FASAB

Federal Accounting Standards Advisory Board

August 12, 2004

TO: Members of FASAB

FROM: Richard Fontenrose, Assistant Director

THROUGH: Wendy Comes, Executive Director

SUBJECT: **Social Insurance Liability Project**

> NOTE: FASAB staff prepares memos and other materials to facilitate discussion of issues at Board meetings. This material is presented for discussion purposes only; it is not intended to reflect authoritative views of the FASAB or its staff. Official positions of the FASAB are determined only after extensive due process and deliberations.

At the conclusion of the July Board meeting the chairman set the objective for the next meeting for the Social Insurance Liability Project: Decide whether a "present obligation" arises for Social Security earlier than when benefits are "due and payable." As a focal point for doing this he asked that Social Security program characteristics be compared with those of other federal programs, and directed the staff to focus on the three liability characteristics. A "present obligation" is, of course, one of the three essential [working] characteristics of a liability. The other two are: future outflow of resources and past transaction or event.

This paper presents a discussion of six issues based on the chairman's direction. The staff seeks to determine whether a consensus exists relative to certain critical issues (see Issues 1-3 immediately below). Issue 4 and Table 1, page 13, present a comparison of selected program characteristics for Social Security, Medicare and certain other social programs – Medicaid, Food Stamps, SSI, and TANF – in order to discuss how social insurance programs may differ from other programs. Additional programs could be compared at subsequent Board sessions. Issues 5-6 explore other less critical, albeit relevant, issues for the Board to discuss as time permits.

Table 2, page 15, presents for discussion certain questions involving liability concepts applied to the programs in Table 1. More detailed information about Medicare, Medicaid, Food Stamps, SSI, and TANF is provided in the attached "Facts Sheets" starting on page 20.

Staff also has prepared three graphs for discussion. Graphs 1 and 2 on pages 17 and 18, respectively, illustrate the accumulated benefit concept discussed in the staff paper. Also, Graph 3 on page 19 presents for discussion a schematic of the range of explicit and implicit obligations.

Several definitional issues were discussed at the July 1 meeting. The Board discussed whether the word "probable" ought to be in the definition, and whether "past transaction or event" should be mentioned in the definition or was inherent in the existence of a present obligation. However, the Social Insurance Liability Project's objective is limited to the question of whether a liability should be recognized for the social insurance programs earlier than when benefits are "due and payable." Definitional issues will be addressed in the Elements – Liability Definition Project.

Board Consensus

At the Board session on July 1 there appeared to be a consensus among members on several issues. The staff is presenting Issues 1-3 below to confirm that a consensus exists and/or clarify the Board's position on these subjects.

1. Present vs. Future Obligations – The distinction between a present obligation and a future obligation is fundamental to liability recognition and should be emphasized in the Social Insurance Liability Project. Does the Board agree?

   Discussion

   Present Obligation

   Certain federal activity arguably creates present obligations, e.g., employing workers and promising them pensions or adversely affecting the environment via nuclear or other activity. There is a nexus between past obligating events and future outflows, and vice versa. Conversely, much federal activity involves future obligations that relate to what might happen in the future and that lack a past obligating event, e.g., new weapon systems acquisitions and food stamps.

   Some argue that present obligations arise for Social Security as a consequence of the program's structure, e.g., accumulative benefits linked to participants' past work in covered employment. [Issue 4 below compares selected Social Security program characteristics with other federal programs for discussion.]

   Heretofore accrued liabilities and "present obligations" have arisen under the FASAB standards as a result of exchange transactions or events. The current FASAB standards make a fundamental accounting distinction between exchange and non-exchange transactions or events. Although the notion of "exchange-like" [1] transactions appears to

1 GASB Statement 33 defines "exchange-like" transactions and applies the same accounting treatment to them as to exchange transactions. "[i]n contrast to a 'pure' exchange transaction, an exchange-like transaction is one in which the values exchanged though related, may not be quite equal or in which the direct benefits may not be exclusively for the parties to the transaction. Nevertheless, the exchange characteristics of the transaction are strong enough to justify treating the transaction as an exchange for accounting recognition." (GASB Statement 33, par. 1, fn. 1.)

have been applied in some cases, e.g., Pension Benefit Guarantee Corporation, the FASAB has not definitively addressed it, although the issue was discussed in SFFAS 17. Some have argued – including past Board members – that there is an important exchange element in Social Security and other social insurance programs that differentiates them from social assistance or other future-oriented obligations. Others have argued that the transactions are predominantly non-exchange. Still others have argued that the existence of a present obligation is based on the structure of the program, the implicit or explicit promise therein, and an obligating event, and does not require an exchange or exchange-like event.

In Issue 4 below the staff will be seeking the members' views on the recognition point for Social Security liability recognition, e.g., whether work in covered employment and/or payroll taxes paid by participants and/or other Social Security program characteristics are sufficient to create a present obligation; and, if so, when does it arise.

Future Obligations

Some FASAB members have asked how one could consider the obligations of one group of programs – such as Social Insurance – to be present obligations while considering obligations of other programs– such as national defense – to be "future obligations."

It could be argued that the obligation to provide specific future services is similar to an executory contract in the private sector. The text *Accounting Theory* by Wolk, Dodd and Tearney, offers the following commentary:

> A long-standing problem in accounting has been the question of how to account (if at all) for **mutually unperformed** executory contracts.[11] A mutually unperformed executory contract is a contract unperformed by both parties. The traditional accounting view is that no recognition is required in financial statements because a binding exchange has not yet occurred. The contract is prospective. Two examples of such contracts are employment contracts and long-term purchase agreements. In both cases, neither an asset nor a liability is recorded under present practices. However, it can be argued in the case of an employment contract that the employer incurs a liability to pay future wages and receives a benefit in the form of securing future employee services. Similarly, a long-term purchase agreement could be considered a liability for future payments and an asset for future purchases made under the agreement, However, conventional accounting wisdom regards such contracts as too uncertain and contingent for accounting recognition. [Executory contracts were discussed in accounting literature as early as Canning (1929).]

The authors continue and conclude by recommending "the suggestion to book executory contracts is certainly deserving of attention." [see pg. 323-324] This discussion of executory contracts is presented to highlight the long-standing debate on discerning present from future obligations. It is not intended to foreclose debate but to highlight the difficulty of the issue.

In addition to programs that are specified with sufficient detail to be equivalent to executory contracts, there are general obligations of the government to provide basic services such as national defense. These would present even greater issues of uncertainty.

Past Transaction or Event

The Social Insurance Liability Project staff notes that the Elements – Liability Definition Project will address an issue raised in the Financial Accounting Standards Advisory Council paper[2] with respect to whether an explicit reference to "past transaction or event" is necessary. The FASAC paper notes that the Financial Accounting Standards Board (FASB):

> [A]pparently included [past transaction or event] in the definition to emphasize the earliest point at which recognition of a liability could occur. However... the obligating event only demarcates the beginning of a liability's existence; the end of its existence is demarcated by what might be called the *settlement event.* If the obligating event is deemed to be essential to the definition, then the settlement event seemingly would be equally essential to it, yet the definition makes no mention of that event. [FASAC paper, p. 7]

The FASAC paper further noted, as did Mr. Reid at the July 1 meeting, that the phrase "obligating event" is unnecessary in the liability definition because the existence of a present obligation assumes it. The FASAC paper states that:

> The obligating event is redundant ... because the definition requires the reporting entity to have a *present obligation* in order to have a liability. If the entity has a present obligation, the event that obligated it must have occurred. (Having a present obligation also indicates that the settlement event has not yet occurred.) In addition, the notion of a present obligation establishes limits regarding the *future sacrifices of economic benefits* that can be considered because those sacrifices must stem from a present obligation. Accordingly, any future sacrifices not stemming from a present obligation—regardless of how probable those sacrifices might be—(such as the salaries that the entity will pay its employees when they render their services next year) are excluded from consideration. [FASAC paper, p. 7]

2. Constructive and/or Equitable Obligations –The concept of constructive and/or equitable obligations appears to be of limited usefulness for the Social Insurance Liability Project. The Board's discussions reveal some discomfort with requiring an assessment of what one could "reasonably expect" or "rely upon" in order to determine the existence of a liability. On the other hand, the Board does not appear to favor a requirement that all liabilities be strictly legally enforceable. Moreover, some current federal long-term

[2] *The FASB's Conceptual Framework: Issues Involving the Definition of Liabilities, June 2004* (provided to the Board with July briefing materials).

liabilities – such as those involving environmental cleanup – are not strictly legally enforceable at the time of recognition, since, for example, appropriations must be enacted to extinguish them. On the other hand, the FASB noted in its recent work on liability issues that constructive or equitable objections also may be legally enforceable, e.g.. through the notion of promissory estoppel. That is, the constructive/equitable and legal obligation categories are not mutually exclusive.

For the purposes of the Social Insurance Liability Project the staff recommends the working assumption that liabilities do not have to be strictly or technically legally enforceable. However, this is not to say that the concept of constructive and equitable obligations would be discarded. The concept presumably would be developed further in the Elements – Liability Definition Project.

Does the Board agree that the project should proceed under the assumptions that (1) it is not necessary to develop the concept of constructive obligation further for the purposes of the Social Insurance Liability Project; and (2) strict or technical legal enforceability of liabilities is not required for recognition?

Discussion

In prior briefing material the staff discussed the concept of constructive and/or equitable liabilities because, over the years, a key consideration in regard to Social Security accounting has been that most future Social Security benefits lack legal enforceability in the sense that Congress can change the law. The staff presented four possible criteria[3] to identify constructive and/or equitable obligations for liability consideration. The concepts were derived from current public sector and other accounting projects and standards, especially the IFAC Public Sector Committee's Invitation to Comment and FASB SFAC 6.

There appeared to be a consensus at the July 1 meeting that criteria 2-3 – expectations and reliance – generally would support the existence of a "present obligation," but that they are broad and contain a significant element of subjectivity. A liability might be recognized even though the participants' expectations or degree of reliance is not conclusively determinable. A "reasonable person" standard would seem useful but is not likely to provide additional concreteness. Also, there may be other criteria that would contribute to a conclusion that a present obligation exists.

3. Current Law. The importance of current law in the consideration of a liability beyond the due and payable amount for social insurance programs should be emphasized in the Social Insurance Liability Project. Does the Board agree?

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[3] The four criteria were:

1. By established pattern of past practices, published policies or a sufficiently specific current statement, including legislation,[3] the entity has indicated and communicated to another party (or parties) that it will accept certain responsibilities;
2. As a result, the entity has created a reasonable expectation on the part of that other party (or those parties) that it will discharge those responsibilities;
3. The other party (or parties) has relied on the expectation over a period of time; and
4. The entity has little or no discretion but to settle the obligation in the future.

Discussion

At the July 1 meeting the Board discussed the importance of current law. Congress creates and changes federal programs via current law. The individual federal entity does not have discretion under current law (or any other law) to avoid carrying out that program. It is important to separate Congress' ability to make changes in a program from the individual federal entity's lack of discretion under current law in carrying out that program. A federal entity might have "little or no discretion" but to settle the obligation with respect to a program even though Congress could ultimately change the law. The discretion in question is that of the individual federal entity.

Unless and until Congress changes it, current law provides the authorization, the dedicated taxes, and the permanent and indefinite appropriations for certain programs to make payments under specified conditions. The Social Security Administration is authorized to make specific benefit payments at a specific time from specific resources under specific conditions. A beneficiary would ultimately have legal recourse against SSA to recover benefits "due and payable" under current law.

Staff notes that although current law may be an important consideration when considering whether a liability should be recognized, the mere existence of a law authorizing a program presumably would not trigger liability recognition. Current law may authorize a program on a permanent basis, e.g., Social Security, Medicare, and Medicaid; or the authority may be annual, e.g., certain national defense personnel and asset acquisitions.

