financial operations for Medicare are handled through two trust funds, one for HI (Part A) and one for SMI (Parts B and D). These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Program Financing

The HI trust fund is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by Part A and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The Part A tax rate is 1.45 percent of earnings, to be paid by each employee and a matching amount by the employer for each employee, and 2.90 percent for self-employed persons. Beginning in 1994, this tax is paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) The Part A tax rate is specified in the Social Security Act and cannot be changed without legislation.

Part A also receives income from the following sources: (1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries, (2) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily, (3) reimbursements from the general fund of the U.S. Treasury for the cost of providing Part A coverage to certain aged persons who retired when Part A began and thus were unable to earn sufficient quarters of coverage (and those federal retirees similarly unable to earn sufficient quarters of Medicare-qualified federal employment), (4) interest earnings on its invested assets, and (5) other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

The SMI trust fund differs fundamentally from the HI trust fund with regard to the nature of its financing. As previously noted, SMI is now composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The nature of the financing for both parts of SMI is similar, in that both parts are primarily

financed by beneficiary premiums and contributions from the general fund of the U.S. Treasury.

Part B is financed through premium payments (\$78.20 per month per beneficiary in 2005) and contributions from the general fund of the U.S. Treasury. (Penalties for late enrollment may apply.) Beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Therefore, the contributions from the general fund of the U.S. Treasury are the largest source of Part B income.

Similarly, in 2006, Part D will be financed primarily through premium payments and contributions from the general fund of the U.S. Treasury, with general fund contributions accounting for the largest source of Part D income, since beneficiary premiums are to represent, on average, 25.5 percent of the cost of standard coverage (as described in the next section). The premiums and general fund contributions for Part D will be determined separately from those for Part B. (In 2004 and 2005, the general fund of the U.S. Treasury will finance the transitional assistance benefit for low-income beneficiaries by providing funds to a transitional assistance account within the SMI trust fund. The proceeds will be transferred to the Part D account at the conclusion of the temporary program.)

The SMI trust fund also receives income from interest earned on its invested assets, as well as from a small amount of miscellaneous income. For Parts B and D each, beneficiary premiums and general fund payments are redetermined annually to match estimated program costs for the following year. (Beginning in 2007, the Part B premium will be increased for beneficiaries meeting certain income thresholds.)

Capitation payments to Medicare Advantage plans are financed from the HI trust fund and the Part B account within the SMI trust fund, in proportion to the relative weights of Parts A and B benefits to the total benefits paid by the Medicare program.

Beneficiary Payment Liabilities

Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of Parts A and B. These liabilities may be paid (1) by the Medicare beneficiary; (2) by a third party, such as an employer-sponsored retiree health plan or private Medigap insurance; or (3) by Medicaid, if the person is eligible. *Medigap*, or Medicare supplemental insurance, is sold by private insurance companies to pay, within limits, most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are

offered by Blue Cross and Blue Shield and various commercial health insurance companies.

For beneficiaries enrolled in Medicare Advantage plans, payment is based on the cost-sharing structure of the specific plan selected by the beneficiary since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. Such beneficiaries pay the monthly Part B premium and may, depending on the plan, pay an additional plan premium.

For hospital care covered under Part A, a beneficiary's fee-for-service payment includes a one-time deductible amount at the beginning of each benefit period (\$912 in 2005). This deductible covers part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments (\$228 per day in 2005) are required through day 90 of a benefit period. Each Part A beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments (\$456 per day in 2005) are required.

For skilled nursing care covered under Part A, Medicare fully covers the first 20 days of care in a benefit period. But for days 21 through 100, a copayment (\$115 per day in 2005) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing. Home health care requires no deductible or coinsurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first 3 pints or units of nonreplaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by Part A. Eligibility is generally earned through the work experience of the beneficiary or of the beneficiary's spouse. However, most aged people who are otherwise ineligible for premium-free Part A coverage can enroll voluntarily by paying a monthly premium, if they also enroll in Part B. For people with fewer than 30 quarters of coverage as defined by the Social Security Administration (SSA), the Part A monthly premium rate is \$375 in 2005; for those with 30 to 39 quarters of coverage, the rate is reduced to \$206. Voluntary coverage upon payment of the Part A premium, with or without enrolling in Part B, is also available to disabled individuals for whom cash benefits have ceased because of earnings in excess of those allowed for receiving cash benefits. (Penalties for late enrollment may apply.)

For Part B, the beneficiary's payment share includes the following: one annual deductible (\$110 in 2005),

monthly premiums, coinsurance payments for Part B services (usually 20 percent of the medically allowed charges), a deductible for blood, certain charges above the Medicare-allowed charge (for claims not on assignment), and payment for any services not covered by Medicare. For outpatient mental health treatment services, the beneficiary is liable for 50 percent of the approved charges.

For Part D, standard coverage in 2006 includes a \$250 deductible, with 25 percent coinsurance (or other actuarially equivalent amounts) for drug costs above the deductible and below an initial coverage limit of \$2,250. The beneficiary is then responsible for all costs until a \$3,600 out-of-pocket limit is reached. For higher costs, there is catastrophic coverage that requires enrollees to pay the greater of 5 percent coinsurance or a small copay (\$2 for generic or preferred brands and \$5 for any other drug). After 2006, these benefit parameters are indexed to the growth in per capita spending in Part D. When determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted. The exception to this provision is cost-sharing assistance from Medicare's low-income subsidies and from state Pharmacy Assistance programs. The monthly premiums required for Part D coverage are described in the previous section.

Provider Payments

Before 1983, Part A payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under PPS, a specific predetermined amount is paid for each inpatient hospital stay, which is based on each stay's diagnosis-related group (DRG) classification. In some cases the payment the hospital receives is less than the hospital's actual cost for providing Part A-covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays. Payments for skilled nursing care, home health care, inpatient rehabilitation, and long-term hospital care are made under separate prospective payment systems. Payments for psychiatric hospital care are currently reimbursed on a reasonable cost basis, but a prospective payment system is expected to be implemented in the near future, as required by the BBA.

For Part B, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of (1) the physician's actual charge, (2) the physician's customary charge, or (3) the prevailing charge for similar services in that locality. Beginning

January 1992, allowed charges were defined as the lesser of (1) the submitted charges or (2) the amount determined by a fee schedule based on a relative value scale (RVS). Payments for DME and clinical laboratory services are also based on a fee schedule. Most hospital outpatient services are reimbursed on a prospective payment system, and home health care is reimbursed under the same prospective payment system that is in place under Part A.

If a doctor or supplier agrees to accept the Medicare-approved rate as payment in full (“takes assignment”), then payments provided must be considered as payments in full for that service. The provider may not request any added payments (beyond the initial annual deductible and coinsurance) from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by Medigap insurance). Limits now exist on the excess that doctors or suppliers can charge. Physicians are “participating physicians” if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since Medicare beneficiaries may select their doctors, they have the option to choose those who participate.

Medicare payments to Medicare Advantage plans are based on a blend of local and national capitated rates, generally determined by the capitation payment methodology described in section 1853 of the Social Security Act. Actual payments to plans vary on the basis of demographic characteristics of the enrolled population. New “risk adjusters” based on demographics and health status are currently being phased in to better match Medicare capitation payments to the expected costs of individual beneficiaries. As previously mentioned, the Medicare Advantage program will undergo changes beginning in 2006. Plan bids will be replacing the current payment structure for Medicare Advantage plans.

For Part D, in 2006 and later, PDPs (including the prescription drug portion of Medicare Advantage plans) will pay for most FDA-approved prescription drugs and biologicals under the benefit structure described in the previous section. Plans may set up formularies for their prescription drug coverage, subject to statutory standards.

Claims Processing

Medicare’s Part A and Part B fee-for-service claims are processed by nongovernment organizations or agencies that contract to serve as the fiscal agent between providers and the federal government. These claims processors are known as intermediaries and carriers. They

apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare intermediaries process Part A claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. They also process outpatient hospital claims for Part B. Examples of intermediaries are Blue Cross and Blue Shield (which utilizes its plans in various states) and other commercial insurance companies. Intermediaries’ responsibilities include the following:

- Determining costs and reimbursement amounts,
- Maintaining records,
- Establishing controls,
- Safeguarding against fraud and abuse or excess use,
- Conducting reviews and audits,
- Making the payments to providers for services, and
- Assisting both providers and beneficiaries as needed.

Medicare carriers handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plans in a state, and various commercial insurance companies. Carriers’ responsibilities include the following:

- Determining charges allowed by Medicare,
- Maintaining quality-of-performance records,
- Assisting in fraud and abuse investigations,
- Assisting both suppliers and beneficiaries as needed, and
- Making payments to physicians and suppliers for services that are covered under Part B.

Claims for services provided by Medicare Advantage plans (that is, claims under Part C) are processed by the plans themselves.

Once Part D begins in earnest in 2006, plans will be responsible for claims processing, as is the case under Part C. However, there are a number of complex Part D claims processing provisions, and the administration of some of these provisions is not yet fully resolved. Future versions of the *Supplement* will address these issues as they unfold.

Quality improvement organizations (QIOs; formerly called peer review organizations, or PROs) are groups of practicing health care professionals who are paid by the federal government to generally oversee the care provided to Medicare beneficiaries in each state and to

improve the quality of services. QIOs educate other health care professionals and assist in the effective, efficient, and economical delivery of health care services to the Medicare population. The ongoing effort to combat monetary fraud and abuse in the Medicare program was intensified after enactment of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), which created the Medicare Integrity Program. Before this 1996 legislation, the Centers for Medicare & Medicaid Services (CMS) was limited by law to contracting with its current carriers and fiscal intermediaries to perform payment safeguard activities. The Medicare Integrity Program ensured that CMS had stable and increased funding for payment safeguard activities, as well as new authorities to contract with entities to perform specific payment safeguard functions.

Administration

The Department of Health and Human Services (DHHS) has the overall responsibility for administration of the Medicare program. Within DHHS, responsibility for administering Medicare rests with CMS. SSA assists, however, by initially determining an individual's Medicare entitlement, by withholding Part B premiums (and, beginning in 2006, Part D premiums) from the Social Security benefit checks, and by maintaining Medicare data on the Master Beneficiary Record, which is SSA's primary record of beneficiaries. The Internal Revenue Service in the Department of the Treasury collects the Part A payroll taxes from workers and their employers.

A Board of Trustees, composed of two appointed members of the public and four members who serve by virtue of their positions in the federal government, oversees the financial operations of the HI and SMI trust funds. The secretary of the Treasury is the managing trustee. Each year, around the first day of April, the Board of Trustees reports to Congress on the financial and actuarial status of the Medicare trust funds.

State agencies (usually state health departments under agreements with CMS) identify, survey, and inspect provider and supplier facilities and institutions wishing to participate in the Medicare program. In consultation with CMS, these agencies then certify the facilities that are qualified.

Data Summary

The Medicare program covers 95 percent of our nation's aged population, as well as many people who are on Social Security because of disability. In 2003, Part A covered about 41 million enrollees with benefit payments of \$152.1 billion, and Part B covered about 38 million enrollees with benefit payments of \$123.8 billion. Administra-

tive costs for Parts A and B were less than 2 percent of disbursements in 2003. Total disbursements for Medicare in 2003 were \$280.8 billion.

Note: Medicare enrollment data are based on estimates prepared for the 2004 annual report of the Medicare Board of Trustees to Congress (available on the Web at <http://www.cms.hhs.gov/publications/trusteesreport/>). Medicare benefits, administrative costs, and total disbursements for 2003 are actual amounts for the calendar year, as reported by the Department of the Treasury.

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Medicare: History of Provisions

This section is a summary of select Medicare provisions, based on general interest. It should be used only as a broad overview of the history of the provisions of the Medicare program. This section does not render any legal, accounting, or other professional advice and is not intended to explain fully all the provisions and exclusions of the relevant laws, regulations, and rulings of the Medicare program. Original sources of authority should be researched and utilized.

Insured Status

Entitlement to Medicare Part A (also known as Hospital Insurance, or HI) Benefits

- 1965.** Individual aged 65 or older entitled to monthly benefits under the Social Security or Railroad Retirement program, or aged 65 before 1968, or 3 quarters of coverage (QC) after 1965 and before attainment of age 65.
- 1967.** 3 QC for each year after 1966 and before attainment of age 65.
- 1972.** Disabled individual, under age 65, entitled to disability benefits for 24 consecutive months under the Social Security or Railroad Retirement program (excludes spouses and children of disabled individuals). Individual under age 65 who has end-stage renal disease (ESRD) and who is either fully or currently insured, or is entitled to monthly benefits under the Social Security or Railroad Retirement program, or is the spouse or dependent child of such an insured individual or beneficiary. Entitlement begins on the first day of the third month following the initiation of a course of renal dialysis and ends with the 12th month following the month in which either the dialysis terminates or the individual has a renal transplant.

Individual aged 65 or older enrolled in the Part B program who is not otherwise entitled to HI benefits, upon voluntary participation with payment of HI premium.

1980. Individual who would be entitled to monthly benefits under the Social Security or Railroad Retirement program if application were made.

Disabled individual under age 65 entitled to disability benefits for at least 24 months, not necessarily consecutive, under the Social Security or Railroad Retirement program.

Coverage extended for up to 36 months for disabled individuals whose disability continues, but whose monthly benefit ceased because they engaged in substantial gainful activity.

Second waiting period eliminated if a former disabled-worker beneficiary becomes entitled again within 5 years (7 years for disabled widows and widowers and disabled children aged 18 or older).

1982. Federal employees covered under HI based on QC for earnings as federal employees and/or based on deemed QC for earnings as federal employees before 1983.

1983. Employees of nonprofit organizations, effective January 1, 1984.

1986. Mandatory coverage for state and local government employees not covered under Social Security and hired after March 31, 1986.

1987. Second waiting period eliminated if a former disabled beneficiary becomes entitled again (no time limit).

1989. Disabled individuals under age 65 who are no longer entitled to Social Security disability benefits because their earnings exceeded the substantial gainful activity level have the option to purchase Medicare coverage by paying the HI and Supplementary Medical Insurance (SMI) Part B premiums.

2000. The 24-month waiting period (otherwise required for an individual to establish Medicare eligibility on the basis of a disability) is waived for persons with amyotrophic lateral sclerosis, effective July 1, 2001. The entitlement to Medicare begins with the first month of the Social Security Administration's determination of eligibility for Disability Insurance benefits.

Entitlement to Medicare Part B (also known as Supplementary Medical Insurance Part B Account, or SMI Part B) Benefits

1965. U.S. resident (citizen or lawfully admitted alien with 5 years continuous residence) aged 65 or older or

any individual entitled to HI benefits, upon voluntary participation with payment of Part B premium.