The same is true for financing. Some programs have "permanent and indefinite" budget authority where Congress has already provided continuing financing and authority to make payments. In the case of Social Security, for example, Congress has provided not only permanent program authority but also the dedicated payroll taxes and the investment and the spending authority. Congress need not intervene thereafter to keep the program operating and financed, although not necessarily at a 100 percent level. [The 2004 Social Security Trustees' Report notes that the current law projections show 100 percent financing of scheduled benefits continues only until 2042. Thereafter the SSA would be able to pay 73 percent of scheduled benefits. Mr. Gokhale referred to this in his June 30th roundtable briefing as the "financing constraint" for that individual program.]

Thus, current law is one important consideration among others with respect to the existence of a present obligation. Some programs with permanent operational authority and permanent and indefinite budget authority may not be present obligations due to the failure to meet other liability recognition criteria, especially the requirement for a past obligating transaction or event. If current law alone could create a present obligation, then there would be no practical limit to liabilities.

Issue #4 – Program Characteristics

4. Do Members Find that Social Security Program Characteristics Distinguish Them from Other Programs for the Purpose of Liability Consideration?
The staff is seeking the members views on whether work in covered employment and/or payroll taxes paid by participants and/or other Social Security program characteristics are sufficient to create a present obligation.

Discussion

Staff has prepared tables summarizing and comparing program characteristics for Social Security and Medicare and four other social programs: Medicaid, Food Stamps, Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF).

Tables

1. Table No. 1 – Social Insurance and Other Federal Programs – Compares the program characteristics of Social Security with other programs.
2. Table No. 2 – Questions About Selected Federal Programs – Compares liability concepts across programs.

More detailed information about these programs is provided in the attached "Facts Sheets" on Medicare, Medicaid, Food Stamps, SSI, and TANF starting on page 20.

Characteristics:

a. Means testing – The first characteristic listed in Table 1 is "means tested." The participants' benefits are contingent upon continuing to meet a "means" – resource and/or income – test. Selected other characteristics are listed below.

b. Accumulated Benefits – Do Social Security benefits accumulate or accrue with the passage of time as participants ***work in covered employment***? See Graph 1 for recognition points and accumulated benefits illustration.

   OASDI benefits are based on earnings averaged over most of a worker's lifetime. A worker's actual earnings are first adjusted or "indexed" to account for changes in his or her average wages since the year the earnings were received. SSA calculates a worker's average monthly indexed earnings during the 35 years in which the worker earned the most. SSA applies a formula to these earnings to arrive at the worker's basic benefit, or "primary insurance amount" (PIA). This is the amount the worker would receive at the worker's full retirement age (FRA), which, for most people, is age 65. (FRA is increasing.)

c. Dedicated Collections – Do ***payroll taxes dedicated to the program*** contribute to a claim to benefits distinguishable from income taxes collected by the general fund? Are the participants' dedicated payroll taxes an essential element in deciding whether a liability (beyond the "due and payable" amount) exists for Social Security? If not, is it an important element?

Discussion

Some argue that dedicated payroll taxes contribute to a liability for financial reporting purposes. They would argue that the payroll taxes are the participant's contribution and make the transaction "exchange-like" in nature. Some argue that dedicated payroll taxes justify more reliance by the participant on such programs than for other programs financed by the general fund.

Some argue further that, unlike many federal programs, Social Security is provided through a formal, compulsory system that is or very closely resembles a contributory pension plan. Others argue that, because they are compulsory, dedicated payroll taxes are very unlike a "contribution."

Most would agree that surplus dedicated payroll taxes are a resource for the Social Security trust fund entity. The accumulated payroll taxes are not merely taken from the Social Security entity but rather are loaned to the general fund.

Others argue that dedicated payroll taxes are similar to income or other taxes. They argue that dedicated payroll taxes supposedly go to a "trust fund" for the Social Security program but in actuality are used for other programs like any other tax. They argue that a reasonable person might assume he or she participates in all federal programs and would have expectations about them. They might argue that, in a broad sense, they "earn" such benefits as much as Social Security participants "earn" theirs.

Other would argue that dedicated payroll taxes are different than income or other taxes. They would argue that dedicated payroll taxes to Social Security provide legal authority for these programs to spend without the need for annual appropriation bills. They would argue that this alters the political method for determining the program's expenditures and may increase the probability that they will be financed at a certain level; that this method of financing provides a means of collective decision making whereby the government simultaneously determines the tax and expenditure sides of a program, which changes decision making and, some would argue, affects the level of both, i.e., stimulating or restraining them. Thus, dedicated taxes are considered different in these ways from income and other taxes. They would argue that these differences imply that the government needs to account separately for the use of dedicated taxes in order to ensure they are being accurately measured and used as required by law.

Still others argue that dedicate payroll taxes are not essential in the creation of a liability because the promise (some would dispute the use of the word "promise") of future benefits based on current work in covered employment creates the liability.

d. Financed with General Funds, User Fees -- Similar to c. above, is there a fundamental distinction relevant to the liability definition between programs funded by dedicated payroll taxes, general taxes, and user fees? If not, is the distinction necessary?

e. Type of Budget Authority – Some programs like Social Security and Medicare have permanent and indefinite budget authority. Other programs received annual or relatively limited budget authority. For the former programs, no additional Congressional action is necessary to provide spending authority. Is budget authority a fundamental distinction between programs? If not, is the distinction necessary?

Issues 5 and 6

Balance Sheet Presentation

5. Do the members want to consider the question of a liability for social insurance, beyond the "due and payable" amount, in the context of balance sheet reporting as a whole (objective, format, etc.) or as a separate issue?

Discussion

In addition to introducing the four criteria for identifying constructive liabilities, the staff paper for the April Board meeting raised the issue of the objective of reporting the "due and payable" or other point estimate on the balance sheet. For example, is the objective to convey information about "financial position," or sustainability, or inter-period equity, or all of these?[4]

[4] The winter 2004 edition of Harvard law school's Journal on Legislation, volume 41, issue no. 1 [http://www.law.harvard.edu/students/orgs/jol/issues/vol41iss1.html] contains an article by Professor Howell Jackson entitled "Accounting for Social Security and Its Reform," in which he argues that the United States should measure Social Security through an accrual accounting method. The latter would recognize commitments to make future benefit payments when those obligations are actually incurred. He argues that, were the finances of the Social Security system restated under principles of accrual accounting, the Social Security trust funds would have had to report a loss of several hundred billion dollars in 2002, and the balance sheet as of December 31, 2002, would have revealed more than $14.0 trillion of accrued liabilities to Social Security participants and beneficiaries and unfunded obligations on the order of $10.5 trillion as of year-end 2002. He argues that not using an accrual accounting method misrepresents the magnitude of the Social Security system's looming financial crisis, and the current accounting system for Social Security distorts public debate over Social Security reform proposals and confuses the relationship between Social Security and the rest of the federal budget. He asserts that accrual accounting, in contrast, would provide a clearer picture of the true state of the Social Security system's current financial shortfall and the extent to which the system's burden on

The balance sheet is one component of financial position. The concept of financial position is that of a point-in-time snapshot of an entity's economic resources and the claims on those resources, based on the entity's transaction or "core" data, as adjusted for environmental factors.[5] The past transactions involve inflows and outflows of resources or promises to provide them.[6]

Transaction data assigned to a period that has elapsed are "recognized" in the operating statement, e.g., as an expense or revenue of that period. Transaction data pertaining to the future are recognized in the balance sheet as assets and liabilities.[7]

As more environmental data are added to the core data, the broader and more forward-looking concept of financial condition emerges. For the U.S. government, the additional data could include expected implications of environmental degradation, or expected changes in the population's composition in terms of age, gender, longevity, education, health, and income.[8] Information about financial condition can be conveyed in a variety of schedules, notes, projections, and narrative disclosures.[9]

The FASAB Objectives (SFFAC 1, par. 137) state that

> [a]ssessing whether the government's financial position improved or deteriorated over the period is important not only because it has financial implications but also because it has social and political implications. This is because analysis of why financial position improved or deteriorated helps to explain whether financial burdens were passed on by current-year taxpayers to future-year taxpayers without related benefits. The latter notion is sometimes referred to as "interperiod equity."

Financial position has been described as the starting point for an assessment of "financial condition." Reporting on financial condition requires financial and nonfinancial information about the national economy and society, as well as about the government itself.[10] SFFAC 1 states that

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future generations is increasing each year. It would also create political incentives for political leaders to address Social Security's difficulties in a timely manner, and enhance the quality of public debate over the relative merits of competing reform proposals.

Volume 41 also includes seven articles in response to Professor Jackson most of which provide opposing views. For example, Professor Robert Clark, of North Carolina State University, who was chairman of the 2003 OASDI Technical Panel on Assumptions and Methods, states that recognizing accrued liabilities is a useful and important aspect of evaluating the financial status of OASDI, but it is not necessarily the best method nor a method that is sufficient alone. He says that, first, promised benefits are not guaranteed; and, second, OASDI is likely to be retained in some form. He says that the current cash accounting approach is based on existing law; and so, to assess the financial status of Social Security under the assumption that the program with continue, we should consider the projections of promised benefits along with scheduled taxes. For another example, Peter A. Diamond and Peter R. Orszag state that Professor Jackson's article represents a thoughtful piece of analysis, but accrual accounting measures should not replace the central measures now used in policy discussions, especially in the federal budget. They argue that small changes in assumptions would cause the accrual measures of Social Security (in the annual federal budget) to generate very large changes in budget outcomes. This would put political pressure on the managers to alter projection assumptions and pose serious risks to the perceived legitimacy of the actuarial projections.

[5] SFFAC 1, par. 178. See endnote A for selections from SFFAC 1 used for this staff discussion.
[6] SFFAC 1, pars. 166, 168.
[7] SFFAC 1, par. 169.
[8] SFFAC 1, par. 180.
[9] SFFAC 1, par. 181.

> Indicators of financial position, measured on an accrual basis, are the starting point for reporting on financial condition but must be supplemented in a variety of ways. For example, subobjective 3B[11] might imply reporting, among other things, a current law budget projection under a range of alternative assumptions. Reports intended to achieve subobjective 3C might disclose, among other things, the contribution that the government is making to national wealth by financing assets that are not federally owned, such as research and development, education and training, and state-owned infrastructure. Information on trends in total national wealth and income is also important.[12]

If the main objective of a comprehensive balance sheet ultimately must be financial position ... of the program entity and, for CFS, for the government as a whole, then whatever is reported for social insurance must be consistent with that objective, and lead to that overall goal.

6. <u>Does a "fair presentation" of Social Security require a liability beyond the "due and payable" amount on the balance sheet? Should the Board address other disclosures after the balance sheet is considered?</u>
   <u>Discussion</u>

   Some argue that a program where benefits are "earned" during a 40-year career is not fairly presented when amounts are reported only after retirement and that the federal balance sheet is seriously flawed or misleading without a liability for accumulated benefits for Social Security.

   Some have argued that the actuarial present values presented in SSA's financial reports and the CFS, pursuant to SFFAS 17, provide the most useful information about sustainability and about inter-generational equity. The total for the SOSI represents an open group estimate over a 75-year horizon that is important for assessing sustainability. The SOSI subtotals provide a generational perspective: closed group estimates for three cohorts – participants 62 and over, participants 15-61, and future participants – over a 75-year horizon.

   Also, some members have discussed new balance sheet constructs and/or disclosures, e.g., the possibility of a new balance sheet element like "responsibilities" or "commitments."