1972. Individual under age 65 entitled to HI benefits, upon voluntary participation with payment of Part B premium.

Entitlement to Medicare Part D (also known as Supplementary Medical Insurance Part D Account, or SMI Part D) Benefits

2003. For temporary Medicare-endorsed prescription drug discount card program (as a prelude to the new Part D prescription drug program), individual entitled or enrolled under Part A or enrolled in Part B, upon voluntary participation with payment of up to \$30 annual enrollment fee. Under a Transitional Assistance provision, beneficiary whose income does not exceed 135 percent of the federal poverty level and does not have third-party prescription drug coverage is entitled to further benefits. Enrollment begins in May 2004, access to discounts begins in June 2004, and program phases out as drug benefit becomes available in 2006 (see next entry).

Beginning January 1, 2006, individual entitled to benefits under Part A or enrolled under Part B, upon voluntary enrollment in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage (MA) plan that offers Part D coverage in its benefit package.

Medicare Benefits

Under Part A

1965. In each benefit period, inpatient hospital services, 90 days. Includes semiprivate accommodations, operating room, hospital equipment (including renal dialysis), laboratory tests and X-ray, drugs, dressings, general nursing services, and services of interns and residents in medical osteopathic or dentistry training. Inpatient psychiatric hospital care limited to 190-day lifetime maximum. Outpatient hospital diagnostic services. Post-hospital extended-care services, 100 days (including physical, occupational, and speech therapy). Post-hospital home health services, 100 visits. Deductible and coinsurance provisions (see Table 2.C1).

1967. Lifetime reserve of 60 additional days of inpatient hospital services. Outpatient hospital diagnostic services transferred to SMI.

1972. Services of interns and residents in podiatry training.

1980. Unlimited home health visits in a year. Requirement for prior hospitalization eliminated. Home

health services provided for up to 4 days a week and up to 21 consecutive days.

Alcohol detoxification facility services.

1981. Part A coinsurance is based on the deductible for the calendar year in which services are received rather than the deductible in effect at the time the beneficiary's spell of illness began, starting in 1982.

Alcohol detoxification facility services eliminated.

1982. Beneficiaries expected to live 6 months or less may elect to receive hospice care benefits instead of other Medicare benefits. May elect maximum of two 90-day and one 30-day hospice care periods, effective November 1, 1983, to October 1, 1986.

1984. For durable medical equipment provided by home health agencies, the payment amount is reduced from 100 percent of costs to 80 percent of reasonable charges.

1986. Set the Part A deductible for 1987 at \$520 with resulting increases in cost sharing. Increased the Part A deductible annually by the applicable percentage increase in the hospital prospective payment rates.

Hospice care benefit (enacted in 1982) made permanent.

1987. Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

1988. Enrollee pays annual hospital deductible (set at \$560 for 1989) and Medicare pays balance of covered charges, regardless of the number of days of hospitalization (except for psychiatric hospital care, which is still limited by 190-day lifetime maximum).

The number of days in a skilled nursing facility changed to 150 per year. Deletes the requirement for a prior hospital stay of 3 or more consecutive days.

Expands home health care to provide care for less than 7 days per week and up to 38 consecutive days.

Hospice care extended beyond 210 days when beneficiary is certified as terminally ill.

All 1988 provisions became effective January 1, 1989.

1989. The spell of illness and benefit period coverage of laws prior to 1988 return to the determination of inpatient hospital benefits in 1990 and later. After the deductible is paid in benefit period, Medicare pays 100 percent of covered costs for the first 60 days of inpatient hospital care. Coinsurance applies for the next 30 days in a benefit period.

The requirement for a prior hospital stay of 3 or more consecutive days is reinstated for skilled nursing facility services. Coverage returns to 100 days post-hospital care per spell of illness with a daily coinsurance rate in effect for days 21 through 100.

Home health services return to a limit of 21 consecutive days of care. Provision providing for home health care for fewer than 7 days per week continued due to a court decision.

Hospice care is returned to a lifetime limit of 210 days.

1990. Hospice care is extended beyond 210 days when beneficiary is certified as terminally ill.

1997. Home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or a skilled-nursing facility stay. The cost to the SMI trust fund of the transferred services will phase in over a 6-year period (that is, the HI trust fund will transfer funds to the SMI trust fund during that period).

Limits on the number of hours and days that home health care can be provided have been clarified.

Part-time now defined as skilled nursing and home health aide services (combined) furnished any number of days per week, for less than 8 hours per day and 28 or fewer hours per week. *Intermittent* now defined as skilled nursing care provided for fewer than 7 days each week, or less than 8 hours each day (combined) for 21 days or less.

Hospice benefit periods are restructured to include two 90-day periods, followed by an unlimited number of 60-day periods.

Medicare coverage provided for a number of prevention initiatives, most of which are covered under SMI program. HI program affected mainly by two of the initiatives: (1) annual prostate cancer screening for male beneficiaries aged 50 or older, effective January 1, 2000; and (2) colorectal screening procedures, including fecal-occult blood tests and flexible sigmoidoscopies, for beneficiaries aged 50 and older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances.

2000. The homebound criterion for home health services is clarified to specify that beneficiaries who require home health services may attend adult day care for therapeutic, psychosocial, or medical treatment and still remain eligible for the home health

benefit. Homebound beneficiaries may also attend religious services without being disqualified from receiving home health benefits.

Screening colonoscopies are covered for all beneficiaries, not just for those at high risk, beginning July 1, 2001. For persons not at high risk, a screening colonoscopy is covered 10 years after a previous one, or 4 years after a screening flexible sigmoidoscopy. (See 1997.)

Under Part B

1965. Physician and surgeon services. In-hospital services of anesthesiologists, pathologists, radiologists, and psychiatrists. Limited dental services. Home health services, 100 visits in calendar year. Other medical services including various diagnostic tests, limited ambulance services, prosthetic devices, rental of durable medical equipment used at home (including equipment for dialysis), and supplies used for fractures. For deductible and coinsurance provisions, see Table 2.C1.

Beginning in 1966, the beneficiary pays a \$50 deductible, with a 3-month carryover provision.

1967. Outpatient hospital diagnostic services transferred from HI. Includes physical therapy services in a facility. Purchase of durable medical equipment.

1972. Physical therapy services furnished by a therapist in his or her office or individual's home (calendar year limit of \$100). Chiropractor services (limited to manual manipulation of the spine). Outpatient services include speech pathology services furnished in, or under arrangements with, a facility or agency. Services of a doctor of optometry in furnishing prosthetic lenses.

Beginning in 1973, the beneficiary pays a \$60 deductible.

1977. Services in rural health clinics.

1980. Home health services. Deductible applicable to home health services is eliminated, effective July 1, 1981.

Facility costs of certain surgical procedures performed in freestanding ambulatory surgical centers.

Increase in annual limit for outpatient therapy from \$100 to \$500.

Recognizes comprehensive outpatient rehabilitation facilities as Medicare providers.

1981. Beginning in 1982, the beneficiary pays a \$75 deductible, with the carryover provision eliminated.

1984. Hepatitis B and pneumococcal vaccines and blood clotting factors and necessary supplies are included

as Part B benefits. Debridement of mycotic toenails is limited.

For outpatient physical therapy services, includes services of a podiatrist. For outpatient ambulatory surgery, includes services of a dentist and podiatrist furnished in his or her office.

1986. Includes vision care services furnished by an optometrist.

For occupational therapy services, includes services furnished in a skilled nursing facility (when Part A coverage has been exhausted), in a clinic, rehabilitation agency, public health agency, or by an independently practicing therapist.

Includes outpatient (in addition to previously covered inpatient) immunosuppressive drugs for 1 year after covered transplant.

Includes occupational therapy services provided in certain delivery settings.

For ambulatory surgical procedures performed in ambulatory surgical centers, hospital outpatient departments, and certain physician offices, the Part B coinsurance and deductible are no longer waived.

1987. Increases the maximum payment for mental health services and includes outpatient mental health services provided by ambulatory hospital-based or hospital-affiliated programs under the supervision of a physician.

Services provided by clinical social workers when furnished by risk-sharing health maintenance organizations and competitive medical plans, physician assistants in rural health manpower shortage areas, clinical psychologists in rural health clinics and community mental health centers, and certified nurse-midwives.

Coverage of outpatient immunosuppressive drugs (see 1986) is broadened and clarified to include prescription drugs used in immunosuppressive therapy.

Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

1988. Beginning January 1, 1990, the beneficiary pays a \$75 deductible and 20 percent coinsurance, but once out-of-pocket expenses for the deductible and coinsurance exceed \$1,370, Medicare pays 100 percent of allowable charges for remainder of year.

Beginning in 1991, Medicare pays 50 percent of the cost of outpatient prescription drugs above \$600. When fully implemented in 1993, Medicare will pay

80 percent of prescription drug costs above a deductible that assumes that 16.8 percent of Part B enrollees will exceed the deductible.

Certain prescription drugs administered in an outpatient or home setting, including immunosuppressive drugs (previously covered for 1 year after a covered transplant), home intravenous drugs, and certain others, will be covered in 1990 under a new prescription drug provision.

1989. Provisions enacted in 1988 and to begin in 1990 and 1991 are repealed, and benefits are restored to levels in effect prior to January 1, 1989.

Limits on mental health benefits eliminated in 1990. Coverage extended to services of clinical psychologists and social workers.

The annual payment limits of \$500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to \$750, for 1990 and later. (See 1980.)

1990. Beginning in 1991, routine mammography screenings are covered.

The Part B deductible is set at \$100 in 1991 and subsequent years.

Beginning in 1992, physicians' services are reimbursed on a fee-schedule basis.

1993. Includes coverage of oral, self-administered anticancer drugs.

Lengthens the coverage period for immunosuppressive drugs after a transplant to 18 months in 1995, 24 months in 1996, 30 months in 1997, and 36 months thereafter. (See 1986.)

The annual payment limits of \$750 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, are raised to \$900 for 1994 and later. (See 1989.)

1997. Home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI are transferred from the HI program to the SMI program, effective January 1998. The HI program will continue to cover the first 100 visits following a hospital stay of at least 3 consecutive days or a skilled nursing facility stay. The cost to the SMI trust fund of the transferred services will phase in over a 6-year period, while the cost of the home health services will phase into the SMI premium over 7 years.

Coverage provided for a number of prevention initiatives, including (1) annual screening mammograms for female beneficiaries aged 40 or older, with SMI deductible waived; (2) screening pap smear and pelvic exam (including clinical breast exam) every

3 years or annually for beneficiaries at higher risk, with SMI deductible waived; (3) annual prostate cancer screening for male beneficiaries aged 50 or older, effective January 1, 2000; (4) colorectal screening procedures, including fecal-occult blood tests and flexible sigmoidoscopies, for beneficiaries aged 50 or older, colonoscopy for beneficiaries at high risk for colorectal cancer, and other procedures, including screening barium enemas under certain circumstances; (5) diabetes outpatient self-management training in nonhospital-based programs (previously covered in hospital-based programs only) and blood glucose monitors and testing strips for all diabetics (previously provided for insulin-dependent diabetics only), effective July 1, 1998; (6) procedures to identify bone mass, detect bone loss, or determine bone quality for certain qualified beneficiaries, at frequencies determined by the secretary of Health and Human Services, effective July 1, 1998.

Beginning January 1999, an annual beneficiary limit of \$1,500 will apply to all outpatient physical therapy services, except for services furnished by a hospital outpatient department. A separate \$1,500 limit will also apply to outpatient occupational therapy services, except for services furnished by hospital outpatient departments. Beginning with 2002, these caps will be increased by the percentage increase in the Medical Economic Index. (See 1993.)

1999. The coverage period for immunosuppressive drugs after a transplant is lengthened to 44 months, for individuals who exhaust their 36 months of coverage in 2000. For those exhausting their 36 months of coverage in 2001, at least 8 more months will be covered. (The secretary of Health and Human Services will specify the increase, if any, beyond 8 months.) For those exhausting their 36 months of coverage in 2002, 2003, or 2004, the number of additional months may be more or less than 8. (The secretary will specify the increase for each of these years.) (See 1993.)

The annual payment limits of \$1,500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, for services furnished by independent practitioners (that is, not by a hospital outpatient department) are suspended for 2000 and 2001. (See 1997.)

2000. Coverage for screening pap smears and pelvic exams (including a clinical breast exam) is provided every 2 years (increased from every 3 years) beginning July 1, 2001. (Annual coverage continues for beneficiaries at higher risk, and SMI deductible continues to be waived.) (See 1997.)

Annual coverage of glaucoma screenings is provided for certain high-risk beneficiaries, effective January 1, 2002.

Screening colonoscopies are covered for all beneficiaries, not just for those at high risk, beginning July 1, 2001. For persons not at high risk, a screening colonoscopy is covered 10 years after a previous one, or 4 years after a screening flexible sigmoidoscopy. (See 1997.)

Coverage is provided for medical nutrition therapy services under certain circumstances for beneficiaries who have diabetes or a renal disease, effective January 1, 2002.

The amount of a beneficiary's copayment for a procedure in a hospital outpatient department is limited, beginning April 1, 2001, to the hospital inpatient deductible applicable for that year. Also, the secretary of Health and Human Services must reduce the effective copayment rate for outpatient services to a maximum rate of 57 percent in 2001 (for services received after April 1); 55 percent in 2002 and 2003; 50 percent in 2004; 45 percent in 2005; and 40 percent in 2006 and later.

Time and budget limitations are removed on the coverage of immunosuppressive drugs, making coverage of these drugs a permanent benefit for beneficiaries who have received a covered organ transplant. (See 1999.)

The annual payment limits of \$1,500 per beneficiary for outpatient physical therapy services and outpatient occupational therapy services, each, for services provided by independent practitioners (that is, not by a hospital outpatient department), which were suspended for 2000 and 2001, are also suspended for 2002. (See 1999.)

The homebound criterion for home health services is clarified to specify that beneficiaries who require home health services may attend adult day care for therapeutic, psychosocial, or medical treatment and still remain eligible for the home health benefit. Homebound beneficiaries may also attend religious services without being disqualified from receiving home health benefits.

2003. The Part B deductible remains at \$100 through 2004 and increases to \$110 in 2005. Beginning in 2006, it will be increased each year by the annual percentage increase in the Part B aged actuarial rate.

A one-time, initial preventive physical exam is covered within 6 months of a beneficiary's first coverage under Part B, beginning January 1, 2005, for beneficiaries whose Part B coverage begins on or after that date.

Certain screening blood tests are covered for the early detection of cardiovascular disease and abnormalities associated with elevated risk for such disease, including certain tests for cholesterol and other lipid or triglyceride levels, effective January 1, 2005, under frequency standards to be established (but not to exceed once every 2 years).

Diabetes screening tests, including a fasting plasma glucose test and other such tests determined appropriate by the secretary of Health and Human Services, are covered for beneficiaries at risk for diabetes, beginning January 1, 2005, under frequency standards to be established (but not to exceed two times per year).

Under Parts A and B

1965. Requires that Medicare be secondary payer to benefits provided by liability insurance policies or under no-fault insurance.

1981. Requires that Medicare be secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely on the basis of end-stage renal disease (ESRD) for up to 12 months.

1982. For workers and their spouses aged 65 to 69, Medicare is the secondary payer when benefits are provided under an employer-based group health plan (applicable to employers with 20 or more employees who sponsor or contribute to the group plan).

Health maintenance organizations (HMOs) will be authorized as providers of benefits. The secretary of Health and Human Services must certify the prospective payment mechanism for HMOs before implementation.

1984. Medicare secondary-payer provisions are extended to spouses aged 65 to 69 of workers under age 65 whose employer-based group health plan covers such spouses.

For HMOs, includes medical and other health services furnished by clinical psychologists.

1985. Provides payment for liver transplant services.

1986. Extends the working-age, secondary-payer provision to cover workers and their spouses beyond age 69.

For HMOs that offered organ transplants as a basic health service on April 15, 1985, such services may be offered from October 1, 1985, through April 1, 1988.

For disabled individuals who are covered by employer-based health plans (with at least 100 employees), Medicare is the secondary payer, effective for the period from 1987 to 1991.

1987. Requires HMOs and competitive medical plans that cease to contract with Medicare to provide or arrange supplemental coverage of benefits related to preexisting conditions for the lesser of 6 months or the duration of an exclusion period.

Specifies in law that to be eligible for home health care, a Medicare beneficiary must have a restricted ability to leave the home, requiring the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

Clarifies that the secondary-payer provision for disabled individuals covered under employer-based health plans for employers with at least 500 employees applies to employers who are government entities.

1990. Requires that Medicare be the secondary payer to employer-based group health plans for beneficiaries entitled to Medicare solely on the basis of ESRD for up to 18 months (extended from 12 months), effective February 1, 1991, to January 1, 1996.

The secondary-payer provision for disabled beneficiaries covered under large employer plans (see 1986) is effective through September 30, 1995.

1993. The secondary-payer provision for disabled beneficiaries covered under large employer plans is effective through September 30, 1998.

The secondary-payer provision for beneficiaries with ESRD applies to all beneficiaries with end-stage renal disease, not only those entitled to Medicare solely on the basis of it. The extension to include the first 18 months of an individual's entitlement on the basis of ESRD is effective through September 30, 1998.

1997. Established an expanded set of options for the delivery of health care under Medicare, referred to as Medicare+Choice (and also known as "Medicare Part C"). All Medicare beneficiaries can receive their Medicare benefits through the original fee-for-service program. In addition, most beneficiaries can choose instead to receive their Medicare benefits through one of the following Medicare+Choice plans:

(1) coordinated care plans (such as HMOs, provider-sponsored organizations, and preferred provider organizations), (2) Medical Savings Account (MSA)/High Deductible plans (through a demonstration available for up to 390,000 beneficiaries), or (3) private fee-for-service plans. Except for MSA plans, all Medicare+Choice plans are required to provide the current Medicare benefit package (excluding hospice services) and any additional health services required under the adjusted community rate (ACR) process. MSA plans provide Medicare benefits after a single high deductible is met, and enrollees receive

an annual deposit in their medical savings account. Transition rules for current Medicare HMO program also provided. (See also HMO provision of 1982.)

The provision making Medicare the secondary payer for disabled beneficiaries covered under large employer plans, previously scheduled to expire September 30, 1998, made permanent.

The provision making Medicare the secondary payer for the first 12 months of entitlement because of ESRD, which had been extended on a temporary basis (through September 30, 1998) to include the first 18 months of entitlement, has been extended, permanently, to include the first 30 months of entitlement on the basis of ESRD.

2003. Medicare+Choice is renamed Medicare Advantage. (It is still sometimes referred to as "Medicare Part C.") As before, beneficiaries having both plans, Medicare Part A and Part B, can receive their Medicare benefits through the original fee-for-service program; most can opt instead to use a Medicare Advantage plan in their area. Medicare Advantage plans include (1) Medicare Managed Care plans (like HMOs), (2) Medicare Preferred Provider Organization plans (PPOs), (3) Private Fee-for-Service plans, and (4) Medicare Specialty plans (available in some areas, to provide Medicare benefits for certain people with special needs, such as beneficiaries in institutions). Beginning in 2006, Medicare Advantage plan choices will be expanded to include regional PPOs. Participating regional PPOs will be required to serve an entire region (10 to 50 regions are to be established), and there are provisions to encourage plan participation. Regional PPOs must have a single deductible for benefits under Parts A and B, and they must include catastrophic limits for out-of-pocket expenditures. Beginning in 2006, the adjusted community rate (ACR) process for determining plan payments is replaced by a competitive bidding process. (Historical reference points to this item include the Medicare+Choice provision of 1997 and the HMO provision of 1982, both of which are displayed in this section.)

Under Part D

2003. Under temporary Medicare-endorsed prescription drug discount card program, for beneficiaries voluntarily enrolling and paying up to \$30 annually, discounts on certain prescription drugs, as specified by card sponsors. Under Transitional Assistance (TA) provision, beneficiaries whose incomes do not exceed 135 percent of the federal poverty level and do not have third-party prescription drug coverage are eligible for (1) financial assistance of up to \$600 per year for purchasing prescription drugs and (2) a subsidized enrollment fee under the temporary Medi-

care-endorsed prescription drug discount card program. Enrollment begins in May 2004, access to discounts begins in June 2004, and program phases out as drug benefit becomes available in 2006 (see next entry).

Beginning January 1, 2006, upon voluntary enrollment in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage (MA) plan that offers Part D coverage in its benefit, subsidized prescription drug coverage. Most FDA-approved drugs and biologicals are covered. (Drugs currently covered in Parts A and B remain covered there.) Standard Part D coverage is defined for 2006 as having a \$250 deductible, with 25 percent coinsurance (or other actuarially equivalent amounts) for drug costs above the deductible and below the initial coverage limit of \$2,250. Beneficiary is then responsible for all costs until the \$3,600 out-of-pocket limit is reached. For higher costs, there is catastrophic coverage; it requires enrollees to pay the greater of 5 percent coinsurance or a small copay (\$2 for generic or preferred multisource brand and \$5 for other drugs). After 2006, these benefit parameters are indexed to the growth in per capita Part D spending. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exception is cost-sharing assistance from Medicare's low-income subsidies (certain beneficiaries with low incomes and modest assets will be eligible for certain subsidies that eliminate or reduce their Part D premiums and cost-sharing) and from State Pharmacy Assistance Programs. A beneficiary premium, representing 25.5 percent of the cost of basic coverage on average, is required (except for certain low-income beneficiaries, as previously mentioned, who may pay a reduced or no premium). For PDPs and the drug portion of MA plans, the premium will be determined by a bid process; each plan's premium will be 25.5 percent of the national weighted average plus or minus the difference between the plan's bid and the average. PDPs and MAs may set up formularies for their drug coverage, subject to certain statutory standards. To help them gain experience with the Medicare population, plans will be protected by a system of risk corridors, which allow Part D to assist plans with unexpected costs and to share in unexpected savings; after 2007, the risk corridors will become less protective. To encourage employer and union plans to continue prescription drug coverage to Medicare retirees, subsidies to these plans are authorized; the plan must meet or exceed the value of standard Part D coverage, and the subsidy pays 28 percent of the allowable costs associated with enrollee prescription drug costs between \$250 and \$5,000.

Medicare Financing

Hospital Insurance Taxes

See Table 2.A3.

Appropriations from General Revenues

1965. For HI costs attributable to transitionally insured beneficiaries.

For HI costs attributable to noncontributory wage credits granted for military service prior to 1957 (see Table 2.A2).

For the Part B program, an amount equal to participant premiums.

1972. For cost of Part B not met by enrollee premiums.

1982. For HI costs attributable to beneficiaries having transitional entitlement based on Medicare-qualified federal employment.

1983. For HI taxes on noncontributory wage credits granted for military service (a) from the inception of HI program through 1983 and (b) on a current basis, annually, beginning in 1984 (see Table 2.A2).

2002. Eliminated for HI taxes on noncontributory wage credits granted for military service on a current basis, for all years after calendar year 2001 (see Table 2.A2).

2003. For Part D costs not met by enrollee premiums or otherwise, beginning in January 2006. (That is, transfers from general revenues [plus smaller income sources, particularly the payments from states described below] will pay for (1) the 74.5 percent subsidy to PDPs and the prescription drug portion of MA plans [which remains after enrollee premiums of 25.5 percent, on average], in the form of a direct subsidy and reinsurance, and (2) for other Part D costs, such as low-income subsidies and subsidies to employers who provide qualifying drug coverage to their Medicare-eligible retirees.)

Participant Premiums

See Table 2.C1.

1965. Part B enrollee premium rate (originally \$3 per month) to be established annually such that it will pay one-half of program costs.

1972. Part B enrollee premium rate increase limited to rate of increase in OASDI cash benefits.

HI premium (originally \$33 per month) to be established annually. Only individuals not otherwise entitled to HI but desiring voluntary participation need to pay the HI premium.

1983. Part B enrollee premiums for July 1983 to December 31, 1983, frozen at premium level of June 30, 1983. Premiums for January 1, 1984, to December 31, 1985, set to cover 25 percent of aged program costs.

1984. Part B enrollee premiums for January 1, 1986, to December 31, 1987, will be set to cover 25 percent of aged program costs. Increases in the Part B premium may not exceed the dollar amount of the Social Security cost-of-living adjustment.

For calculating the amount of Part B premium surcharge for individuals from age 65 up to age 70 not previously enrolled in Part B, the number of years an individual did not enroll because of coverage by employer group health insurance will not be taken into account.

1985. Extends through calendar year 1988 the requirement that Part B premiums be set to cover 25 percent of aged program costs and that increases in the Part B premium may not exceed the dollar amount of the Social Security cost-of-living adjustment.

Premium-paying individuals who do not purchase Part A coverage within a specific time after becoming eligible because of age are subject to a 10 percent penalty for each 12 months they are late in enrolling. There is a cutoff on the length of time these individuals will have to pay an enrollment penalty. The 10 percent premium penalty would be limited to twice the number of years enrollment was delayed. Therefore, if enrollment were delayed 1 year, the penalty would be assessed for 2 years. Individuals in this category and already enrolled will have the length of time the higher premium was paid credited to them.

1987. Extends through calendar year 1989 the provisions requiring that the Part B premium be set to cover 25 percent of aged program costs, prohibiting any increase in the premium if there is no Social Security cost-of-living adjustment, and continuing to hold beneficiaries harmless from Social Security check reductions as a result of a premium increase.

1988. Increases in the Part B premium may not exceed the dollar amount of the Social Security cost-of-living adjustments for 1989 and beyond.

1989. Extends through calendar year 1990 the requirement that Part B premiums be set to cover 25 percent of aged program costs.

1990. The Part B premium is set at \$29.90 in 1991, \$31.80 in 1992, \$36.60 in 1993, \$41.10 in 1994, and \$46.10 in 1995.

1993. Part B enrollee premiums for January 1, 1996, to December 31, 1998, will be set to cover 25 percent of aged program costs.

1997. The Part B premium is permanently set at 25 percent of program costs.

2003. Beginning January 2007, the Part B premium is increased for beneficiaries meeting certain income thresholds. (Beneficiaries with modified adjusted gross incomes under \$80,000 will continue to pay premiums that are 25 percent of twice the actuarial rate. *Actuarial rate* is defined as one-half of the Part B expected monthly cost per enrollee. For beneficiaries with incomes between \$80,000 and \$100,000, the applicable percentage is 35 percent; for those with incomes between \$100,000 and \$150,000, the percentage is 50 percent; for incomes between \$150,000 and \$200,000, the percentage is 65 percent; and for incomes more than \$200,000, the percentage is 80 percent. For married couples, the income thresholds are doubled. These thresholds are to be updated each calendar year by the consumer price index (CPI). There is a 5-year adjustment period for this provision as well; that is, the amount of premium above 25 percent of twice the actuarial rate is phased in—at 20, 40, 60, 80, and 100 percent for 2007 to 2011 and later, respectively.)

For military retirees who enroll(ed) in Part B during the period from 2001 to 2004, the late enrollment penalty imposed on beneficiaries who do not enroll in Part B upon becoming eligible for Medicare is waived for premium payments for January 2004 and later. (Also, a special enrollment period for these military retirees is to begin as soon as possible and end December 31, 2004.)

For Part D, beginning in January 2006, a beneficiary premium, representing 25.5 percent of the cost of basic coverage on average, is required (except for certain low-income beneficiaries, who may pay a reduced or no premium). For PDPs and the drug portion of MA plans, the premium will be determined by a bid process; each plan's premium will be 25.5 percent of the national weighted average plus or minus the difference between the plan's bid and the average. A late enrollment penalty will apply for beneficiaries who fail to enroll at the first opportunity and who do not maintain creditable coverage (external prescription drug coverage, such as through a retiree group health plan that meets or exceeds the actuarial value of standard Part D coverage) elsewhere.

Income from Taxation of OASDI Benefits

1993. The additional income tax revenues resulting from the increase in the taxable percentage applicable to OASDI benefits (an increase from 50 percent to

85 percent, see Table 2.A31) are transferred to the HI trust fund.

Payment from States

2003. Beginning in January 2006, with the availability of drug coverage and low-income subsidies under Part D, Medicaid will no longer be primary payer for full-benefit dual eligibles, and states are required to make payments to defray a portion of the Part D drug expenditures for these beneficiaries. States pay 90 percent of the estimated costs for 2006, phasing down over a 10-year period to 75 percent for 2015 and later.

Interfund Borrowing

1981. See Table 2.A6.

1983. See Table 2.A6.

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Medicaid

The following are brief summaries of complex subjects. They should be used only as overviews and general guides to the Medicare and Medicaid programs. The views expressed herein do not necessarily reflect the policies or legal positions of the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services (DHHS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.¹

Overview

Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, state legislatures may change Medicaid eligibility, services, and reimbursement during the year.