   However, neither the SOSI open or closed group estimates provide the accumulated benefits of all the participants as of the reporting date, i.e., the benefits already accumulated. The accumulated benefits require a different calculation, one that reflects what the entity is committed to as of the reporting date, and what benefits

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[10] SFFAC 1, par. 144.
[11] SFFAC 1, Objective 3: Federal financial reporting should assist report users in assessing the impact on the country of the government's operations and investments for the period and how, as a result, the government's and the nation's financial condition has changed and may change in the future. 3B: Whether future budgetary resources will likely be sufficient to sustain public services and to meet obligations as they come due. 3C: Whether government operations have contributed to the nation's current and future well-being.
[12] SFFAC 1, par. 145.

participants have accumulated via their work in covered employment. It reflects what has happened period by period, what has been accumulated, and what has been paid off.

Graphs 1 and 2 on pages 17 and 18, respectively, illustrate the accumulated benefit at the reporting date. Also, Graph 3 on page 19 presents for discussion a schematic of the range of explicit and implicit obligations.

1 **Table No. 1 – Social Insurance and Other Federal Programs**

	OASI	DI	Medicare			Medicaid	Food Stamps	SSI	TANF (formerly Aid to Families w/ Children)
			HI Part A	SMI Part B	PDP Part D				
Means Tested?	13, 14	See OASI note 13		√ 15		√	√	√	√
Eligibility based on work in covered employment?	√	√	√	√	√				
Financed with dedicated collections?	√	√	√	√[1]	√				
Financed with general funds?	16	See OASI note	See OASI note	√	√	√	√	√	√
Financed with user fees?				√	√	√			

[13] Based on income, some people must pay income tax on their Social Security benefits. These people have substantial income in addition to Social Security benefits (such as wages, self-employment, interest, dividends and other taxable income that you have to report on your tax return). Combined income between $25,000 and $34,000 for individual filers ($32,000-$44,000 for joint filers) subjects 50 percent of Social Security benefits to income tax. "Combined income" is the sum of adjusted gross income plus nontaxable interest plus one-half of your Social Security benefits. Up to 85 percent of Social Security benefits are subject to income tax if combined income is above $34,000 ($44,000 for joint filers). No one pays taxes on more than 85 percent of his or her Social Security benefits and some pay on a smaller amount, based on these IRS rules. Income tax on Social Security benefits is credited to the Social Security fund.

[14] For beneficiaries under full retirement age (FRA) who start getting Social Security payments, $1 in benefits is deducted for each $2 earned above the annual limit. For 2004 that limit is $11,640. The earliest age that Social Security retirement benefits can be received remains 62 even though the FRA is rising. In the year the beneficiary reaches his or her FRA, $1 in benefits is deducted for each $3 earned above a different limit, but only counting earnings before the month FRA is reached. For 2004, this limit is $31,080. There is no limit on earnings starting with the month FRA is reached.

[15] On December 8, 2003, President Bush signed into law the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (Public Law 108-173). The law creates a voluntary prescription drug benefit program (Part D) for all individuals eligible for Medicare under which they will pay a monthly premium for coverage in helping them purchase prescription drugs. Part D is effective January 1, 2006. The law establishes a transitional drug discount card, includes provisions for combating fraud, waste, and abuse in the Medicare program, and makes revisions in existing Parts A and B of Medicare including provisions relating to rural health care, inpatient hospital services, skilled nursing facility services and home health care. The law also reduces the Medicare Part B premium subsidies for certain individuals and establishes tax-free Medical Savings Accounts. The law requires, beginning in 2007, that Part B Medicare beneficiaries with modified adjusted gross incomes over $80,000 for an individual and $160,000 for a married couple pay a higher Part B premium than individuals with lesser incomes. The amount of the increased premium will be based on ranges of income specified in the law. For example, an individual with modified adjusted gross income between $100,000 and $150,000 would pay a higher Part B premium than an individual with income between $80,000 and $100,000.

[16] OASI, DI, and HI receive payments from the general fund – the taxes on OASI and DI benefits. The taxes are general fund income tax receipts, but with amounts equal to the tax on certain benefits (as defined by law) required to be paid by the general fund to the trust funds. The receipts by the trust funds are dedicated collections to these trust funds but paid out of the general fund rather than "directly" by the public.

Table No. 1 – Social Insurance and Other Federal Programs Facts Sheets Summary

	OASI	DI	Medicare			Medicaid	Food Stamps	SSI	TANF (formerly Aid to Families w/ Children)
			HI Part A	SMI Part B	PDP Part D				
Investment authority re surplus funds?	√	√	√	√					
Budget authority ("A" = annual, "MY" = multi-year, "PI" = permanent and indefinite, "TI" = temporary and indefinite. NY = "no year")?	PI	PI	PI	PI		NY/ TI [17]	A [18]	NY [19]	[20]

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[17] While Medicaid is permanently authorized and there is no cap on the amount of matching federal funding to be provided, Medicaid is still appropriated every year. The annual appropriation language from P.L. 108-199 regarding the 2004 annual Medicaid appropriations is as follows:

"CENTERS FOR MEDICARE AND MEDICAID SERVICES GRANTS TO STATES FOR MEDICAID

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $130,892,197,000, to remain available until expended. For making, after May 31, 2004, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2004 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary. For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the first quarter of fiscal year 2005, $58,416,275,000, to remain available until expended. Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter."

[18] While the Food Stamp program is permanently authorized by legislation, annual one-year appropriations are provided (note: funds made available for Employment and Training remain available until expended).

[19] Per Public Law 108-199, appropriated amounts are to remain available until expended. However, funds provided to a state in the fiscal year and not obligated by the state during the year shall be returned to Treasury.

[20] Public Law 108-262 temporarily reauthorized TANF from June 30, 2004 through September 30, 2004, and appropriated such sums as may be necessary for the fourth quarter of FY 2004.

1 **Table No. 2 – Questions About Selected Federal Programs**

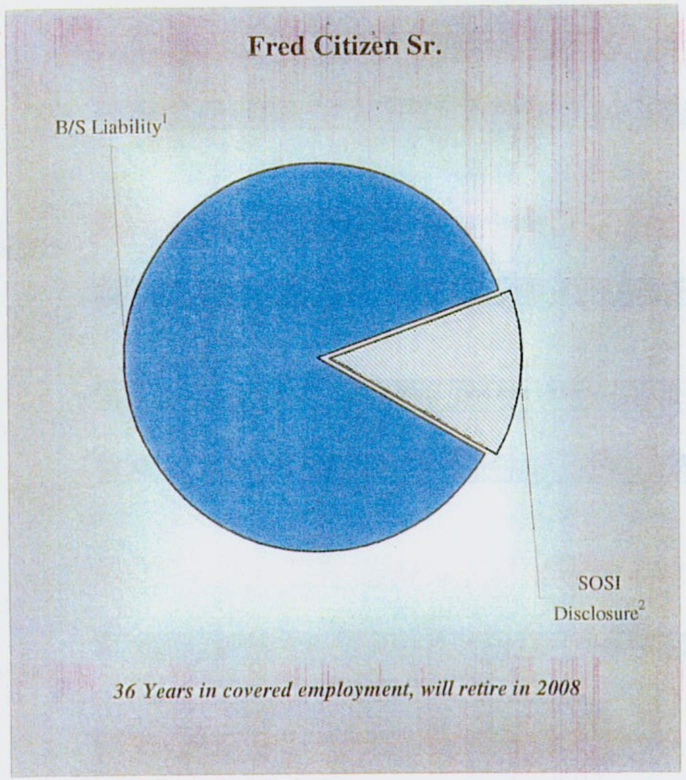
	OASDI	*Medicare*	*Medicaid*	*Food Stamps*	*TANF*	*SSI*
What is Nature of Benefit?	Cash	Services	Services	Goods[1]	Cash/Services[2]	Cash
How is Individual Eligible for Benefits?	Beneficiary must have worked in covered employment for 10 years	Must have either worked 10 years in covered employment and be 65 or older; be disabled or have ESRD	Must be pregnant, under 18, over 65 or disabled and meet means test.	Must meet means test; also work requirements for able-bodied adults.	Vary widely by State. In general, must be a family w/ children, meet means test and also a work requirement	Be over 65, blind or disabled and meet means test.
What is Current Liability Treatment Under FASAB?[3]	Considered non-exchange, recognized at due & payable	Same as OASDI	Same as OASDI	Same as OASDI	Same as OASDI	Same as OASDI
What is Treatment Under FASB?[4]	Social ins. not addressed; possible analogies: Pension obligations	Same as OASDI	Due & Payable on continued means testing and other eligibility requirements	Same as Medicaid	Same as Medicaid	Same as Medicaid
Do Benefits Accumulate Over Time?	to be determined	to be determined	No	No	No	No
At what Point is Participant Informed of Future Benefits That will be Paid Under Current Law?	Upon receipt of personal social security statement	Same as OASDI	In response to a claim	n/a	n/a	n/a
How could Program be Characterized: 100% Exchange, 100% Non-Exchange or In Between?	In Between	In Between	In Between[5]	100% Non-exchange	100% Non-exchange	100% Non-exchange
Is it primarily Federally or State Administered?	Federally	Federally	State[6]	State[6]	State[6]	State[6]

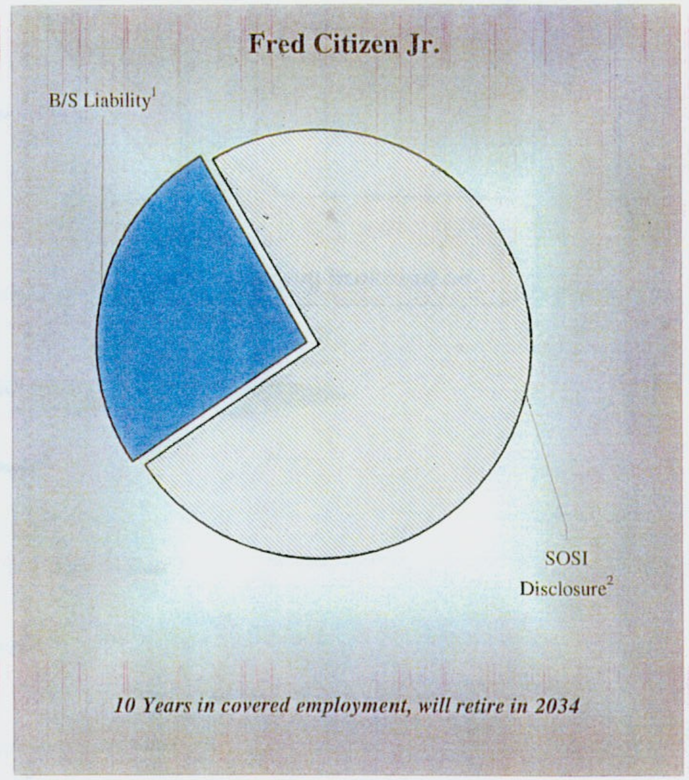
Table No. 2 – Questions About Selected Federal Programs

1. With the move to 100% electronic benefits cards, the participant must redeem the benefits for eligible food, seeds, and/or plants. There is no longer the option to receive cash back for partially redeemed coupons.
2. The States have wide discretion as to whether to pay cash, provide services, or a combination of the two.
3. FASAB liability definition from SFFAS 5: A liability for federal accounting purposes is a probable future outflow or other sacrifice of resources as a result of past transactions or events.
4. FASB liability definition from SFFAC 6: Liabilities are probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or provide services to other entities in the future as a result of past transactions or events.
5. Some participants pay a nominal fee (co-payment, co-insurance or deductible) for services depending on the state and the nature of the service.
6. States have wide discretion in most cases over eligibility, benefit, and participant characteristics.