1. These summaries were prepared by Earl Dirk Hoffman Jr., Barbara S. Klees, and Catherine A. Curtis, Office of the Actuary, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244. The authors wish to express their gratitude to Mary Onnis Waid, who originated these summaries and diligently prepared them for many years before her retirement.

Basis of Eligibility and Maintenance Assistance Status

Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups designated below. Low income is only one test for Medicaid eligibility for persons within these groups; their resources also are tested against threshold levels (as determined by each state within federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, however, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most states have additional "state-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for state-only programs. The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996;
- Children under age 6 whose family income is at or below 133 percent of the federal poverty level (FPL);
- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care);
- Supplemental Security Income (SSI) recipients in most states (some states use more restrictive Medicaid eligibility requirements that predate SSI);
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act;
- Special protected groups (typically individuals who lose their cash assistance because of earnings from work or from increased Social Security benefits but who may keep Medicaid for a period of time);
- All children born after September 30, 1983, who are under age 19, in families with incomes at or below the FPL; and
- Certain Medicare beneficiaries (described later).

States also have the option of providing Medicaid coverage for other “categorically related” groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which states will receive federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each state);
- Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their state on July 16, 1996;
- Institutionalized individuals eligible under a “special income level” (the amount is set by each state—up to 300 percent of the SSI federal benefit rate);
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers;
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage but below the FPL;
- Recipients of state supplementary income payments;
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work;
- Tuberculosis-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to tuberculosis-related ambulatory services and tuberculosis drugs);
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control and Prevention. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides these women with medical assistance and follow-up diagnostic services through Medicaid;
- “Optional targeted low-income children” included within the State Children’s Health Insurance Program (SCHIP) established by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33); and
- Medically needy persons (described below).

The medically needy (MN) option allows states to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income or

resources or both are above the eligibility level set by their state. Persons may qualify immediately or may spend down by incurring medical expenses that reduce their income to or below their state’s MN income level.

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy and may be quite restrictive. Federal matching funds are available for MN programs. However, if a state elects to have a MN program, there are federal requirements that certain groups and certain services must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A state may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services within its MN program. As of August 2002, 35 states plus the District of Columbia have elected to have a MN program and are providing at least some MN services to at least some MN beneficiaries. All remaining states utilize the “special income level” option to extend Medicaid to the near poor in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193)—known as the welfare reform bill—made restrictive changes regarding eligibility for SSI coverage that had an impact on the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, are ineligible for Medicaid for 5 years. States have the option of providing Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of the new restrictions regarding SSI coverage, Medicaid coverage for them can continue only if these persons can be covered under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstated by Public Law 105-33, the BBA.

In addition, welfare reform repealed the open-ended federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides states with grants to be spent on time-limited cash assistance. TANF generally limits a family’s lifetime cash welfare benefits to a maximum of 5 years and permits states to impose a wide range of other requirements as well—in particular, those related to employment. However, the impact on Medicaid eligibility is not expected to

be significant. Under welfare reform, persons who would have been eligible for AFDC in effect on July 16, 1996, generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a new program initiated by the BBA. In addition to allowing states to craft or expand an existing state insurance program, SCHIP provides more federal funds for states to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid on the basis of the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options from which states may select to provide health care coverage for more children, as prescribed within the BBA's Title XXI program.

Medicaid coverage may begin as early as the third month prior to application—if the person would have been eligible had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows states to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provides or continues Medicaid coverage to certain disabled beneficiaries who work despite their disability. Beneficiaries with higher incomes may pay a sliding-scale premium based on income.

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within states' Medicaid plans. However, some federal requirements are mandatory if federal matching funds are to be received. A state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services;
- Outpatient hospital services;
- Prenatal care;
- Vaccines for children;
- Physician services;

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

States may also receive federal matching funds to provide certain optional services. Following are the most common of the 34 currently approved optional Medicaid services:

- Diagnostic services,
- Clinic services,
- Intermediate care facilities for the mentally retarded (ICFs/MR),
- Prescribed drugs and prosthetic devices,
- Optometrist services and eyeglasses,
- Nursing facility services for children under age 21,
- Transportation services,
- Rehabilitation and physical therapy services, and
- Home and community-based care to certain persons with chronic impairments.

The BBA included a state option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 and older who require a nursing facility level of care. The PACE team offers and manages all health, medical, and social services and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both Titles XVIII and XIX, without amount, duration, or scope limitations and without application of any deductibles, copayments, or other cost sharing. The

individuals enrolled in PACE receive benefits solely through the PACE program.

Amount and Duration of Medicaid Services

Within broad federal guidelines and certain limitations, states determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits, and (2) limits on benefits may not discriminate among beneficiaries on the basis of medical diagnosis or condition.

In general, states are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under federal law, must be covered even if those services are not included as part of the covered services in that state's plan, and (2) states may request waivers to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, states have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, states may not provide room and board for the beneficiaries). With certain exceptions, a state's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or states may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each state for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and to other low-

income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. From 1988 to 1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing federal expenditures for Medicaid. Under legislation passed in 1991, 1993, and again within the BBA of 1997, the federal share of payments to DSH hospitals was somewhat limited. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554) increased DSH allotments for 2001 and 2002 and made other changes to DSH provisions that resulted in increased costs to the Medicaid program.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency and family planning services.

The federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In fiscal year 2004, the FMAPs varied from 50 percent in 12 states to 77 percent in Mississippi and averaged 60.2 percent overall. The BBA also permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent and raised the FMAP for Alaska from 50 percent to 59.8 percent through 2000. The BIPA of 2000 further adjusted Alaska's FMAP to a higher level for fiscal years 2001 to 2005. The Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108-27), to bring about state fiscal relief in the current troubled economy, has made three temporary modifications to the states' FMAP calculation: (1) the FMAP for the last two quarters of 2003 will equal the greater of the current law FMAPs for 2002 or 2003; (2) the FMAP for the first three quarters of 2004 will equal the greater of the current law FMAPs for 2003 or 2004; and (3) for the last two quarters of 2003 and first three quarters of 2004, the newly calculated (under 1 and 2 above) FMAP will increase by 2.95 percentage points. The federal government pays states a higher share for children covered through the SCHIP program. This enhanced FMAP averages about 70 percent for all states, compared with the general Medicaid average of 60.2 percent.

The federal government also reimburses states for 100 percent of the cost of services provided through facilities of the Indian Health Service, provides financial help to the 12 states that furnish the highest number of emergency services to undocumented aliens, and shares in each state's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the SCHIP program, the Qualifying Individuals (QI) program (described later), and DSH payments, federal payments to states for medical assistance have no set limit (cap). Rather, the federal government matches (at FMAP rates) state expenditures for the mandatory services, as well as for the optional services that the individual state decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into Public Law 106-113, the appropriations bill for the District of Columbia for fiscal year 2000) increased the amount that certain states and the territories can spend on DSH and SCHIP payments, respectively. The BIPA set upper payment limits for inpatient and outpatient services provided by certain types of facilities.

Summary and Trends

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations, as a result of federal mandates, population growth, and economic recessions;
- The expanded coverage and utilization of services;
- The DSH payment program, coupled with its inappropriate use to increase federal payments to states;

- The increase in the number of very old and disabled persons requiring extensive acute and long-term health care and various related services;
- The results of technological advances to keep a greater number of very low-birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care;
- The increase in drug costs and the availability of new expensive drugs; and
- The increase in payment rates to providers of health care services, when compared with general inflation.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. National data for 2001, for example, indicate that Medicaid payments for services for 23.3 million children, who constitute 50 percent of all Medicaid beneficiaries, average about \$1,305 per child (a relatively small average expenditure per person). Similarly, for 11.6 million adults, who comprise 25 percent of beneficiaries, payments average about \$1,725 per person. However, certain other specific groups have much larger per-person expenditures. Medicaid payments for services for 4.4 million aged, constituting 9 percent of all Medicaid beneficiaries, average about \$10,965 per person; for 7.7 million disabled, who make up 16 percent of beneficiaries, payments average about \$10,455 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 2001 payments to health care vendors for 47.0 million Medicaid beneficiaries average \$3,965 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for over 41 percent of the total cost of care for persons using nursing facility or home health services in 2001. National data for 2001 show that Medicaid payments for nursing facility services (excluding ICFs/MR) totaled \$37.2 billion for more than 1.7 million beneficiaries—an average expenditure of \$21,890 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled \$3.5 billion for more than 1.0 million beneficiaries—an average expenditure of \$3,475 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid

health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the states with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow states to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow state-wide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided states with a new option to use managed care. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 14 percent of enrollees in 1993 to 59 percent in 2003.

More than 46.0 million persons received health care services through the Medicaid program in fiscal year 2001 (the last year for which beneficiary data are available). In fiscal year 2003, total outlays for the Medicaid program (federal and state) were \$278.3 billion, including direct payment to providers of \$197.3 billion, payments for various premiums (for HMOs, Medicare, etc.) of \$52.1 billion, payments to disproportionate share hospitals of \$12.9 billion, and administrative costs of \$16.0 billion. Outlays under the SCHIP program in fiscal year 2003 were \$6.1 billion. With no changes to either program, expenditures under Medicaid and SCHIP are projected to reach \$445 billion and \$7.5 billion, respectively, by fiscal year 2009.

The Medicaid-Medicare Relationship

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their state's Medicaid program, according to eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the payer of last resort.

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their state Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medi-

care Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI, or Part B) premiums and the Medicare coinsurance and deductibles, subject to limits that states may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums. A third category of Medicare beneficiaries who may receive help consists of disabled and working individuals. According to the Medicare law, disabled and working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Part B. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

For Medicare beneficiaries with incomes that are above 120 percent and less than 175 percent of the FPL, the BBA establishes a capped allocation to states, for each of the 5 years beginning January 1998, for payment of all or some of the Medicare Part B premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a state plan. The payment of this QI benefit is 100 percent federally funded, up to the state's allocation.

The Centers for Medicare & Medicaid Services (CMS) estimates that Medicaid currently provides some level of supplemental health coverage for about 6.5 million Medicare beneficiaries.

Starting January 2006, the new Medicare prescription drug benefit will provide drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, individuals eligible for Medicare and Medicaid will also receive the low-income subsidy for the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid will no longer provide drug benefits for Medicare beneficiaries.

Since the Medicare drug benefit and low-income subsidy will replace a portion of state Medicaid expenditures for drugs, states would see a reduction in Medicaid expenditures. To offset this reduction, the Medicare Prescription Drug, Improvement, and Modernization Act of

2003 (Public Law 108-173) requires each state to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006, this payment is 90 percent of the projected 2006 reduction in state spending. After 2006, the percentage decreases by $1 \frac{2}{3}$ percent per year to 75 percent for 2014 and later.

Note: Medicaid data are based on the projections of the Mid-Session Review of the President's Fiscal Year 2005 Budget and are consistent with data received from the states on Forms CMS-2082, MSIS, CMS-37, and CMS-64.

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Unemployment Insurance

Through federal and state cooperation, 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. Workers in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands are covered under unemployment insurance programs.

To induce states to enact unemployment insurance laws, the Social Security Act of 1935 provided a tax offset incentive. A uniform national tax was imposed on payrolls of industrial and commercial employers who employed eight or more workers in 20 or more weeks in a calendar year. Employers who paid taxes to a state with an approved unemployment insurance law could credit (offset) up to 90 percent of the state tax against the federal tax. This insured that employers in states without an unemployment insurance law would not have an advantage competing with similar businesses in states with such a law because they would still be subject to the federal payroll tax, and 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. Later, Puerto Rico adopted its own program, which was incorporated in 1961 into the federal-state system. A similar program for workers in the Virgin Islands was added in 1978.

If employers are to receive an offset against federal taxes and if states are to receive federal grants for administration, federal law requires state unemployment insurance programs to meet certain requirements. These requirements are intended to ensure that a state participating in the program has an unemployment insurance system that is fairly administered and financially secure.

One requirement is that all contributions collected under state laws be deposited in the unemployment trust fund of the U.S. Treasury Department. 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. At any time, a state may withdraw money from its account in the trust fund, but only to pay benefits. Thus, unlike the situation in the majority of states having workers' compensation and temporary disability insurance laws, unemployment insurance benefits are paid exclusively through a public fund. Private plans cannot be substituted for the state plan.

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

Coverage

Originally, coverage had been limited to employment covered by the Federal Unemployment Tax Act (FUTA), which relates primarily to industrial and commercial workers in private industry. However, several federal laws added substantially to the number and types of workers protected under the state programs, such as the Employment Security Amendments of 1970 and the Unemployment Compensation Amendments of 1976.

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

Agricultural workers are covered on farms with a quarterly payroll of at least \$20,000 or employing 10 or more employees in 20 weeks of the year. Domestic employees in private households are subject to FUTA if their employer pays wages of \$1,000 or more in a calendar quarter. Excluded from coverage are workers employed by their families and the self-employed.

Before 1976, employment in state and local governments and nonprofit organizations were exempt from FUTA. However, as a result of federal legislation enacted in 1976, most employment in these groups must now 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.

Through special federal legislation, federal civilian employees and ex-servicemembers of the armed forces were brought under the unemployment insurance system. Benefits for those persons are financed through federal funds but are administered by the states and paid in accordance with the provisions of the state laws. A separate unemployment insurance law enacted by Congress covers railroad workers.

Amendments to FUTA made in 2000 added Indian tribes to the set of entities for whom coverage is required, although they are not liable for FUTA taxes. As a result, workers performing services for tribes are now potentially eligible to receive unemployment insurance benefits. Coverage is required when service is performed for any Indian tribe, band, nation, or other organized group community that is recognized as eligible for federal assistance because of their status as Indians. The same permissible exclusion from coverage that is applicable to other governmental entities also applies to services performed for Indian tribes. If an Indian tribe fails to make payments to states as required, the tribe loses its FUTA exemption and may lose coverage.

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 or earnings in covered employment. All workers whose employers contribute to or make payments in lieu of contributions to state unemployment funds, federal civilian employees, and ex-servicemembers are eligible if they are involuntarily unemployed, able to work, available for work, and actively seeking work. Workers must also meet the eligibility and qualifying requirements of the state law and be free from disqualifications. Workers who meet these eligibility conditions may still be denied benefits if they are found to have voluntarily quit their jobs without good cause or were discharged for misconduct.

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 4 quarters of the last 5 completed calendar quarters preceding the claim for unemployment benefits.

Benefits

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 states, the formula is designed to compensate for a fraction of the usual weekly wage, normally about 50 percent, subject to specified dollar maximums.

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

Each state establishes a ceiling on the weekly benefit amount, and no worker may receive an amount larger than the ceiling. The maximum may be either a fixed dollar amount or a flexible amount. Under the latter arrangement, which has been adopted in 34 jurisdictions, the maximum is adjusted automatically in accordance with the weekly wages of covered employees.

Twelve states provide additional allowances for certain dependents. They all include children under age 16, 18, or 19 (and, generally, older if incapacitated); eight states include a nonworking spouse; and two states consider other dependent relatives. The amount allowed per dependent varies considerably by state but generally is \$24 or less per week and, in the majority of states, the amount is the same for each dependent.

All but 13 states require a waiting period of 1 week of total unemployment before benefits can begin. Four states pay benefits retroactively for the waiting period if unemployment lasts a certain period or if the employee returns to work within a specified period.

Except for two jurisdictions, states provide a statutory maximum duration of 26 weeks of benefits in a benefit year. However, jurisdictions vary the duration of benefits through various formulas.

Extended Benefits

In the 1970s, a permanent federal-state program of Extended Benefits was established for workers who exhaust their entitlement to regular state benefits during periods of high unemployment. The program is financed equally from federal and state funds. Employment conditions in an individual state trigger Extended Benefits. This happens when the unemployment rate among insured workers in a state averages 5 percent or more over a 13-week period and is at least 20 percent higher than the

rate for the same period in the 2 preceding years. If the insured unemployment rate reaches 6 percent, a state may by state law disregard the 20 percent requirement in initiating Extended Benefits. Once triggered, Extended Benefit provisions remain in effect for at least 13 weeks. When a state's benefit period ends, Extended Benefits to individual workers also end, even if they have received less than their potential entitlement and are still unemployed. Further, once a state's benefit period ends, another statewide period cannot begin for at least 13 weeks.

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

Before the 1992 legislation, the Extended Benefits program was based on the insured unemployment rate (IUR)—the number of unemployed workers receiving benefits in a state as a percentage of the number of persons in employment that is covered by unemployment insurance in that state. By definition, the IUR does not include workers who have exhausted their benefits but are still unemployed.

The 1992 legislation (P.L. 102-318) provided states with the option of adopting an additional formula for triggering the permanent Extended Benefits program. Effective March 1993, states had the option of amending their laws to use alternative total unemployment rate triggers in addition to the current insured unemployment rate triggers. Under this option, Extended Benefits would be paid when (1) the state's seasonally adjusted total unemployment rate for the most recent 3 months is at least 6.5 percent, and (2) that rate is at least 110 percent of the state average total unemployment rate in the corresponding 3-month period in either of the 2 preceding years.

States triggering on to the Extended Benefits program under other triggers would provide the regular 26 weeks of unemployment benefits in addition to 13 weeks of Extended Benefits (which is the same number of weeks of benefits provided previously). In addition, states that have chosen the total unemployment rate option will also amend their state laws to add an additional 7 weeks of Extended Benefits (for a total of 20 weeks) where the total unemployment rate is at least 8 percent and is 110 percent of the state's total unemployment rate for the same 3 months in either of the 2 preceding years. As of October 17, 2004, Extended Benefits were not payable in any state.

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Workers' Compensation

Workers' compensation was the first form of social insurance to develop widely in the United States. It is designed to provide cash benefits and medical care when employees suffer work-related injuries or illnesses, and survivor benefits to the dependents of workers whose deaths result from a work-related incident. In exchange for receiving benefits, workers who receive workers' compensation are generally not allowed to bring a tort suit against their employers for damages of any kind.

The federal government was the first to establish a workers' compensation program, covering its civilian employees with an act that was passed in 1908 to provide benefits for workers engaged in hazardous work. The remaining federal workforce was covered in 1916. Nine states enacted workers' compensation laws in 1911. By 1920, all but 7 states and the District of Columbia had workers' compensation laws.

Today each of the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands has its own program. The federal government covers its employees through its own program. It also administers the Longshore and Harbor Workers' Compensation Act, enacted in 1927, which covers longshore and harbor workers throughout the United States.

Coal miners suffering from pneumoconiosis, or "black lung" disease, are covered by the Black Lung Benefits Act of 1972, with the initial benefits enacted as part of the Coal Mine Health and Safety Act of 1969. Under this program, monthly cash benefits are payable to miners disabled by black lung disease and to their dependents or survivors. Medical benefits are also payable on the basis of a diagnosis of pneumoconiosis.

The Energy Employees Occupational Illness Compensation Program Act of 2000 instituted a new program that covers employees, contractors, and subcontractors of the Department of Energy (DOE) for exposure to beryllium and the contraction of chronic beryllium disease. In addition, employees of private companies providing beryllium to DOE are covered. Employees' survivors also receive cash benefits.

This same act also covers employees disabled or killed by cancers that developed after beginning employment at a DOE or an atomic weapons facility, as long as the cancer was at least "as likely as not" related to this employment, subject to a number of guidelines relating to radiation exposure, type of cancer, and other relevant factors. It also provides benefits for silica-related diseases and to uranium miners and their survivors who

have received lump-sum payments under the Radiation Exposure Compensation Act and establishes an Office of Worker Advocacy in the U.S. Department of Energy to deal with other claims of work-related occupational disease.

Coverage

In 2002, state and federal workers' compensation laws covered about 125.6 million employees. Covered payroll in 2002—that is, total wages paid to covered workers—was \$4.62 trillion.

Common exemptions from coverage are domestic service, agricultural employment, small employers, and casual labor. However, 39 programs have some coverage for agricultural workers, and 25 programs have some coverage for domestic workers.

Many programs exempt employees of nonprofit, charitable, or religious institutions. The coverage of state and local public employees differs widely from one state program to another.

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 have health insurance and short-term and long-term cash benefit plans that cover disabilities whether or not the conditions are work-related. In addition, under federal laws these workers retain the right to bring tort suits against their employers for negligence in the case of work-related injuries or illness.

The programs are compulsory for most private employment, except in Texas, where it is elective. That is, in Texas employers may accept or reject coverage under the law. If they reject it, they lose the customary common-law defenses against suits by employees in private industry.

Benefits

The benefits provided under workers' compensation include periodic cash payments and medical services to the worker during the period of disablement for the disabling condition. They also include death and funeral benefits to the workers' survivors. Lump-sum settlements are permitted under most programs.

Approximately three-fourths of all workers' compensation cases involve only medical benefits. Cash wage

replacement benefits are categorized according to the duration and severity of the worker's disability.

Temporary and Permanent Total Disability

A large majority of compensation cases involving cash payments involve temporary total disability. That is, the employee is unable to work at all while he or she is recovering from the injury but the worker is expected to recover. When workers' lost time exceeds the waiting period (3 to 7 days, depending on the state), they receive a percentage of their weekly wages—typically two-thirds—up to a maximum weekly amount. The maximum is generally set at some percentage of the state's average weekly wage, ranging from 66 2/3 percent to 200 percent, but typically 100 percent.

In some cases, workers return to work prior to the date they reach maximum medical improvement and thus have reduced responsibilities and an accompanying lower salary. In those cases they receive temporary partial disability benefits.

After the date of maximum medical improvement, if a disability is severe enough, the worker receives permanent total disability benefits. In only a very few cases is the worker found to have a permanent total disability.

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. The system for determining benefits in these cases is very complex and varies significantly across jurisdictions. Some states provide benefits based on an impairment rating scheme. The level of impairment, often expressed as a percentage of total disability, is used to determine the benefit amount. Some states provide benefits based on the loss of earning capacity. They use impairment ratings with modifications based on vocational factors, such as the worker's education, job experience, and age. Other states use systems that attempt to compensate workers for actual lost wages.

Death Benefits

Generally, compensation is related to earnings and to the number of dependents and is payable to the survivors of workers who die from a work-related illness or injury. Benefits are capped in 26 states.

Medical Benefits

All compensation acts require that medical aid be furnished to workers suffering from a work-related injury or illness without delay, whether or not the condition entails

work interruption. This care includes first-aid treatment, physician services, surgical and hospital services, nursing, medical drugs and supplies, appliances, and prosthetic devices. Care is typically provided with no co-payment from the worker.

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

Financing

Workers' compensation programs are financed almost exclusively by employers and are based on the principle that the cost of work-related accidents is a business expense. Depending on state laws, employers can purchase insurance from a private carrier or state fund, or they can self-insure. No program relies on general taxing power to finance workers' compensation. Employers in most programs are permitted to carry insurance against work accidents with commercial insurance companies or to qualify as self-insurers by giving proof of financial ability to carry their own risk. In seven jurisdictions, however, commercial insurance is not allowed. In four of these areas, including Puerto Rico and the Virgin Islands, employers must insure with an exclusive state fund, and in three others, they must either insure with an exclusive state insurance fund or self-insure. In 19 jurisdictions, state funds have been established that compete with private insurance carriers. Federal employees are provided protection through a federally financed and operated system.

Program Highlights

Benefit payments under workers' compensation programs increased to \$53.4 billion in 2002, which was a 7.4 percent increase from the benefit figure of \$49.8 billion in 2001. When compared with covered wages, benefits grew by 6.9 percent from \$1.08 to \$1.16 per \$100 of covered wages.

In 2002, medical benefits accounted for \$24.3 billion, and wage loss compensation accounted for \$29.2 billion. The latter amount includes payments to disabled workers and the survivors of deceased workers.

The \$53.4 billion for workers' compensation benefit payments in 2002 includes more than \$827 million in benefits for the Black Lung program. This program is described separately (see Tables 9.D1–9.D3).

The employers' cost of providing workers' compensation coverage generally varies according to risk, industrial classification, and experience rating. Nationally, in 2002, such costs were approximately \$1.58 per \$100 of cov-

ered wages, or about \$580 for each of the 125.6 million protected employees.

The year 2002 is the second year since 1992 that benefits grew faster than wages. It is also the second year since 1993 that employer costs increased relative to covered wages.

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Temporary Disability 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. Those programs are known as temporary disability insurance (TDI) because the duration of the payments is limited.

Federal law does not provide for a federal-state system of short-term disability comparable with 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 TDI took advantage of it: California, New Jersey, and Rhode Island. The first state law was enacted by Rhode Island in 1942, followed by legislation in California and the railroad industry in 1946, New Jersey in 1948, and New York in 1949. Then came a hiatus of two decades before Puerto Rico and Hawaii passed laws in 1968 and 1969, respectively.

The five state temporary disability insurance laws and the Puerto Rico law cover most commercial and industrial wage and salary workers in private employment if the employer has at least one worker. In no state is coverage under TDI identical with that of the unemployment insurance program. Principal occupational groups excluded are domestic workers, family workers (parent, child, or spouse of the employer), government employees, and the self-employed. State and local government employees are included in Hawaii, and the other state programs generally provide elective coverage for some or all public employees.

Agricultural workers are covered to varying degrees in California, Hawaii, New Jersey, and Puerto Rico, but they are not covered in other jurisdictions. The California law permits self-employed individuals to elect coverage on a voluntary basis. Workers employed by railroads, railroad associations, and railroad unions are covered by TDI under the national system included in the Railroad Unemployment Insurance Act.

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, covered employers may provide supplemental benefits in any manner they choose. 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 require employers to provide their own disability insurance plans for their workers by setting up an approved self-insurance plan, by reaching 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 state-operated competitive carrier. Both Hawaii and New York operate special funds to pay benefits to workers who become disabled while unemployed or whose employers have failed to provide the required protection. In other jurisdictions, benefit payments for the disabled unemployed are made from the regular state-operated funds.

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 received certain types of income during the period of disability.

Earnings or Employment Requirements

A claimant must have a specified amount of past employment or earnings to qualify for benefits. 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 to 3 months. Upon cessation of employment after a specified period, workers generally lose their 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 dis-

ability during unemployment in New Jersey and New York. All the laws pay full benefits for disability due to pregnancy.

Disqualifying Income

All the laws restrict payment of disability benefits when the claimant is also receiving workers' compensation payments. 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).

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 their disablement. Railroad workers are not eligible for TDI benefits while they receive sick leave pay.

In all seven TDI systems, as with unemployment insurance, weekly benefit amounts are related to a claimant's previous earnings in covered employment. In general, the benefit amount for a week is intended to replace at least one-half the weekly wage loss for a limited time. All the laws, however, specify minimum and maximum amounts payable for a week. The maximum duration of benefits varies from 26 weeks to 52 weeks. Hawaii, New York, and Puerto Rico provide for benefits of a uniform duration of 26 weeks for all claimants; California and the railroad program have maximum benefit periods of 52 weeks; New Jersey, 26 weeks; and Rhode Island, 30 weeks. Under the railroad program, duration of benefits varies from 26 weeks to 52 weeks, based on the total number of years of employment in the industry. In the other jurisdictions, limited predisability "base period" wages reduce benefit duration. A noncompensable waiting period of a week or 7 consecutive days of disability (4 days for railroad workers) is generally required before the payment of benefits for subsequent weeks.

The 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, those provisions represent standards against which the private plan can be measured (in accordance with provisions in the state law).

Financing and Administration

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

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

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

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Black Lung Benefits

The Black Lung benefit program established by the Federal Coal Mine Health and Safety Act of 1969 provides monthly benefit payments to coal miners totally disabled as a result of pneumoconiosis, to the widows of coal miners who died as a result of pneumoconiosis, and to their dependents. The Social Security Administration (SSA) was responsible for the payment and administration of these Part B benefits (miner, survivor, and dependent) with respect to claims filed through June 30, 1973 (and certain survivor cases, before December 31, 1973).

On October 1, 1997, responsibility for maintenance and payment of Part B was transferred from SSA to the Department of Labor (DOL); SSA, however, maintains responsibility for conducting formal hearings necessary to resolve contested issues with respect to Part B claims. Only data on these Part B claims are reported on in this *Supplement*. Part C claims are reported in the *OWCP Annual Report to Congress*, U.S. Department of Labor, Office of Workers' Compensation Programs.

Under the Black Lung Benefits Act of 1972, DOL was assigned jurisdiction over Part C benefits, generally claims filed July 1, 1973, and later. Different financing provisions are applicable to these claims.

Legislation enacted on November 2, 2002 (P.L. 107-275), transferred permanently the responsibility for all Black Lung claims (Parts B and C) to the Office of Workers' Compensation Programs (OWCP) of the Department of Labor. The Social Security Administration will only continue to handle a small number of pending Part B appeals cases on a reimbursable basis.

The basic Black Lung benefit rate is set by law at 37 1/2 percent of the monthly pay rate for federal employees in the first step of grade GS-2. The basic rate

to a miner or widow may be increased according to the number of qualified dependents—50 percent of the basic benefit rate if one dependent qualifies, 75 percent for two dependents, and 100 percent for three or more dependents.