1 **Graph No. 2 – Balance Sheet and SOSI Treatment**

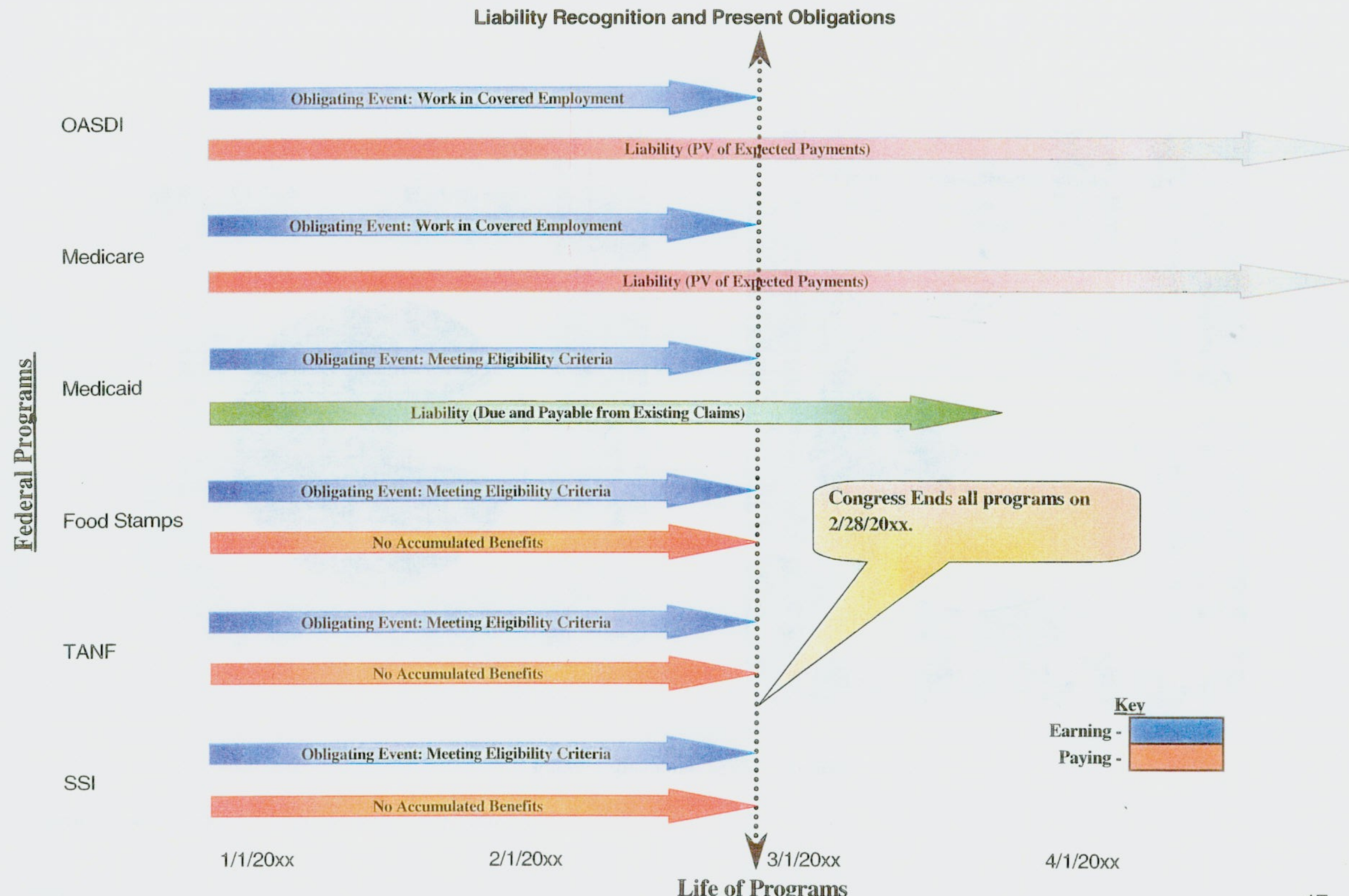
Balance Sheet and SOSI Treatment





1. Balance Sheet Liability is equal to the present value of future benefits scheduled to be paid based on past earnings as of balance sheet date
2. Disclosure in Statement of Social Insurance is equal to present value of benefits to be paid based on lifetime earnings.

1 **Graph No. 1 – Liability Recognition and Present Obligations**



Graph No. 3 – Monetary and Non-Monetary Benefits

Monetary Benefits (Cash Payment)

	Benefits Accumulate[21]	Benefits Do Not Accumulate
Explicit	– Annual Leave – Federal Employees' Compensation Act – Pension (FERS, CSRS, and Military) – Veterans' and survivors' compensation benefits – **Veterans' pension benefits**[22]	
Implicit	– Social Security (OASDI)	– Temporary Assistance for Needy Families (TANF)[23] – Supplemental Security Income

Non-Monetary Benefits (Goods/Services)

	Benefits Accumulate	Benefits Do Not Accumulate
Explicit	– Veterans' benefits (burial and plot)	
Implicit	– Medicare	– Medicaid – TANF[3] – Food Stamps

- Consider liability recognition (also bold Veterans' pension benefits)

- Consider additional disclosure

[21] The term "accumulate" as used in this sense means "to gather or pile up especially little by little" as defined in Merriam Webster Online. Accumulate is to be used as an illustrative opposite to "due and payable" where obligations only become attributable to an individual when they become "due and payable." Using the term "accumulate" is to imply that the benefits become attributable to an individual at a point earlier than they become "due and payable."

[22] Future Veterans' pension benefit payments are not currently reported as a liability on the balance sheet. The projected estimate of future payments for pension benefits as of September 30, 2003, and September 30, 2002, respectively, were $102.7 and $91.6 billion, respectively.

[23] The TANF program is state-administered and the states have wide flexibility on how funds are spent. Some states provide services to low-income families eligible for assistance while other states choose to make cash payments or a combination of the two.

Medicare Facts Sheet

Introduction

Medicare was established in 1965 as a federal social insurance program because the private health care market failed to provide adequate, affordable, health insurance to much of America's elderly population. In 1965, Congress recognized that few older people in the United States were free of the fear that expensive health services could do away with any and all of their savings. The Medicare program was enacted to provide health insurance for people 65 years of age and older. This protection was expanded to people receiving Social Security Disability Insurance and people with serious kidney disease in 1972[24].

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, and works in partnership with the States to administer Medicaid, State Children's Health Insurance Program (SCHIP), and health insurance probability standards. Through Medicare, Medicaid and SCHIOP about one in four Americans receive health care coverage. Over 75 million people are covered by at least one of these programs; they spend about one in three of the Nation's health care dollars.

With the passing of the Medicare Prescription Drug, Improvement and Modernization Act in December 2003, Medicare will undergo many changes in the upcoming years. The 2003 legislation authorized the biggest expansion in coverage since the program was created in 1965. For the first time, Medicare beneficiaries will have prescription drug coverage for drugs they consume at home. This is a major policy change since drugs have become an increasingly important component in modern health care[25].

Medicare Characteristics

Enacted by the Social Security Act Amendments of 1965, Medicare is the nation's largest health insurance program, covering nearly 40 million Americans (approx. 14% of pop.) at an annual cost of just under $300 billion. Medicare provides health insurance to:

- People age 65 or older;
- Some people with disabilities under age 65; and
- People with permanent kidney failure requiring dialysis or a transplant.

Medicare has 3 components: Hospital Insurance (Part A), Medical Insurance (Part B) and the new Prescription Drug Benefit (Part D)[26].

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[24] National Academy of Social Insurance, *Medicare and the American Social Contract – Final Report of the Study Panel on Medicare's Larger Social Role* (Washington, DC: National Academy of Social Insurance, February 1999)
[25] National Academy of Social Insurance, *Social Insurance Sourcebook*, website material, http://www.nasi.org/publications3901/publications.htm, Washington, DC.
[26] Medicare Part C, which provides Part A and Part B coverage and, optionally Part D coverage, through private managed care plans; also called Medicare Advantage

- Medicare Part A helps pay for inpatient hospital services, skilled nursing facility services, home health services, and hospice care.
- Medicare Part B helps pay for doctor services, outpatient hospital services, medical equipment and supplies, and other health services and supplies.
- Medicare Part D (begins 01/01/2006) provides coverage on prescription drugs. For 2004 and 2005 there is discount card and Transitional Assistance worth up to $600/beneficiary.

Table I.C1.—Medicare Data for Calendar Year 2003

	HI	SMI	Total
Assets at end of 2002 (billions)	$234.8	$34.3	$269.1
Total income	$175.8	$115.8	$291.6
Payroll taxes	149.2	—	149.2
Interest	15.9	2.0	17.0
Taxation of benefits	8.3	—	8.3
Premiums	1.6	27.4	29.0
General revenue	0.5	86.4	86.9
Other	1.1	0.0	1.1
Total expenditures	$154.6	$126.1	$280.8
Benefits	152.1	123.8	275.9
Hospital	109.4	17.9	127.3
Skilled nursing facility	14.3	—	14.3
Home health care	2.6	7.1	9.7
Physician fee schedule services	—	48.3	48.3
Managed care	19.5	17.2	36.8
Other	6.3	33.3	39.6
Administrative expenses	$2.5	$2.3	$4.9
Net change in assets	$21.2	-$10.3	$10.9
Assets at end of 2003	$256.0	$24.0	$280.0
Enrollment (millions)			
Aged	34.6	33.1	35.0
Disabled	6.0	5.3	6.0
Total	40.6	38.5	41.0
Average benefit per enrollee	$3,747	$3,219	$6,966

Note: Totals do not necessarily equal the sums of rounded components [27]

The traditional Medicare plan is fee for service, available everywhere in the United States. Beneficiaries are free to go to any doctor, specialist, or hospital that accepts Medicare and most providers participate in the Medicare program.

People who qualify for Medicare may have choices beyond the traditional Medicare plan. Some people may have Medicare Managed Care Plans or Private Fee-for-Service Plans (Part C) available in their area. These options are health plans offered by private insurance companies. Medicare pays a set amount of money every month to the private healthcare provider administering the plan. In turn, that organization manages the Medicare coverage for its members.

The Medicare Program

What is Medicare Part A? Medicare Part A (Hospital Insurance or HI) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some

[27] Medicare Board of Trustees, 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Washington, DC, March 23, 2004, page 3.

home health care. Cost: Most people don't have to pay a monthly payment, called a premium, for Part A. This is because they or a spouse worked in covered employment and paid Medicare taxes. If an individual did not work in covered employment and pay Medicare taxes a sufficient amount of time, they may still be able to buy Part A coverage.

What is Medicare Part B? Medicare Part B (Supplemental Medical Insurance or SMI) helps cover doctors' services and outpatient hospital care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. Cost: Unlike Part A, recipients must pay the Medicare Part B premium each month ($66.60 in 2004) – see below for more on the premium structure. New premium rates become effective every year in January. If the participant receives Social Security benefits, RRB benefits, or OPM retirement benefits the premium is taken out of those monthly payments[28]. Medicare Part B is a voluntary program, for which you must enroll in at the time you are eligible.

What is Medicare Advantage? Medicare Advantage, or Part C as it is sometimes referred to, is the new name for Medicare+Choice. This is Medicare's managed care option. Under this plan, private health care providers agree to provide Medicare-covered services to enrollees in return for fixed rate of payment from Medicare for each enrollee (a "capitation rate"). Medicare law establishes how the capitation rate is established for each Medicare enrollee who chooses to join a Medicare managed care plan, based on a variety of factors including Medicare costs in area, beneficiary age and sex, and whether the beneficiary is institutionalized. Currently, almost all Medicare health plans paid under capitation arrangements offer some benefits beyond those covered under standard Medicare fee-for-service plans.