Since Black Lung payments are tied directly to federal employee salary scales, increases are automatically payable when federal salaries are increased. Reflecting a 2.7 percent adjustment, monthly benefit rates effective January 1, 2004, are:

- Miner or widow, \$549.00
- Miner or widow and 1 dependent, \$823.50
- Miner or widow and 2 dependents, \$960.80
- Miner or widow and 3 or more dependents (family benefit), \$1,098.00

If a miner or surviving spouse is receiving workers' compensation, unemployment compensation, or disability insurance payments under state law, the Black Lung benefit is offset by the amount being paid under these other programs.

The 1972 amendments extended benefit payments to full orphans, parents, brothers, and sisters of deceased miners. Under earlier law, survivor payments were limited to widows and their dependent children (if the miner and spouse were both deceased, no benefits were payable to surviving children). The 1972 amendments also expanded coverage to include surface as well as underground coal miners.

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Veterans' Benefits

A variety of programs and benefits are available to servicemembers and veterans of military service: disability payments, educational assistance, health care, vocational rehabilitation, survivor and dependents benefits, life insurance, burial benefits, special loan programs, and hiring preference for certain jobs. Most of the veterans programs are administered by the Department of Veterans Affairs (VA).

Monetary Benefits

Two major cash benefit programs are available for veterans. The first program provides benefits to veterans with service-connected disabilities and, on the veteran's death, benefits are available for eligible surviving spouses, children, and dependent parents. These benefits are payable regardless of other income or resources. The second program provides benefits to needy veterans who have non-service-connected disabilities. These benefits are means tested.

Compensation for Service-connected Disabilities

Disability compensation is a monetary benefit paid to veterans who are disabled by injury or disease incurred in or aggravated during active military service. Individuals discharged or separated from military service under dishonorable conditions are generally not eligible for compensation payments. The amount of monthly compensation depends on the degree of disability, rated as the percentage of normal function lost. Payments in 2003 range from \$104 a month for a 10 percent disability to \$2,193 a month for total disability. Veterans who have at least a 30 percent service-connected disability are entitled to an additional dependent's allowance. The amount is based on the number of dependents and degree of disability.

Pensions for Non-service-connected Disabilities

Monthly benefits are provided to wartime veterans with limited income and resources who are totally and permanently disabled because of a condition not attributable to their military service. To qualify for these pensions, a veteran must have served in one or more of the following designated war periods: The Mexican Border Period, World War I, World War II, the Korean Conflict, the Vietnam Era, or the Gulf War. The period of service must have lasted at least 90 days, and the discharge or separation cannot have been dishonorable. Service less than 90 days is acceptable if the veteran was discharged with a service-connected disability.

Pension payments are reduced by countable income. Some medical and other expenses are allowed as deductions from countable income. Veterans aged 65 years or older who meet service, net worth, and income requirements are eligible for a pension, regardless of current physical condition.

Effective December 1, 2002, maximum benefit amounts for non-service-connected disabilities range from \$807 per month for a veteran without a dependent spouse or child to \$1,597 per month for a veteran who is in need of regular aid and attendance and who has one dependent. For each additional dependent child, the pension is raised by \$136 per month.

Benefits for Survivors

The dependency and indemnity compensation (DIC) program provides monthly benefits to the surviving spouse, children (under age 18, disabled, or students), and certain parents of service persons or veterans who die as the result of an injury or disease incurred while in or aggravated by active duty or training, or from a disability otherwise compensable under laws administered by the Department of Veterans Affairs.

DIC payments may also be authorized for survivors of veterans who were totally disabled by service-connected conditions at the time of death, even though their service-connected disabilities did not cause their deaths.

Eligibility for survivor benefits based on a non-service-connected death of a veteran with a service-connected disability requires a marriage of at least a 1-year duration before the veteran's death. A surviving spouse is generally required to have lived continuously with the veteran from marriage until his or her death. Entitlement for death benefits ends with the surviving spouse's remarriage, but may be restored upon termination of the remarriage.

The monthly benefit amount payable to surviving spouses of veterans who died before January 1, 1993, depends on the last pay rate of the deceased service person or veteran. In 2003, for pay grades E-1 through E-6, a flat monthly rate of \$948 is paid to surviving spouses. Monthly benefits for grades E-7 through E-9 range between \$980 and \$1,165. For veterans who died after January 1, 1993, surviving spouses receive a flat \$948 a month. An additional \$204 a month will be paid to supplement the basic rate if the deceased veteran had been entitled to receive 100 percent service-connected compensation for at least 8 years immediately preceding

death. The amounts payable to eligible parents are lower and depend on (1) the number of parents eligible, (2) their income, and (3) their marital status.

Pensions for Non-service-connected Death

Pensions are paid on the basis of need to surviving spouses and dependent children (under age 18, disabled, or students) 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. In 2002, pensions range from \$541 a month for a surviving spouse without dependent children to \$1,032 a month for a spouse who is in need of regular aid and attendance and who has a dependent child. The pension is raised by \$137 a month for each additional dependent child. Pension payments are reduced by countable income. Some medical and other expenses are allowed as deductions from countable income.

Hospitalization and Other Medical Care

The Department of Veterans Affairs (VA) provides a nationwide system of health care through a system of hospitals and community-based outpatient clinics to eligible veterans.

Enrollment and Provision of Hospitalization and Outpatient Medical Care to Veterans

To receive health care, veterans generally must be enrolled with the VA and may apply for enrollment at any time. Veterans do not have to be enrolled if they (1) have a service-connected disability of 50 percent or more, (2) want care for a disability that the military determined was incurred or aggravated in the line of duty but that the VA has not yet rated during the 12-month period following discharge, or (3) want care for a service-connected disability.

Enrolled veterans and those not subject to enrollment are eligible to receive comprehensive medical benefits, which include basic and preventive care.

Eligibility Requirements

Basic eligibility for hospital care and outpatient medical services are based on a veteran's character of discharge

from active military service. Veterans discharged prior to September 7, 1980, for other than dishonorable conditions have basic eligibility for care. However, veterans discharged after September 7, 1980, must have completed 24 consecutive months of active-duty service. Reservists who were called or ordered to active duty may also be eligible for care as a veteran if they complete the full period for which they were called or ordered to active duty. The 24-month minimum service time requirement does apply to veterans who were discharged for reasons of early-out under Title 38, U.S.C. 1173, discharged for a disability incurred or aggravated in the line of duty, was awarded VA compensation, or is in need of care for an adjudicated service-connected disability.

Care for Dependents and Survivors

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

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

Nursing Home Care

A veteran seeking nursing home care must meet the established eligibility requirements for admission to a Department of Veterans Affairs nursing home. The Veterans Millennium Health Care and Benefits Act (P.L. 106-117, passed by Congress on November 30, 1999) made amendments to the original authority for nursing home placement. The new law requires that the VA:

- Provide nursing home care to any veteran in need of such care for a service-connected disability;
- Provide nursing home care to any veteran who is in need of such care and who has a service-connected disability rated at 70 percent or greater;
- Provide nursing home care, either directly or through contracts when clinically indicated for eligible veterans;
- Facilities will determine the need for nursing home care based on a comprehensive interdisciplinary assessment.

Other Medical Benefits

Other Department of Veterans Affairs programs and medical benefits are available to certain veterans. Veterans do not need to be enrolled in the VA health care system to be eligible for any of the following benefits, although there may be restrictions: domiciliary care, alcohol and drug dependency treatment; prosthetic appliances; modification in certain veterans' homes when so ordered by his or her physician, subject to cost limitations; compensation and pension examinations; care as part of a VA-approved research project; readjustment counseling and treatment for Vietnam veterans; sexual trauma counseling for veterans suffering from trauma of a sexual nature during active military service; counseling; vocational rehabilitation counseling; special registry examinations and dental care.

Educational Assistance

The post-Vietnam Veterans' Educational Assistance Program (VEAP) is a voluntary contributory matching

program for persons entering service after December 31, 1976. To be eligible, the servicemember must have initially contributed to VEAP before April 1, 1987. The Montgomery GI Bill—Active Duty program provides education benefits for individuals entering military service on or after July 1, 1985, and for certain other individuals. Servicemembers entering active duty have their basic pay reduced \$100 a month for the first 12 months of their service unless they specifically elect not to participate. An educational assistance program is also available for individuals who enter the Selected Reserve on or after July 1, 1985.

The Department of Veterans Affairs also pays educational assistance for dependents if a veteran is permanently and totally disabled from a service-related cause, or dies as a result of service, or while completely disabled from service-related causes.

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Temporary Assistance for Needy Families

On August 22, 1996, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 became law. This comprehensive, bipartisan legislation changed the nation's welfare system into one requiring work in exchange for time-limited assistance. It created the Temporary Assistance for Needy Families (TANF) program, which replaced the Aid to Families with Dependent Children (AFDC), Emergency Assistance (EA), and Job Opportunities and Basic Skills Training (JOBS) programs. The law marks the end of federal entitlement to assistance. In TANF, states and territories operate programs, and Indian tribes have the option to run their own programs. States, territories, and tribes each receive a block grant allocation, and states must maintain a historical level of state spending known as maintenance of effort. The basic block grant provides states and tribes with \$16.5 billion in federal funds each year, through 2002. This amount covers benefits, administrative expenses, and services targeted to needy families.

The 1996 law offers states great flexibility in designing individual state TANF programs. Unless expressly provided under the statute, the federal government may not regulate the conduct of states.

States may use TANF funds in any manner "reasonably calculated to accomplish the purposes of TANF." The purposes are assisting needy families so that children can be cared for in their own homes; reducing dependency of needy parents by promoting job preparation, work, and marriage; preventing out-of-wedlock pregnancies; and encouraging the formation and maintenance of two-parent families.

Program Features

Work Requirements

With few exceptions, recipients must work as soon as job ready, or no later than 2 years after coming on assistance. In fiscal year 1997, each state had to ensure that 25 percent of all families in the state were engaged in work activities. This percentage increased to 50 percent in fiscal year 2002. Minimum participation rates for two-parent families started at 75 percent in fiscal year 1997 and increased to 90 percent. (If a state reduces its caseload without restricting eligibility, it can receive a caseload reduction credit. This credit reduces the minimum participation rates the state must achieve.) During 1997 and 1998, single parents had to participate in work activities for at least 20 hours per week; by fiscal year 2000, they had to participate at least 30 hours per week. Two-parent families had to participate in work activities for at least 35 or 55 hours per week, depending upon the cir-

cumstances. Failure to participate in work requirements can result in a reduction or a termination of benefits to the family. However, states cannot penalize single parents with a child under 6 for failing to meet work requirements if they cannot obtain child care. A state may exempt single parents with children under the age of 1 from the work requirements and disregard these individuals in the calculation of participation rates for up to 12 months.

Work Activities

Activities that count toward a state's participation rates are unsubsidized or subsidized employment, on-the-job training, work experience, community service, job search, vocational training, job skills training related to work, or education directly related to work; satisfactory secondary school attendance; and providing child care services to individuals who are participating in community service. However, no more than 12 months of vocational training, no more than 6 total weeks of job search, and no more than 4 consecutive weeks of job search may count. Further, effective in fiscal year 2000, no more than 30 percent of those meeting the participation rates may count toward the work requirement on the basis of participation in vocational training or by being a teen parent in secondary school.

Five-Year Time Limit

Families with an adult who has received federally funded assistance for a total of 5 years (or less at state option) are not eligible for cash aid under the TANF program. States may extend assistance beyond 60 months to up to 20 percent of their caseload. They may also elect to provide assistance to families beyond 60 months using state-only funds, or they may provide services to families that reach the time limit using Social Services Block Grants.

State Maintenance of Effort Requirements

The TANF block grant program has an annual cost-sharing requirement, referred to as "maintenance of effort," or MOE. Every fiscal year each state must spend a certain minimum amount of its own money to help eligible families in ways that are consistent with the purposes of the TANF program. The required MOE amount is based on an "applicable percentage" of the state's (nonfederal) expenditures on AFDC and the AFDC-related programs in 1994. The applicable percentage depends on whether the state meets its minimum work participation rate requirements for that fiscal year. A state that does not meet the required minimum work participation rate requirements must spend at least 80 percent of the

amount it spent in 1994. A state that meets its minimum work participation rate requirements must spend at least 75 percent of the amount it spent in 1994.

In addition to the federal TANF block grant funding, needy states with economic problems may request federal funds from the Contingency Fund. The Contingency Fund has a more rigorous MOE requirement.

The fiscal year 2004 budget follows the framework proposed in the president's fiscal year 2003 budget request that includes reauthorization of the Personal Responsibility and Work Opportunity Reconciliation Act. The reauthorization maintains current program funding levels for the following activities: Family Assistance Grants to States, Tribes and Territories; Matching Grants to Territories; and Tribal Work Programs. Authority for both the Contingency Fund and Supplemental Grants for Population Increases would be reinstated. In addition, a new TANF Research, Demonstration, and Technical Assistance program that will include promotion of family formation and healthy two-parent marriage activities would be established, as well as a new matching grant program focused on marriage promotion. Finally, the Bonus to Reward High Performance States would be refocused to provide for bonuses on employment achievement. The president's appropriation request for this account assumes passage of pending legislation included in the president's fiscal year 2004 request.

Penalties

The Department of Health and Human Services (HHS) may reduce a state's block grant if it fails to do any of the following:

- Satisfy work requirements. A penalty of 5 percent accrues in the first year. The penalty amount increases 2 percent per year for each consecutive failure. The penalty is adjusted based on degree of failure. The maximum penalty is 21 percent.
- Comply with 5-year limit on assistance. Failure to comply results in a 5 percent penalty.
- Meet the state's basic maintenance of effort requirements. The penalty is based on the amount of the state's underspending. The state also loses its Welfare-to-Work funds.
- Meet the state's contingency fund MOE requirement. The penalty is a reduction of the state's federal TANF grant by the amount of contingency funds received and not remitted.
- Reduce recipient grants for refusing to participate in work activities without good cause. A penalty of between 1 percent and 5 percent is assessed based on the degree of noncompliance.

- Maintain assistance when a single custodial parent with a child under 6 cannot obtain child care. Failure to comply results in a penalty of 5 percent.
- Submit required data reports. A penalty of 4 percent accrues.
- Comply with paternity establishment and child support enforcement requirements. Failure to comply results in a penalty of up to 5 percent.
- Participate in the Income and Eligibility Verification System. A penalty of up to 2 percent accrues.
- Repay a federal loan on time. The penalty will be based on the amount unpaid.
- Use funds appropriately. Misuse of funds can result in states being penalized for the amount misused. If this misuse is found to be intentional, an additional penalty of 5 percent will be assessed.
- Replace federal penalty reductions with additional state funds. This provision results in a penalty of up to 2 percent and requires states to contribute state funds to make up for any reductions in federal funds due to penalties.