A substantial increase in Medicare Advantage plans is projected for 2006 as the provisions of the *Medicare Prescription Drug, Improvement and Modernization Act* give higher payments to Medicare Advantage plans. The higher payments provide incentives for expansion of coverage areas and for the provision of additional benefits to plan enrollees. In addition, preferred provider plan demonstrations are being conducted from 2003 through 2005 that will increase total managed care enrollment for those years[29].

What is Medicare Part D? This is the new Prescription Drug Plan included in the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (Public Law 108-173). Beginning January 1, 2006, all Medicare beneficiaries (those entitled to Part A and/or enrolled in Part B) are eligible for subsidized prescription drug coverage under Part D. Beneficiaries may access the subsidized coverage by enrolling in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage plan

[28] Recipients may be able to receive assistance from their states to pay for both Part A or Part B.
[29] Medicare Board of Trustees, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* Washington, DC, March 23, 2004, page 133.

that offers Part D coverage alongside the Medicare medical benefit. Since the new plan does not become effective until 2006, in the transitional period Medicare recipients will be provided discount cards as well as a $600 credit for lower income individuals to use on prescription drugs purchases. The new Part D coverage for 2006 is[30]:

- A $250 Deductible
- 25% co-insurance coverage for expenses $250 - $2,250
- Beneficiary is responsible for all costs until $3,600 out-of-pocket limit is reached
- Catastrophic coverage: pay higher of 5% Co-insurance or a minimal co-payment

Beneficiaries with low incomes and modest assets will be eligible for subsidies that eliminate or reduce their Part D premiums and cost sharing. Following are some of the rules that apply:

- For dual eligible[31] beneficiaries whose income does not exceed 100% of the Federal poverty level (FPL), there is no premium or deductible, and co-payments are reduced to $1 for generic drugs and $3 for all other drugs. There is also no cost sharing in the catastrophic coverage.
- For dual eligible beneficiaries whose incomes does not exceed 135% FPL, and whose assets are less than three times the SSI limit[32], there is no premium or deductible, co-payments are $2 for generic drugs and $5 for any other drugs. There is also no cost sharing in the catastrophic coverage.
- For beneficiaries not in the above categories, whose incomes are below 150% FPL and who have less than $10,000 in assets ($20,000 for a couple), the premium is reduced on a linear sliding scale (down to $0 at or below 135% FPL); the deductible is reduced to $50; the co-insurance is reduced to 15%. After reaching the catastrophic coverage, co-payments are $2 for generic drugs and $5 for any other drugs.

Eligibility Requirements

In general, you are eligible for Medicare HI if you or your spouse worked at least 40 quarters in Medicare-covered employment and you are 65 years old and a citizen or permanent resident of the United States. You might also qualify for coverage if you are a younger person with a disability or with End-Stage Renal Disease.

Here are some simple guidelines. You can receive HI at age 65 without paying premiums if:

- You are already receiving retirement benefits from Social Security or the RRB

[30] Medicare Board of Trustees, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Washington, DC, March 23, 2004, page 144.
[31] Beneficiaries eligible for both Medicare (Part A and/or B) and Medicaid
[32] SSI limits assets to $2,000 for individuals and $3,000 for couples.

- You are eligible to receive Social Security or RRB benefits but have not yet filed for them
- You or your spouse had Medicare-covered government employment

If you are under 65, you can get Part A without having to pay premiums if:

- You have received Social Security or RRB disability benefits for 24 months
- You are a kidney dialysis or kidney transplant patient

While you do not have to pay a premium for HI if you meet any of the above conditions, you must pay for SMI if you want it. The SMI monthly in 2004 is $66.00.

What if I have not worked the required 40 quarters in covered employment? Although most Medicare beneficiaries do not pay a premium for HI services, there are instances where individuals who have not yet met all requirements for Medicare may obtain coverage. Seniors and certain persons under 65 with disabilities who have fewer than 30 quarters of coverage may obtain Part A by paying a monthly premium set according to a formula in the Medicare statute, for 2004 the monthly premium was $343. In addition, seniors with 30-39 quarters of coverage, and certain disabled persons with 30 or more quarters of coverage, are entitled to pay a reduced premium, for 2004 it was $189.[33]

How is Medicare Financed?[34]

Medicare is the biggest health program in the United States: it covers 35.1 million persons over the age of 65, and 5.5 million disabled persons.

Payroll Taxes and Premiums. The HI component of Medicare is financed by a tax levied on all wage and salary income. The tax is 1.45% each for the employee and the employer.

Example: Jo Waller makes $50,000 a year would pay $725 a year. Her employer also would pay $725.

The wage base for Social Security in 2004 is $87,900, the maximum amount on which taxes can be levied. But there is no maximum wage base for Medicare taxes. An individual making $1,000,000 a year would pay a Medicare payroll tax of $14,500, and his employer would pay an equal amount. Self-employed persons pay 2.9% of earnings.

For SMI, Medicare beneficiaries pay a premium of $66.60 a month in 2003 for their part B coverage. This can be deducted from the beneficiary's monthly Social Security benefit check. These premiums pay for about 25% of the cost of Part B spending; the rest comes from general tax revenues.

[33] U.S. Department of Health and Human Services, *HHS Announces Premium and Deductible Rates for 2004*, website material, http://www.hhs.gov/news/press/2003.html, October 16, 2003.
[34] National Academy of Social Insurance, *Social Insurance Sourcebook*, website material, http://www.nasi.org/publications3901/publications.htm, Washington, DC.

With the passing of the Medicare Modernization Act of 2003, the Part B premium will be increased, beginning in 2007, for beneficiaries meeting certain thresholds. Beneficiaries with modified adjusted gross incomes under $80,000 will continue to pay premiums that are 25% of twice the actuarial rate (no change from current premium). For beneficiaries with incomes between $80,000 and $100,000, the applicable percentage is 35%; for those with incomes between $100,000 and $150,000, the percentage is 50%; for incomes between 150,000 and $200,000, the percentage is 65%; and for incomes above $200,000, the percentage is 80%. For married couple the income thresholds are doubled. These thresholds are to be updated each calendar year by the CPI.[35] There is a 5-year adjustment period for this provision, that is, the amount of premium above the 25% of twice the actuarial rate is phased in – at 20, 40, 60, 80, and 100 percent for 2007 to 2011 and later, respectively.

If the differential premiums were in effect in 2004, according to estimates by Commerce Clearing House, a beneficiary with an income of $80,000 a year would pay $82.18 a month for the Part B premium. The maximum, for someone earning over $200,000 a year, would be $187.84 a month. The provision will affect a very small number of Medicare beneficiaries—less than 5% of the Medicare population has an income of $70,000 a year or more, according to the Centers for Medicare and Medicaid Services (CMS).

The new Part D drug benefits will also be financed by a new beneficiary premium. The premium represents 25.5% of the cost of basic coverage on average. For prescription drug plans (PDPs) and the drug portion Medicare Advantage (MA) plans, the premium will be determined by bids. Taken together, all PDP bids and MA drug bids will form a national weighted average (weighted by plan enrollment). Each plan's premium will be 25.5% of the national weighted average plus or minus the difference between the plan's bid and the average. The remaining 74.5% represents a federal subsidy.

A new Medicare Prescription Drug Account within the SMI trust fund will be established to fund Part D. Amounts in this account will be kept separate from other funds in Part B and do not affect the computation of the Part B premium. The account will generally consist of periodically appropriated general revenues, premiums from Part D enrollees, State contributions to Medicare drug costs, interest, and any leftover balance from temporary drug discount card's Transitional Assistance Account.

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[35] Medicare Board of Trustees, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Washington, DC, March 23, 2004, page 152.

Appendix 1: Tables and Charts

Table II.A3.—Medicare Enrollment
[In thousands]

Calendar year	HI	SMI			
	Part A	Part B	Part D	Part C[1]	Total[2]
Historical data:					
1970	20,104	19,496	—	—	20,398
1975	24,481	23,744	—	—	24,864
1980	28,002	27,278	—	—	28,433
1985	30,621	29,869	—	842	31,081
1990	33,747	32,567	—	1,181	34,251
1995	37,175	35,641	—	2,714	37,594
1996	37,701	36,104	—	3,672	38,122
1997	38,099	36,445	—	4,735	38,514
1998	38,472	36,756	—	5,732	38,889
1999	38,765	37,022	—	6,191	39,187
2000	39,257	37,335	—	6,233	39,688
2001	39,669	37,667	—	5,608	40,102
2002	40,100	38,049	—	5,005	40,523
2003	40,589	38,465	—	4,655	41,004
Intermediate estimates:					
2004	41,399	39,041	4,651	4,698	41,805
2005	42,006	39,547	4,726	5,305	42,404
2006	42,680	40,083	40,736	9,528	43,069
2007	43,463	40,713	41,468	11,232	43,843
2008	44,347	41,447	42,296	12,221	44,718
2009	45,268	42,216	43,158	13,253	45,629
2010	46,241	43,069	44,069	13,588	46,592
2011	47,359	43,923	45,117	13,961	47,700
2012	48,697	45,055	46,374	14,344	49,029
2013	50,173	46,332	47,761	14,741	50,496
2015	53,198	48,967	50,607	15,386	53,505
2020	61,608	56,349	58,800	[3]	61,886
2025	70,917	64,673	67,606		71,185
2030	78,794	72,060	75,063		79,063
2035	83,806	76,530	79,818		84,078
2040	86,792	79,247	82,659		87,064
2045	88,992	81,273	84,758		89,265
2050	91,230	83,449	86,884		91,504
2055	93,878	85,992	89,393		94,153
2060	97,084	88,951	92,432		97,361
2065	100,040	91,591	95,237		100,317
2070	102,924	94,240	97,971		103,200
2075	105,325	96,466	100,244		105,597
2080	107,770	98,746	102,184		108,037

[1] Number of beneficiaries enrolled in a Medicare Advantage plan. From early 1980s to 1997 represents those enrolled in a risk HMO, and from 1998 to 2003 represents those enrolled in a Medicare+Choice plan. In order to enroll in a Medicare Advantage plan, a beneficiary must be enrolled in both Part A and Part B. Therefore, Part C enrollment is a subset of both Part A and Part B enrollment.
[2] Number of beneficiaries with HI and/or SMI coverage.
[3] Enrollment in Medicare Advantage plans is not explicitly projected beyond 2015.

[36]

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[36] Medicare Board of Trustees, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* Washington, DC, March 23, 2004, page 27.