The total penalty assessed against a state in a given year may not exceed 25 percent of a state's block grant allotment. In some situations, states may avoid penalties (1) if they demonstrate that they had reasonable cause for failing to meet the program requirements or (2) if they develop a corrective compliance plan, receive approval of their plan, and correct or discontinue the violation.

Personal Employability Plans

States must make an initial assessment of a recipient's skills. States may develop personal responsibility plans for each recipient to identify the education, training, and job placement services needed to move into the workforce.

Teen Parent Live-At-Home and Stay-In-School Requirement

Unmarried minor parents must participate in educational and training activities and live with a responsible adult or in an adult-supervised setting in order to receive assistance. States are responsible for assisting in locating adult-supervised settings for teens who cannot live at home.

State Plans

The Department of Health and Human Services (HHS) reviews state plans for completeness only. States must allow for a 45-day comment period on the state plan by local governments and private organizations and consult

with them. The state plan must have "objective criteria" for eligibility and benefits that are "fair" and "equitable." The plan must explain appeal rights.

Job Subsidies

The law allows states to create jobs by taking money that is now used for welfare checks and using it to create community service jobs, provide income subsidies, or provide hiring incentives for potential employers.

Waivers

States that received approval for welfare reform waivers before January 1, 1997, have the option to operate their cash assistance program under some or all of these waivers, until the waivers expire.

Effective Dates

States had until July 1, 1997, to submit state plans and begin implementing TANF, although they had the option to implement earlier. For states to remain eligible (that is, continue to qualify to receive funding under TANF), they will need to submit TANF renewal plans during the applicable 27-month period described in section 402 of the Social Security Act. Thus, state plans remain effective for about 3 years. States may choose to submit TANF renewal plans before their funding period expires; however, this will move up the time for the next renewal of the state's eligibility status. Only eligible states may receive a TANF block grant.

HHS published final regulations covering the state TANF programs on April 12, 1999. These regulations took effect October 1, 2000.

Tribal Programs

Federally recognized Indian tribes may apply directly to HHS to operate a TANF block grant program. Eligible tribes include the federally recognized tribes in the lower 48 states and 13 designated entities in Alaska (that is, the 12 Alaska Native regional nonprofit associations and Matlakatla). TANF allotments for Indian tribes are based upon previous state expenditures of federal dollars in AFDC, Emergency Assistance (EA), and JOBS on tribal members in fiscal year 1994. Tribal TANF programs could be implemented as early as July 1, 1997. Like states, Indian tribes can use their TANF funding in any manner reasonably calculated to accomplish the purposes of TANF. They have broad flexibility to determine eligibility, method of assistance, and benefit levels. Unlike state plans, the federal government approves tribal plans. Tribes and HHS must reach agreement on time limits, work requirements, and minimum participation rates.

In addition to authorizing tribes to administer TANF, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced the former tribal JOBS program with the Native Employment Works (NEW) program. The NEW program provides funding for tribes and intertribal consortia to design and administer tribal work activities that meet the unique employment and training needs of their populations while allowing tribes and states to provide other TANF services.

HHS published final regulations for the tribal TANF and NEW programs on February 18, 2000.

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Food Stamps

Overview

The Food Stamp program provides a means for persons with no or little income to obtain a nutritionally adequate diet. The program issues monthly allotments of coupons that are redeemable at retail food stores, or provides benefits through electronic benefit transfer (EBT). Eligibility and allotments are based on household size, income, assets, and other factors.

Households without income receive an amount equal to 100 percent of the June monthly cost of the Thrifty Food Plan (TFP—a nutritionally adequate diet) for a reference family of four adjusted for household size and economies of scale. This amount is updated every October for the new fiscal year to account for food price increases.

As of October 2004, an eligible four-person household in the continental United States with no income receives \$499 per month in food stamps. Households with income receive food stamps valued at the difference between the maximum allotment and 30 percent of their income, after certain allowable deductions.

To qualify for food stamps, a household must have

1. Less than \$2,000 in disposable assets (\$3,000, if at least one member is aged 60 or older or is disabled),
2. Gross income below 130 percent of the poverty guidelines for the household size, and
3. Net income of less than 100 percent of the poverty guidelines' allowable deductions.

Households with a person aged 60 or older or a disabled person receiving either Supplemental Security Income (SSI), Social Security (OASDI), state general assistance, or veterans' disability benefits (or interim disability assistance pending approval of any of the above programs) may have gross income exceeding 130 percent of the poverty guidelines if the income is lower than 100 percent of the poverty guidelines' allowable deductions.

One- and two-person households that meet the applicable standard receive at least \$10 a month in food stamps.

All households in which all members receive Temporary Assistance for Needy Families (TANF) or SSI are categorically eligible for food stamps and are not subject to the income or asset limits.

Net income is computed by subtracting the following deductions from monthly gross income:

1. Twenty percent of earned income;
2. Standard deduction of \$153 for fiscal year 2005 for five-person households and \$175 for larger households;
3. Amount paid for dependent care (up to \$200 a month for each child under age 2 and \$175 for all other dependents) while the dependent's caretaker is working or looking for work;
4. Out-of-pocket medical expenses in excess of a \$35 deductible for a person aged 60 or older or a disabled person (if more than one person in the household is aged or disabled, \$35 is subtracted once before deducting combined medical expenses);
5. Legally owed child support payments; and
6. Excess shelter expenses, which are total shelter costs including utilities minus 50 percent of income after all the above deductions have been subtracted (effective October 1, 2004, the limit was \$388; the limit does not apply to households with an aged or disabled member).

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 12-month period, although states may request a waiver allowing for a 24-month certification period for these households. Households must report monthly income or expense changes of \$25 or more or other changes in circumstances that would affect eligibility.

Families with income or food loss resulting from disaster situations such as tornadoes or floods may be eligible for food stamps for up to 1 month if they meet the special disaster income and asset limits.

Special provisions allow the homeless, drug addicts, alcoholics, blind, or disabled residents in certain group living arrangements, residents of shelters for battered spouses and children, and persons aged 60 or older to use their coupons for meals prepared at a nonprofit facility. The elderly and homeless may also use their coupons to purchase concession-priced meals from authorized restaurants.

Households with members who are elderly (aged 60 or older), disabled, or lack transportation to the food

stamp office may be certified for food stamps through a telephone interview or a home visit.

Initiated on a pilot basis in 1961, the Food Stamp program was formally established by the Food Stamp Act of 1964, with 22 states operating 43 projects serving 350,000 people. The Food Stamp Act of 1977, as amended (P.L. 95-113), has been extended to all 50 states, the District of Columbia, Guam, and the Virgin Islands. Authorization for this program extends through September 30, 2002. (Since July 1982, Puerto Rico receives a block grant for nutrition assistance rather than participating in the Food Stamp program.)

The Food Stamp program is administered nationally by the Food and Nutrition Service of the Department of Agriculture (USDA) 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 stamp benefits, but federal and state agencies share administrative costs.

An average of 21.3 million persons per month participated in the Food Stamp program during fiscal year 2003 (October 2002 through September 2003). The average monthly value of food stamps per person was \$83.93, and the total value of benefits issued that year was \$21.4 billion. Total federal government costs for this program were \$23.9 billion.

History of Provisions

The Food Stamp Act of 1984 (P.L. 88-525) established the Food Stamp program. Originally, participants were required to purchase food stamp coupons. The difference between the face value of the coupons and the amount the participant paid was known as the "bonus value." The amount paid for coupons varied according to household income.

Amendments to the 1964 Act, enacted in 1971 (P.L. 91-671), established uniform national eligibility standards and uniform national benefit levels, required family allotments large enough to purchase a nutritionally adequate diet, provided free food stamps to the poorest recipients, required automatic cost-of-living increases in food stamp allotments, and established work-registration requirements for able-bodied adult household members up to age 65 (except students and those needed at home to care for children under age 18).

The Agriculture and Consumer Protection Act of 1973 (P.L. 93-86) expanded the program (while phasing

out the family food distribution program), provided for semiannual allotments of coupon adjustments, and broadened the categories of persons eligible to participate. This legislation extended the program nationwide, requiring all states to participate in the Food Stamp program.

The Food and Agricultural Act of 1977 (P.L. 95-113) made sweeping changes to the Food Stamp program. It eliminated the purchase requirement and allowed households to receive only the bonus portion of their coupon allotments. Deductions from income were limited to a standard deduction, a 20 percent earnings deduction, and a combined excess shelter and child care deduction. The poverty guidelines became the new eligibility limits and, for the first time, households receiving Aid to Families with Dependent Children (AFDC) or SSI payments were required to meet asset and income limits. The work registration requirements were tightened for students and for caretakers, whose children now had to be under age 12. Parents of children aged 12 or older were required to register for work. However, the age at which the registration exemption for older persons became effective was lowered from age 65 to age 60.

The Food Stamp Act Amendments of 1979 (P.L. 96-58) provided a medical deduction to elderly and disabled persons, removed the limit on their shelter deduction, and tightened fraud provisions.

Legislation enacted in 1980 provided for an annual, rather than semiannual, adjustment to benefit levels and the amount of the standard deduction. This legislation also restricted student eligibility.

The Omnibus Budget Reconciliation Act (P.L. 97-35) and the Food Stamp and Commodity Distribution Amendments of 1981 (P.L. 97-98) mandated further changes in the Food Stamp program. For the first time, a gross income eligibility standard was applied to all households not containing an aged or disabled person. The earnings deduction was lowered to 18 percent. The updates to the TFP to account for inflation were postponed until October 1982, and the deduction limits were postponed until July 1983. For new participants, benefits for the first month were prorated from the day the application was filed. Boarders and persons who take part in strikes were excluded from the program, and the definition of what constitutes a household was tightened. Provisions facilitating claims and overpayment collection and fraud recovery were also enacted.

The program in Puerto Rico was replaced by a block grant. Monthly reporting and retrospective accounting systems were made mandatory for all states effective October 1983. Households composed solely of all aged or disabled persons, as defined above, were exempted

from the monthly reporting requirements, and migrant households were exempted from both requirements.

Further revisions were made by the Food Stamp Amendments of 1982 (P.L. 97-252). The maximum allotment was reduced from 100 percent to 99 percent of the TFP, and adjustments to the standard and shelter deductions were delayed until October 1, 1983. (P.L. 98-473 restored maximum food stamp allotments to the full cost of the TFP beginning November 1, 1984.) A net income limit for nonelderly and nondisabled households was added to the existing gross income limit. Benefit computations and adjustments were rounded down to the nearest dollar, and new restrictions were placed on the use of the Standard Utility Allowance for the excess shelter expense deduction. At the same time, the definition of disability for food stamp purposes was expanded to include those persons receiving certain veterans' payments, and annual cost-of-living adjustments to SSI payments and Social Security benefits were not counted in determining food stamp amounts for 3 months.

The Food Stamp program authorization was extended for 5 years by the Food Security Act of 1985 (P.L. 99-198). Among the revisions enacted, the definition of disability for food stamp purposes was again extended to include recipients of state supplementary SSI payments, government disability benefits, and Railroad Retirement disability payments.

Households in which all members receive AFDC or SSI were made categorically eligible for food stamps. The earned income, child care, excess shelter cost deductions, and asset limits were increased as of May 1986. Portions of the income received under the Job Training Partnership Act were now considered countable income. Further, all states were required to implement an employment and training program for food stamp recipients by April 1987.

The Hunger Prevention Act of 1988 (P.L. 100-435) made several changes in the program. It raised the maximum food stamp allotments and established allotments as specified percentages of the TFP as of the preceding June. For fiscal year 1989, the allotments were 100.65 percent of the TFP for June 1988; for fiscal year 1990, they were 102.05 percent of the TFP for June 1989; and for fiscal years 1991 and on, they are to be 103.00 percent of the TFP.

Other provisions of the 1988 legislation required states to institute prospective budgeting for households not required to report monthly and retrospective budgeting for households reporting monthly. It extended disability status to individuals who receive interim assistance pending the receipt of Supplemental Security Income, Social Security, or state disability payments, and allowed

the elderly, disabled, and those without transportation to apply for food stamps via telephone interviews. It required states to process Food Stamp applications jointly with AFDC and general assistance applications. It raised the dependent-care deduction from \$160 per household to \$160 per dependent. It made permanent an amendment in the Homeless Eligibility Clarification Act that exempts residents of shelters from ineligibility as residents of institutions.

Several provisions of the 1988 legislation also affect persons in farming. Households with farm income and expenses were given the option of averaging irregular farm-related expenses and farm income over 12 months and excluding as resources the value of farm land, equipment, and supplies for a period of 1 year after a household member ceases to be self-employed in farming.

The Mickey Leland Memorial Domestic Hunger Relief Act of 1990 (P.L. 101-624) reauthorized the Food Stamp program and the Nutrition Assistance Program in Puerto Rico with no major changes through fiscal year 1995.

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

The Omnibus Budget Reconciliation Act of 1993 (Mickey Leland Childhood Hunger Relief Act, P.L. 103-66) made a number of program revisions, including the following:

- The earnings of elementary or high school students who were aged 21 or younger were disregarded.
- Households that had breaks in participation of less than a month were allowed to receive a full month's benefit for the period of the break.
- The children of drug addicts and alcoholics living in treatment centers were permitted to qualify for food stamps.
- Food stamp households participating in demonstration projects were permitted to accumulate up to \$10,000 in resources.
- The shelter cap was raised to \$231 beginning July 1, 1994, then to \$247 beginning October 1995, and was to be eliminated entirely on January 1, 1997.
- The deduction for care of a child or other dependent was raised to \$200 per month for a child under age 2, and \$175 per month for all other dependents, effective September 1, 1994.
- State agencies were given the option to provide deductions for legally binding child support payments

made to persons outside the household, effective September 1, 1994. This deduction became mandatory October 1, 1995.

- The definition of a food stamp household was simplified to allow adult siblings who lived together and adult children who lived with their parents to form separate households if they purchased or prepared food separately.
- The amount of the Fair Market Value of a household's first vehicle that is excluded from the asset test was increased from \$4,500 to \$4,550, effective September 1, 1995. The limit was to have been raised to \$5,000, effective October 1, 1996, and indexed thereafter.

Legislation enacted in 1994 primarily provided means to combat fraud in the coupon redemption process.

Legislation enacted in 1995 prevented a one-time decrease of food stamp allotments in Alaska for the year beginning October 1, 1994, even though the cost of the TFP for Alaska had declined slightly.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) made sweeping changes to the Food Stamp program. The following additional restrictions were placed on the eligibility of certain low-income persons.