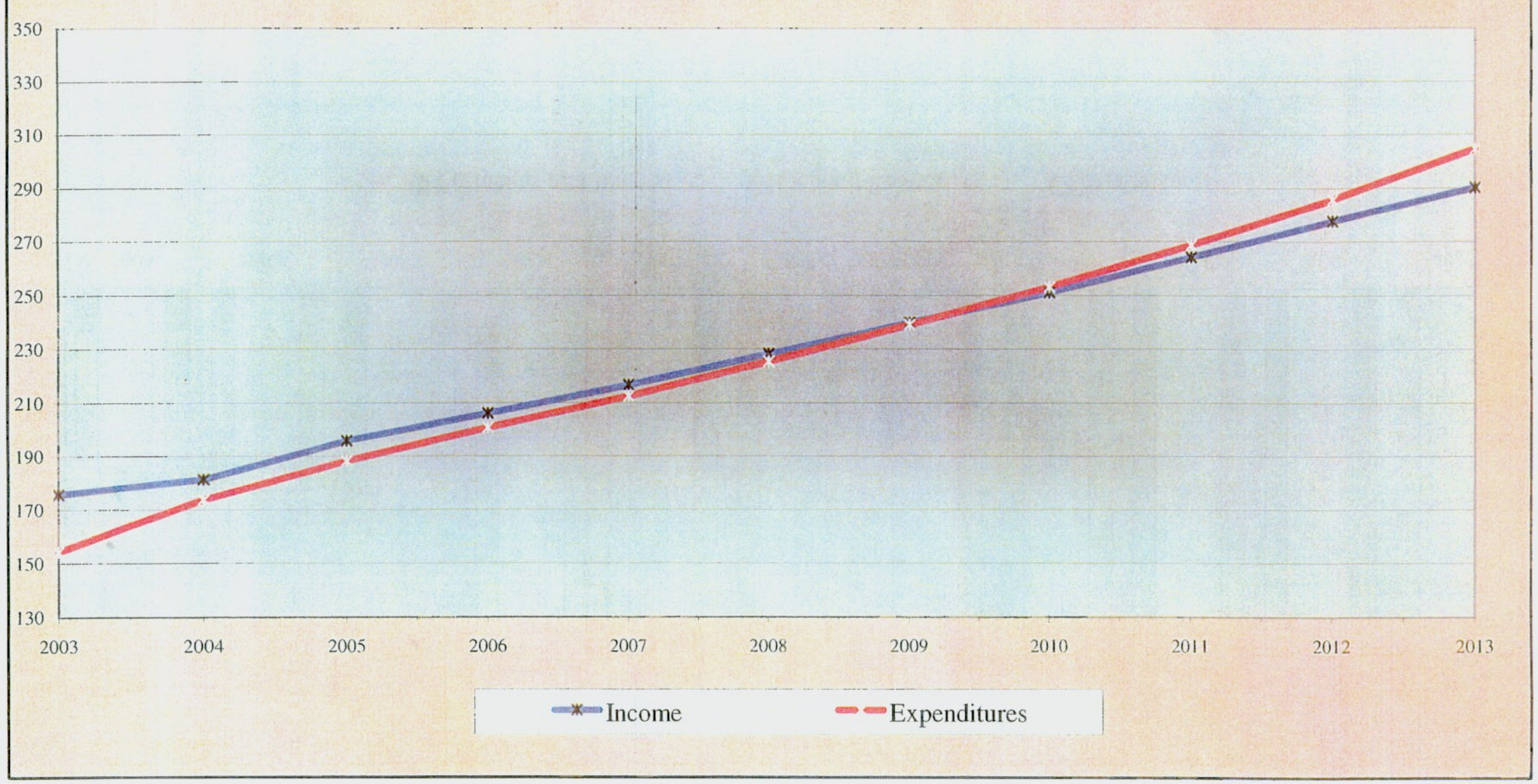
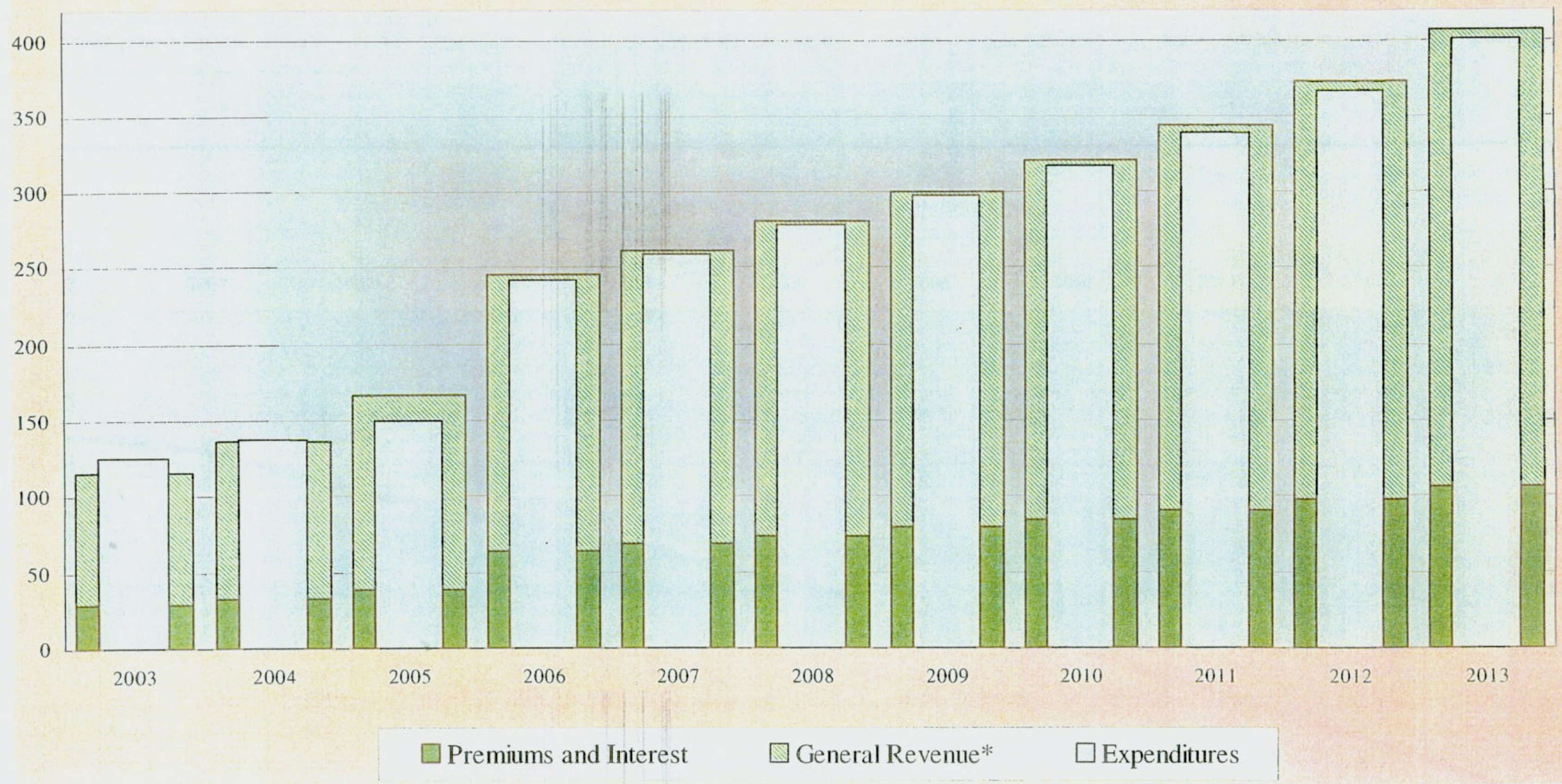


Chart 1. Estimated Operations of the HI Trust Fund Under Intermediate Assumptions, 2003-2013
(Dollar amounts in billions)

Source: Data from Medicare Board of Trustees, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Washington, DC, March 23, 2004, page 10.

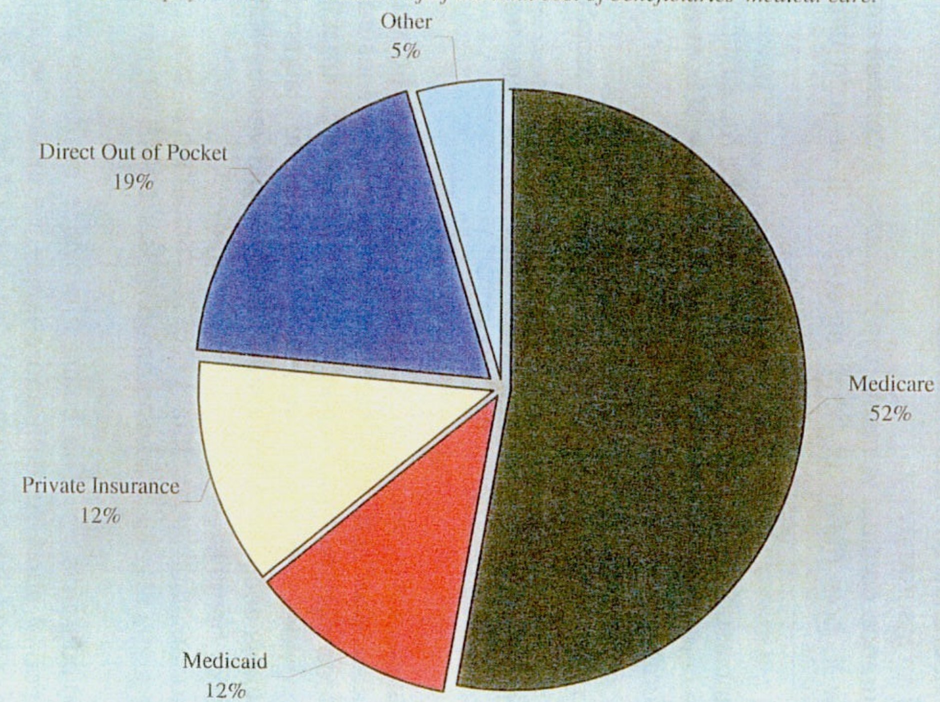
Chart 2. SMI Trust Fund Operations and sources of Revenue, 2003 - 2013
(Dollars in billions)



Source: Data from Medicare Board of Trustees, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* Washington, DC, March 23, 2004, page 71.
* General Revenue includes Part B general fund matching payments, Part D subsidy cost, and certain interest adjustment items.

Chart 3. Sources of Payment for Medicare Beneficiaries' Medical Services, 1999

Medicare pays a little more than half of the total cost of beneficiaries' medical care.



Total Medical Expenses per Medicare Beneficiary = $9,573

Source: U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services, *The CMS Chart Series*, website material, http://www.cms.hhs.gov/charts/series.

Appendix 2: Private Insurance Industries

The primary purpose of insurance is to provide economic protection from identified risks occurring or discovered within a specified period. Some types of risks insured include death, disability, property damage, injury to others, and business interruption. Insurance transactions may be characterized generally by the following:[37]

- The purchaser of an insurance contract makes an initial payment or deposit to the insurance enterprise in advance of the possible occurrence or discovery of an insured event.
- When the insurance contract is made, the insurance enterprise ordinarily does not know if, how much, or when amounts will be paid under the contract.

In general an important issue for insurance organizations is the recognition of revenue on insurance contracts. GAAP requires the classification of contracts (*policies*) as short –duration and long-duration as follows:

- Short-duration contracts – revenue over the policy period in proportion to coverage
- Long-duration contracts – revenue when premium is due from the policyholder

FASB 60 requires that insurance policies be classified as either short-duration contracts or long-duration contracts. In a short-duration contract, the insurance carrier primarily provides insurance protection; in a long-duration contract the insurance company provides services and functions in addition to insurance protection, including loans secured by the insurance policy and various options for the payment of policy benefits.
In determining whether an insurance contract is of short-duration or long-duration, FASB 60 requires that the following be considered (FAS 60, par. 7):[38]

- *Short-duration contracts* The contract provides insurance protection for a fixed period of short duration and enables the insurer to cancel the contract or to adjust the provisions of the contract at the end of any contract period, such as adjusting the amount of premiums charged or coverage provided.

- *Long-duration contracts* The contract generally is not subject to unilateral changes in its provisions, such as noncancelable or guaranteed

[37] Financial Accounting Standards Board, *Current Text: Industry Standards Volume II,* Norwalk, CT, 2001, In6.101.
[38] Financial Accounting Standards Board, *Original Pronouncements: Volume I, Statement 60,* Norwalk, CT, 1998, page 567.

renewable contracts, and requires the performance of various functions and services (including insurance protection) for an extended period.

Most property and liability insurance contracts and some specialized short-term life insurance contracts are classified as short-duration contracts. Most life insurance contracts, noncancelable disability income policies, and title insurance contracts are classified as long-duration contracts. Accident and health insurance contracts may be of short or long duration according to their expected term of coverage.

FASB 60, paragraph 8 states that all premiums for short duration insurance contracts ordinarily shall be recognized as revenue over the period of the contract in proportion to the amount of insurance protection provided. A *liability for unpaid claims* (including estimates of costs for claims relating to insured events that have occurred but have not been reported to the insurer) and a *liability for claim adjustment expenses* shall be accrued when insured events occur.[39]

For long duration contracts premiums shall be recognized when due from policyholders. A liability for expected costs relating to most types of long duration contracts shall be accrued over the current and expected renewal periods of the contracts. The present value of estimated future policy benefits to be paid to or on behalf of policyholders less the present value of estimated future *net premiums* to be collected from policyholders (*liability for future benefits*) shall be accrued when the premium revenue is recognized.[40]

Cash Basis[41]

Usually, insurance companies keep their general ledger on a cash basis. Some reports required by regulatory agencies must be prepared on a cash basis, particularly details of income and expense. Assets that have been recorded on the books of an insurance company are called *ledger assets.* Others are called *nonledger assets.* Nonledger assets arise from adjusting journal entries necessary to convert the cash basis trial balance to the accrual basis. Liabilities are referred to in the same manner, so those recorded on the books are called *ledger liabilities* and others are called *nonledger liabilities.*

Because insurance companies use the cash basis, most liabilities are nonledger. An insurance company will have few nonledger assets, because most of its assets arise from cash transactions.

[39] Financial Accounting Standards Board, *Original Pronouncements: Volume I, Statement 60,* Norwalk, CT, 1998, page 567.
[40] Financial Accounting Standards Board, *FASB Statement No. 60,* Norwalk, CT, paragraph 9 & 21.
[41] Williams, Jan R, PhD, CPA, *Miller GAAP Guide: Restatement and Analysis of Current FASB Standards,* New York, NY, 2003, Pg. 50.43.

When adjusting journal entries are made for workpapers to convert the cash basis trial balance to accrual basis, they are not posted to the book. Therefore, the books of an insurance companies are on the cash basis. The insurance company will keep other records, such as a *claim register*, so that information is available to adjust easily to the accrual basis.

The claims register keeps track of claims pending, paid, negotiated, and rejected, while cash basis trial balance reflects only the claims actually paid. The claims register is used to prepare some of the adjusting journal entries necessary for conversion to the accrual basis.

Medicaid/SCHIP Fact Sheet

Medicaid is health insurance that helps many people who cannot afford medical care pay for some or all of their medical bills. The State Children's Health Insurance Program was established in 1997 to make health care coverage available to even more children.

Summary

Medicaid. Close to 42 million individuals were enrolled in Medicaid in 2003. Medicaid covers approximately one-fourth of the Nation's children and is the largest single purchaser of maternity care and nursing home/long-term care services in the United States. In 2003, the elderly and those with disabilities represented approximately 30 percent of Medicaid beneficiaries but accounted for two-thirds of its spending. Total Medicaid spending for 2005 is estimated to be around $322 billion ($182 billion Federal share).[42]

Title XIX of the Social Security Act is a program that provides medical assistance for certain individuals and families with low incomes and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments (including the District of Columbia and U.S. Territories) to assist States in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people. Within broad national guidelines provided by the Federal government, each of the States:

1. Establishes its own eligibility standards;
2. Determines the type, amount, duration, and scope of services;
3. Sets the rate of payment for services; and
4. Administers its own program.

Thus, the Medicaid program varies considerably from State to State, as well as within each State over time. State legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.[43] Medicaid does not pay money directly to the participants; instead, it sends payments directly to participating health care providers. Depending on each state's rules, the participant may also be asked to pay a small part of the cost (co-payment) for some medical services.

State Children's Health Insurance Program (SCHIP). SCHIP was established in 1997 to make available approximately $40 billion over 10 years for States to provide health care coverage to low-income, uninsured children. SCHIP gives States broad flexibility in

[42] Budget of the United States Government, Fiscal Year 2005 – Health and Human Services (HHS) at http://www.whitehouse.gov/omb/budget/fy2005/.
[43] Facts obtained from the HHS Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov/ medicaid.

program design while protecting beneficiaries through Federal standards. Since the beginning of the Administration, enrollment in SCHIP has grown by over 1 million children, to approximately 5.3 million in 2002.[44]

Title XXI of the Social Security Act established SCHIP. Some of the states administer SCHIP in combination with Medicaid while other states maintain two separate programs. Due to their similarity, they will both be addressed in this paper.

Eligibility[45]

Individuals DO NOT need to be on welfare to receive Medicaid. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) severed the automatic link between eligibility for cash assistance for families and children and Medicaid.

Medicaid

Categorically Needy

Medicaid does not provide medical assistance for all poor persons. Medicaid eligibility is limited to individuals who fall into specified categories. The federal statute identifies over 25 different eligibility categories for which federal funds are available. These categories can be classified in to one of the following broad coverage groups:

- Pregnant Women;
- Children and Teenagers; and,
- Persons who are Aged, Blind, or Disabled.

In general, citizens are encouraged to apply for Medicaid if their income is low; they have few resources; and they are either pregnant, under 18 or over 65, blind, or disabled. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group.

Medically Needy

Thirty-seven states also have optional "medically needy" programs. Individuals that are classified as medically needy have too much money or resources to be eligible as "categorically needy."

[44] Budget of the United States Government, Fiscal Year 2005 – HHS at http://www.whitehouse.gov/omb/budget/ fy2005/.
[45] Medicaid at a Glance 2003 at http://www.cms.hhs.gov/states/maaghm.asp.

Special Groups

In addition, there are several special groups that states can fund through the Medicaid program:

- Medicare Beneficiaries – Medicaid pays Medicare premiums, deductibles, and coinsurance for Qualified Medicare Beneficiaries (QMB) – individuals whose income is at or below 100 percent of the Federal poverty level and whose resources are at or below the standard allowed under SSI; individuals whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and individuals whose income is at least 120 percent but less than 135 percent of the Federal poverty level.
- Qualified Working Disabled Individuals - Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals have income below 200% of the Federal poverty level and resources that are no more than twice the standard allowed under SSI.
- States may also improve access to employment, training and placement of people with disabilities who want to work through expanded Medicaid eligibility. Eligibility can be extended to working disabled people between ages 16 and 65 who have income and resources greater than that allowed under the SSI program. States can extend eligibility even more to include working individuals who become ineligible for the group described above because their medical conditions improve. States may require such individuals to share in the cost of their medical care.
- There are two eligibility groups that states may include under their Medicaid plans. One is a time-limited eligibility group for women who have breast or cervical cancer; the other is for people with tuberculosis (TB) who are uninsured. Women with breast or cervical cancer receive all plan services; TB patients receive only services related to the treatment of TB. The charts below identify the states that include these groups under their Medicaid plans.
- 1115 MEDICAID WAIVERS - Some states have also expanded eligibility under Medicaid waivers. These waivers relate to Section 1115 of the Social Security Act, which provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) that, in the judgment of the Secretary, are likely to assist in promoting the general objectives of Medicaid.
- Long Term Care - All states provide community Long Term Care services for individuals who are Medicaid eligible and qualify for institutional care. Most states use eligibility requirements for such individuals that are more liberal than those normally used in the community.
- Transitional Medical Assistance (TMA) – Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any

Medicaid eligibility group.[46] However, when a family that has received Medicaid for at least three of the preceding six months loses eligibility for Medicaid because of an increase in earned income, the family is entitled to transitional medical assistance, which also is known as extended Medicaid benefits or transitional benefits, for 12 months (to be eligible for the full 12 months of assistance, the family must include a dependent child and the family's earned income minus the cost of child care must not exceed 185 percent of the federal poverty level (42USC1396r-6)).

In addition, under Section 1931 of the Social Security Act, States have numerous options that allow them to cover additional families and/or simplify eligibility requirements and administration. Under section 1931, States have varying flexibility with regards to countable resources, earned income limits, and time limits, among other things.

State Children's Health Insurance Programs (SCHIP)

In addition to the Medicaid program, states administer the State Children's Health Insurance Program (SCHIP) for children up to age 19. In some states the SCHIP is part of the state's Medicaid program, in some states it is separate, and in some states it is a combination of both types of programs. These programs are for children whose parents have too much money to be eligible for Medicaid, but not enough to buy private insurance. Most states offer this insurance coverage to children in families whose income is at or below 200% of the Federal poverty level. Not all the insurance programs provide the same benefits, but they all include shots (immunizations) and care for healthy babies and children at no cost. Families may have to pay a premium or a small amount (co-payment) for other services depending on their income.

Benefits[47]

Title XIX of the Social Security Act allows considerable flexibility within the 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.

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[46] Medicaid: A Brief Summary at http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp

[47] Medicaid Services at http://www.cms.hhs.gov/medicaid/mservice.asp.

- 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.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States must provide at least the following services when the medically needy are included under the Medicaid plans:

- Prenatal and delivery services.
- Post partum pregnancy related services for beneficiaries under age 18 and who are entitled to institutional and ambulatory services defined in a state's plan.
- Home health services to beneficiaries who are entitled to receive nursing facility services under the state's Medicaid plan.

States may also receive matching Federal funds to provide certain *optional* services. Following are the most common of the thirty-four 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.
- Home and community-based care to certain persons with chronic impairments.

Section 1932(b)(2)(A)(i) of the Social Security Act (42 U.S.C. 1396u-2) prohibits prior authorization for coverage of emergency services. This means that services that meet the definition of emergency services must be covered, and beneficiaries must not be charged for these services, except for any permissible nominal cost-sharing amounts. In addition, section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173, authorized federal reimbursement of emergency health services furnished to undocumented aliens, $250 million for each of fiscal years 2005 through 2008.

Funding[48]

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/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment.

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 services 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 (FY) 2003, the FMAPs varied from 50 percent in twelve States to 76.62 percent in Mississippi, and averaged 56.6 percent overall. 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 to the general Medicaid average of 56.6 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 twelve 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.

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[48] Medicaid: A Brief Summary at http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp.

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.

Make America Stronger

10

Food Stamp Program (FSP) Fact Sheet

The Food Stamp Program serves as the first line of defense against hunger. It enables low-income families to buy nutritious food with Electronic Benefits Transfer (EBT) cards.[49] Food stamp benefit recipients can purchase eligible food, seeds, and/or plants in authorized retail stores.

Summary[50]

The purpose of the Food Stamp Program is to end hunger and improve nutrition and health. The program helps low-income households buy the food they need for a nutritionally adequate diet. The program is operated by State and local welfare offices, and the U.S. Department of Agriculture administers the Food Stamp Program at the Federal level through its Food and Nutrition Service (FNS).[51] State agencies administer the program at State and local levels, including determination of eligibility and allotments, and distribution of benefits. The program is in operation in the 50 States, the District of Columbia, Guam and the U.S. Virgin Islands.

The Food Stamp Program helped put food on the table for some 8.2 million households and 19.1 million individuals each day in fiscal year 2002 and cost $20.7 billion. It provides low-income households with electronic benefits they can use like cash at most grocery stores to ensure that they have access to a healthy diet. The Food Stamp Program is the cornerstone of the Federal food assistance programs, and provides crucial support to needy households and to those making the transition from welfare to work. It provided an average of $1.52 billion a month in benefits in fiscal year 2002.