- Legal immigrants became ineligible for benefits, unless they met one of the following criteria: were naturalized citizens, had worked and paid taxes in the country for 40 quarters (or were the spouse or minor child of someone who had met the work requirement), had served in the U.S. armed forces (or were the spouse or child of a veteran), or were refugees, asylees, or persons granted a stay of deportation when admitted and have lived in the United States for less than 5 years. Legal immigrants currently receiving benefits were allowed to receive benefits until their first recertification after April 1, 1997, or until August 22, 1997, whichever date came first.
- Time limits were imposed for childless unemployed adults aged 18–50. Those who are not disabled are limited to receiving 3 months of benefits in any 36-month period, unless they are working 20 hours per week, participating in a work training program for at least 20 hours per week, or participating in work fare. States may request waivers for areas with at least 10 percent unemployment or insufficient jobs.

Other key provisions included the following:

- The maximum allotment was set at 100 percent of the Thrifty Food Plan, effective October 1, 1996.
- The standard deduction was frozen at \$134.
- The excess shelter deduction cap was set at \$250, effective January 1, 1997 (instead of being lifted), to be raised to \$275 on October 1, 1998, and to \$300 on October 1, 2000.
- The earnings of elementary or high school students aged 18–21 were counted again.
- Households with breaks in participation of less than a month received prorated benefits for the period of the break.
- Adult children under age 22 living with their parents were counted in the same household as their parents.
- The amount of Fair Market Value for a household's first vehicle that is excluded from the asset test was frozen at \$4,650, effective October 1, 1996.
- State and local energy assistance was counted as income.
- Recipients could be disqualified or given sanctions for a variety of reasons, such as failure to pay child support, receipt of multiple benefits, or failure to meet work requirements.
- States were permitted to operate a simplified Food Stamp program for households in which all household members participate in the state's Temporary Assistance for Needy Families program. In the simplified Food Stamp program, states may use their TANF rules to determine Food Stamp program benefits, provided that the TANF rules do not increase the aggregate cost of the Food Stamp program.
- States were required to implement Electronic Benefit Transfer (EBT) systems for issuing benefits before October 1, 2002, unless USDA granted a waiver.

The Balanced Budget Act of 1997 (P.L. 105-33) increased funds for the Food Stamp Employment and Training program, restricted the use of these funds, and made them available until spent. States were required to earmark 80 percent of these funds to provide work or training programs to childless, unemployed, able-bodied 18- to 50-year-olds. The Act also allowed states to grant discretionary exemptions from the time limits for up to 15 percent of a state's unwaived caseload of childless, unemployed, able-bodied 18- to 50-year-olds.

The Agricultural Research, Extension, and Education Reform Act of 1998 (P.L. 105-185) partially restored benefits to legal immigrants. Those who were lawfully resid-

ing in the United States on August 22, 1996, and are (1) blind or disabled (using the Food Stamp Act definition of "disability"), (2) aged 65 or older on August 22, 1996, or (3) under the age of 18 were eligible for benefits effective November 1, 1998. In addition, refugees and asylees were made eligible for the first 7 years after admittance into the United States (extended from 5 years). Members of Hmong or Highland Laotian tribes aiding U.S. personnel during the Vietnam War and their spouses or unmarried dependent children were made eligible. Cross-border Native Americans were also made eligible. Other provisions reduced the funding for Employment and Training Programs by \$100 million in 1999 and by \$45 million in 2000 and reduced payments for Food Stamp program administrative costs.

The Electronic Benefit Transfer (EBT) Interoperability and Portability Act of 2000 (P.L. 106-71) required states to make their EBT systems interoperable across state lines by October 2, 2002.

The Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriation Act, 2001 (P.L. 106-387) made the following changes to the Food Stamp program:

- Effective July 2001, at state option, state agencies could substitute TANF vehicle rules in place of food stamp vehicle rules provided that the TANF vehicle rules were more liberal.
- Effective March 2001, for households whose certification period began on or after March 1, 2001, the maximum excess shelter deduction limit rose to \$340 and was to be adjusted for inflation on October 1, 2002, and every year after.

The Farm Security and Rural Investment Act of 2002, H.R. 107-171, reauthorized the Food Stamp program through September 30, 2007. It contained the following provisions:

- Effective April 1, 2003, legal immigrants with 5 years of residency in the United States became eligible for food stamps. Effective October 1, 2003, eligibility was extended to legal immigrants under age 18, regardless of date of arrival in the United States.
- The current fixed standard deduction was replaced with a deduction that varies according to household size (with larger households receiving larger deductions) and is adjusted annually.

- The resource limit for households with a disabled member was increased from \$2,000 to \$3,000, consistent with the resource limit for households with elderly members.
- The requirement that federal costs for electronic benefit transfer systems not exceed the costs of paper coupon systems was eliminated.
- The Quality Control System, which historically measured payment accuracy, was substantially changed, with the liability threshold raised to 105 percent of the national average for 2 consecutive years. The current incentive system was replaced by bonuses for states demonstrating high or most improved performance.

This legislation also provided states with a number of options:

- States could extend from 3 months to 5 months the period of time that households leaving TANF could receive food stamps without recertification. The benefit amount would be equal to the amount received by the household prior to the household leaving TANF, with adjustments made for the loss of TANF income.
- States could exclude certain types of income that were excluded under the state's TANF plan. States could exclude types of resources that were excluded under the state's TANF or Medicaid programs.
- States could disregard reported changes in deductions during certification periods unless the changes were associated with a new residence or earned income.
- States could use the full standard utility allowance (SUA) rather than a prorated SUA for households sharing living quarters.
- States could treat child support payments to non-household members as an income exclusion rather than a deduction.
- States could extend semiannual reporting of changes to all households not exempt from periodic reporting.

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Low-Income Home Energy Assistance Program

The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), signed into law by the President on August 13, 1981, authorized seven block grants to be administered by the Department of Health and Human Services (HHS).¹ As one of its block grants, the Low-Income Home Energy Assistance Program (LIHEAP) is administered by the Administration for Children and Families' Office of Community Services (<http://www.acf.hhs.gov/programs/liheap>). Title XXVI of the Act authorized LIHEAP for fiscal years 1982–1984. Title VI of the Human Services Reauthorization Act of 1984 (P.L. 98-88) reauthorized and amended LIHEAP for fiscal years 1985–1986. Title V of the Human Services Reauthorization Act of 1986 (P.L. 99-425) reauthorized and amended LIHEAP for fiscal years 1987–1990. Title VII of the Augustus F. Hawkins Human Services Reauthorization Act of 1990 (P.L. 101-501) reauthorized and amended LIHEAP for fiscal years 1991–1994. Title XX of the National Institutes of Health Revitalization Act of 1993 (P.L. 103-43) reauthorized LIHEAP for fiscal year 1995. Title III of the Human Services Amendments of 1994 (P.L. 103-252) reauthorized and amended LIHEAP for fiscal years 1995–1999.² Title III of the Coats Human Services Reauthorization Act of 1996 (P.L. 105-285) reauthorized and amended LIHEAP for fiscal years 2000–2004. No new provisions became effective in fiscal year 2002.

Under LIHEAP, grants are provided to grantees to assist eligible households to meet the costs of home energy. In addition to the 50 states and the District of Columbia, grants were provided in fiscal year 2002 to 132 Indian tribes or tribal organizations and 5 insular areas.

In accordance with the Act, the secretary of Health and Human Services has left maximum policy discretion to the grantees. The federal information collection and reporting requirements for grantees were substantially reduced to require only information essential to federal administration and congressional oversight. Grantee decisions, directed by public participation in the development of grant applications, largely replaced federal regulations in shaping the program for fiscal years 1982–2002.

Funding

LIHEAP Block Grant Allotments

At the beginning of fiscal year 2002 (October 1, 2001), Congress passed a series of continuing resolutions that provided a percentage of funds for the LIHEAP program based on the appropriation level of \$1.4 billion for fiscal year 2001.

The president signed on January 10, 2002, the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2002 (Public Law 107-116). This law appropriated \$1.7 billion in LIHEAP block grant funds for fiscal year 2002. After set-asides for tribal and insular area grantees, the states received \$1.65 billion.

LIHEAP Emergency Contingency Fund Allotments

Public Law 107-116 also appropriated \$300 million in LIHEAP emergency contingency funds for fiscal year 2002. The president can release such funds to meet additional home energy needs resulting from floods, earthquakes, tornadoes, hurricanes, or ice storms, as well as abnormal heat or cold. Also, such funds can be released in cases of supply shortages or disruptions and for significant increases in (1) home energy costs; (2) home energy disconnections; (3) participation in a public benefit program such as Food Stamps, Supplemental Security Income, or Temporary Assistance for Needy Families; or (4) unemployment, layoffs, or applications for unemployment benefits. The president has the authority to determine whether to release any of the contingency funds.

For the 6-week period from June 23 to August 3, 2002, parts of the nation experienced much hotter than normal temperatures. On August 8, 2002, the president notified Congress of his intent to make \$100 million in LIHEAP emergency contingency funds available. On August 9, 2002, the secretary released \$100 million to the 34 states (including the District of Columbia) that were most severely affected by the unusual heat to ease the high energy burdens of low-income households resulting from the extreme temperatures.

The contingency funds were allocated among the 34 states on the basis of the number of cooling degree days in excess of the 30-year norm for that period for that state, weighted by the number of households in the state below 125 percent of the poverty level.

1. Effective in fiscal year 1987, the Primary Care Block Grant was repealed by the Health Services Amendment Act of 1985 (P.L. 99-80), enacted April 26, 1986.

2. The 1994 amendments provided that up to 25 percent of leveraging incentive funds may be set aside for the Residential Energy Assistance Challenge (REACH) program.

In the 34 states that received contingency funds, there were 46 Indian tribes or tribal organizations that received direct LIHEAP funding from HHS. These tribes and tribal organizations also received a share of the \$100 million in contingency funds. Their contingency fund grant awards were based on the same share of the state's contingency allotment that the tribe or tribal organization received of the state's regular LIHEAP block grant allotment. All of the \$100 million in contingency funds released on August 9, 2002, had to be obligated by September 30, 2003, or returned to the federal government.

With the release of this \$100 million, \$200 million remained available in emergency contingency funds under the LIHEAP appropriation for fiscal year 2002. These remaining funds expired since they were not released by September 30, 2002.

In addition, the Supplemental Appropriations Act of 2001 (P.L. 107-20), signed into law on July 24, 2001, appropriated \$300 million in LIHEAP energy emergency contingency funds that remained available to HHS until expended (no-year funds). None of these funds were released in fiscal years 2001 and 2002.

Distribution of funds

LIHEAP funds for fiscal year 2002 were distributed approximately as follows:

- \$1.65 billion in block grants to the 50 states and the District of Columbia; \$16.4 million in direct block grants to 132 Indian tribes and tribal organizations; and \$2.3 million in block grants to the Commonwealth of Puerto Rico, Virgin Islands, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands;
- \$99.4 million in emergency contingency funds to 33 states and the District of Columbia and \$613 thousand to 46 Indian tribes and tribal organizations;
- \$19 million in leveraging incentive awards to 38 states and the District of Columbia, \$1.6 million in leveraging incentive awards to 28 Indian tribes and tribal organizations, and \$27 thousand in leveraging incentive awards to the Commonwealth of the Northern Mariana Islands;³
- \$5.5 million in Residential Energy Assistance Challenge (REACH) Option Program awards to 6 states, \$1 million to 7 Indian tribes and tribal organizations, \$150 thousand to the Commonwealth of

the Northern Mariana Islands, and \$265 thousand to states for their second- and third-year REACH administrative costs;⁴ and

- \$0.3 million for training and technical assistance.

The funds appropriated for LIHEAP provide payments to eligible households for heating or cooling costs and for home energy crises. Up to 15 percent of the available funds may be used for low-cost residential weatherization or other energy-related home repairs. Grantees can request from HHS a waiver to allow up to 25 percent of available funds to be spent for low-cost residential weatherization or other energy-related home repairs.

To receive grants in each of the three fiscal years, each grantee had to submit an application consisting of signed assurances by its chief executive officer and a plan describing how the grantee would carry out those assurances. In the assurances, the grantee agreed to

- Use funds only for the purposes of the statute;
- Make payments only to eligible low-income households;
- Conduct outreach activities;
- Coordinate LIHEAP activities with similar and related programs;
- Provide, in a timely manner, that the highest level of assistance will be furnished to those households with the lowest incomes and highest energy costs in relation to income, taking into account family size, except that the grantee may not differentiate between categorically eligible and income eligible households;
- Give consideration to agencies that have previously managed the program when designating local agencies to carry out the purposes of the program;
- Assure that energy suppliers receiving benefits directly on behalf of eligible households not treat assisted households adversely;
- 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 disbursement of and accounting for federal funds, establish procedures for monitoring assistance provided, and prepare an annual audit;
- Permit and cooperate with federal investigations;

3. LIHEAP leveraging incentive funds reward grantees that add private or nonfederal public resources to provide home energy assistance benefits to low-income households beyond what could be provided with federal resources.

4. REACH awards are made to LIHEAP grantees that submit qualifying plans that are approved by HHS for initiatives to implement innovative plans through local community-based agencies to help LIHEAP eligible households reduce their energy vulnerability.

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- Provide for public participation in the development of its plan;
 - Provide an opportunity for a fair administrative hearing to individuals whose claims for assistance are denied or not acted on with reasonable promptness;
 - Cooperate with HHS in collecting and reporting data under section 2610 of the statute;
 - Provide outreach and intake through additional state and local government entities or community-based organizations under certain circumstances; and
 - Use no more than 5 percent of funds to encourage and enable households to reduce their home energy needs.

Eligibility

The unit of eligibility for energy assistance is the household, defined as any individual or group of individuals who are living together as one economic unit for which residential energy is customarily purchased in common, either directly or through rent. The Act limits payments to those households with incomes under the greater of

150 percent of the income guidelines or 60 percent of the state's median income or to those households with members receiving benefits from the Temporary Assistance for Needy Families (TANF) program, SSI, Food Stamps, or needs-tested veterans' benefits. No household may be excluded from eligibility on the basis of income alone if household income is less than 110 percent of the poverty guidelines. Grantees are permitted to set more restrictive criteria as well.

Payments

Grantees make fuel assistance payments directly to eligible households or to home energy suppliers on behalf of eligible households. Payments can be provided in cash, fuel, prepaid utility bills, or as vouchers, stamps, or coupons that can be used in exchange for energy supplies. Payments are to vary in such a way that the highest level of assistance is furnished to households with the lowest incomes and highest energy costs in relation to income, taking into account family size.

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