Households must meet eligibility requirements and provide information – and verification -- about their household circumstances. U.S. citizens and some aliens who are admitted for permanent residency may qualify. The Personal Responsibility and Work Opportunity Reconciliation Act ("welfare reform act") of 1996 ended eligibility for many legal immigrants, though Congress later restored benefits to many children and elderly immigrants, as well as some specific groups. The welfare reform act also placed time limits on benefits for unemployed, able-bodied, childless adults. Able–bodied adults without dependents who are not meeting the work requirements are limited to any 3 months in a 36–month period.[52]

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[49] USDA has completely discontinued use of the paper food stamps. The distribution of benefits is now accomplished completely via electronic benefits cards; California was the last state to move to electronic benefits in June 2004. The program will eventually be given a more relevant name.
[50] Food Stamp Program Frequently Asked Questions at http://www.fns.usda.gov/fsp/faqs.htm
[51] In addition to the Food Stamp Program, FNS also oversees the assistance program for Women, Infants, and Children; the School Meals program; the Summer Food Service Program; the Child and Adult Care Food Program; and the Food Assistance for Disaster Relief and Food Distribution programs.
[52] Public Law 104-193, Sec. 408(a)(7)(A) and Sec. 824(a), August 22, 1996

One note of interest is that in 2001, only an estimated 52 percent of eligible individuals in working families and 70 percent of eligible members of nonworking families participated in the Food Stamp Program.[53] Thus, if future USDA attempts to encourage eligible families to apply for food stamp benefits is successful, the annual expenditures for the Food Stamp Program could increase dramatically.

Eligibility[54]

To participate in the Food Stamp Program:

- Households may have no more than $2,000 in countable resources, such as a bank account ($3,000 if at least one person in the household is age 60 or older, or is disabled).[55]
- The gross monthly income of most households must be 130 percent or less of the Federal poverty guidelines ($1,654 per month for a family of three in most places, effective Oct. 1, 2003 through Sept. 30, 2004).
- Net monthly income must be 100 percent or less of Federal poverty guidelines ($1,272 per month for a household of three in most places, effective Oct. 1, 2003 through Sept. 30, 2004).
- Most able-bodied adult applicants must meet certain work requirements.
- All household members must provide a Social Security number or apply for one.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limits the receipt of food stamps to 3 months in a 3-year period for able-bodied adults without dependents (ABAWDs) who are not working, participating in, and complying with the requirements of a work program for 20 hours or more each week, or a workfare program. Individuals are exempt from this provision if they are:

- under 18 or over 50 years of age;
- responsible for the care of a child or incapacitated household member;
- medically certified as physically or mentally unfit for employment, pregnant; or,
- already exempt from the work requirements of the Food Stamp Act.

States may request a waiver of this provision for people in areas with an unemployment rate above 10 percent or for those in an area with insufficient jobs. States also have authority to exempt individuals using the 15% exemption authorized by the Balanced Budget Act.[56]

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[53] Food Stamp Program: Steps Have Been Taken to Increase Participation of Working Families, but Better Tracking of Efforts Is Needed (GAO-04-346, March 5, 2004)

[54] Food Stamp Program Frequently Asked Questions at http://www.fns.usda.gov/fsp/faqs.htm

[55] There are certain resources that are NOT counted, such as a home and lot, the resources of people who receive Supplemental Security Income (SSI), the resources of people who receive Temporary Assistance to Needy Families (TANF) (formerly AFDC), most retirement (pension) plans, and some vehicles as noted at http://www.fns.usda.gov/fsp/applicant_recipients/resources.htm.

[56] Food Stamp Program ABAWDS at http://www.fns.usda.gov/fsp/rules/Memo/PRWORA/abawds/ABAWDsPage.htm.

The following chart lists the current gross and net income eligibility standards for the continental United States, Guam and the Virgin Islands, effective Oct. 1, 2003 to Sept. 30, 2004. Eligibility levels are slightly higher for Alaska and Hawaii. Households must meet income tests UNLESS all members are receiving Title IV (TANF), SSI, or in some places general assistance.

Household size	Gross Monthly Income (130 percent of poverty)	Net Monthly Income (100 percent of poverty)
1	973	749
2	1,313	1,010
3	1,654	1,272
4	1,994	1,534
5	2,334	1,795
6	2,674	2,057
7	3,014	2,319
8	3,354	2,580
Each Additional Member	+341	+262

A new pre-screening tool can help individuals determine whether they might be eligible for food stamp benefits, and how much they might be eligible to receive, so they can see whether it would be worth their while to go to the local food stamp office and apply.[57] A few states even have an on-line application process.

The Food Stamp Act requires that the States obtain periodic reports of income from households receiving benefits to ensure they still meet the eligibility requirements.[58]

Note: Individuals who receive Supplemental Security Income (SSI) and reside in a State that provides State supplementary payments at a level that has been found by the Commissioner of Social Security to be specifically increased so as to include the bonus value of food stamp benefits are NOT eligible to receive separate food stamp benefits (see fact sheet on SSI for more information on supplementary payments).[59]

Benefits[60]

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

[57] The USDA FNS Food Stamps Pre-Screening Eligibility Tool can be accessed at http://209.48.219.49/fns/.
[58] Food Stamp Act of 1977 [As Amended Through P.L. 108–199, Jan. 23, 2004] §6(c)
[59] Food Stamp Act of 1977 [As Amended Through P.L. 108–199, Jan. 23, 2004] §6(g)

An individual household's food stamp benefits allotment is equal to the maximum allotment for that household's size, less 30 percent of the household's net income. Households with no countable income receive the maximum allotment ($371 per month in Fiscal Year 2004 for a household of three people). Allotment levels are higher for Alaska, Hawaii, Guam, and the Virgin Islands, reflecting higher food prices in those areas.

The average monthly benefit was about $80 per person and almost $186 per household in FY 2002. See the chart below for a listing of maximum benefits available to households of various sizes.

Households **CAN** use food stamp benefits to buy:

- Foods for the household to eat, such as:
- Breads and cereals;
- Fruits and vegetables;
- Meats, fish and poultry; and
- Dairy products.
- Seeds and plants that produce food for the household to eat.

Households **CANNOT** use food stamp benefits to buy:

- Beer, wine, liquor, cigarettes or tobacco;
- Any nonfood items, such as:
- Pet foods;
- Soaps, paper products; and
- Household supplies.
- Vitamins and medicines.
- Food that will be eaten in the store.
- Hot foods

In some areas, restaurants can be authorized to accept food stamp benefits from qualified homeless, elderly, or disabled people in exchange for low-cost meals. Food stamp benefits cannot be exchanged for cash.

The Food Stamp Program served an average of 17.2 million people each month during fiscal year 2002, and cost $20.7 billion. The current maximum allotment levels for the continental United States, in effect from Oct. 1, 2003 to Sept. 30, 2004 are:

Household size	**Maximum allotment level**
1	$141
-	---

[60] Food Stamp Program Frequently Asked Questions at http://www.fns.usda.gov/fsp/faqs.htm

3	371
4	471
5	560
6	672
7	743
8	849
Each additional member	+106

<u>Funding</u>

FNS pays the full cost of food stamp benefits and shares the states' administrative costs—with FNS usually paying 50 percent.[61] A total of $30,945,981,000 was appropriated for the Food Stamp Program for fiscal year 2004, of which $3,000,000,000 shall be reserved to pay for the cost of operations.[62] These monies are allocated based on annual plans submitted by the states. In the event that the sum of the state plans exceeds the appropriation available in any given year, FNS will request that the states revise their plans to the lowest level needed to meet minimum legislative requirements.[63]

FNS is authorized to pay to each State agency an amount equal to 50 per centum of all administrative costs involved in each State agency's operation of the food stamp program, which costs shall include, but not be limited to, the cost of (1) the certification of applicant households, (2) the acceptance, storage, protection, control, and accounting of electronic benefit cards after their delivery to receiving points within the State, (3) the issuance of benefits to all eligible households, (4) food stamp benefits informational activities (excluding recruitment activities), (5) fair hearings, (6) automated data processing and information retrieval, (7) food stamp program investigations and prosecutions, and (8) implementing and operating the immigration status verification system.[64] States can also earn a performance bonus for meeting certain performance criteria established by FNS relating to administration of the Food Stamp Program.[65]

[61] Food Stamp Program: Steps Have Been Taken to Increase Participation of Working Families, but Better Tracking of Efforts Is Needed (GAO-04-346, March 5, 2004)
[62] Public Law 108–199,Jan. 23, 2004
[63] Food Stamp Act of 1977 [As Amended Through P.L. 108–199, Jan. 23, 2004] §18
[64] Food Stamp Act of 1977 [As Amended Through P.L. 108–199, Jan. 23, 2004] §16
[65] Food Stamp Act of 1977 [As Amended Through P.L. 108–199, Jan. 23, 2004] §16

Temporary Assistance for Needy Families (TANF)

Temporary Assistance for Needy Families provides assistance and work opportunities to needy families by granting states the federal funds and wide flexibility to develop and implement their own welfare programs.

Summary

In 1996, the Congress created the Temporary Assistance for Needy Families (TANF) program, which was enacted under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), replacing the Aid to Families with Dependent Children and related welfare programs. TANF is a $16.5 billion a year block grant to the States. Promoting work was the key to the 1996 law, which required minimum levels of work participation and included bonuses for high performance. States were given significant flexibility in designing the eligibility criteria and benefit rules, which require work in exchange for time-limited benefits.[66]

Under the TANF structure, the federal government provides a block grant to the states, which use these funds to operate their own programs. States can use TANF dollars in ways designed to meet any of the four purposes set out in federal law, which are to: "(1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families."[67]

Eligibility[68]

States have broad discretion to determine who will be eligible for various TANF-funded benefits and services. The main federal requirement is that states use the funds to serve families with children. A state can set different eligibility tests for different programs funded by the TANF block grant. For example, a state could choose to limit TANF cash assistance to very poor families, but provide TANF-funded child care or transportation assistance to working families with somewhat higher incomes.

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[66] TANF Fifth Annual Report to Congress at http://www.acf.dhhs.gov/programs/ofa/annualreport5/chap01.htm

[67] Center on Budget and Policy Priorities "An Introduction to TANF" by Martha Coven at http://www.cbpp.org/1-22-02tanf2.htm

[68] Center on Budget and Policy Priorities "An Introduction to TANF" by Martha Coven at http://www.cbpp.org/1-22-02tanf2.htm

An exception to the broad flexibility that states generally have to establish TANF eligibility rules is that federal law bars states from using federal TANF dollars to assist most legal immigrants until they have been in the U.S. for at least five years. This restriction applies not only to cash assistance, but also to TANF-funded work supports and services such as child care, transportation, and job training. A significant percentage of poor children have non-citizen parents who are ineligible for TANF benefits and services. States can use state funds to provide benefits to recent immigrants, but fewer than half do so. Prior to the 1996 welfare law, legal immigrants generally were eligible for benefits, although the income of an immigrant's sponsor was factored in for the first three years.

Two other key elements of state TANF programs are work requirements and time limits, both of which apply to "basic" assistance (cash and other assistance designed to meet basic ongoing needs). Federal law requires that half of the families receiving assistance under TANF must be engaged in some kind of work-related activity for at least 30 hours a week. States get credits for reduced caseloads, however, and are currently effectively required to have much less than half of families engaged in federally-defined work activities. Nonetheless, states have generally exceeded the minimum federal requirements for the number of families participating in work activities.

On time limits, the general rule is that no family may receive federally-funded assistance for longer than five years. States are allowed to use federal TANF dollars to extend time limits, but only so long as no more than 20 percent of the caseload has exhausted the five-year limit. Families receiving assistance funded entirely with state funds are not subject to the federal time limit. While about 20 states have established time limits shorter than five years, states often provide exceptions and exemptions for some groups of families meeting specified criteria.

Not every state currently is required to comply with all of the federal TANF rules. Several states are exempt or partly exempt from TANF requirements because they are operating under a "waiver" already in effect when the 1996 welfare law was enacted. (Prior to the 1996 law, some states had received waivers to change the rules of their AFDC programs.) The rules covered by the waivers and the waiver expiration dates vary by state. States with waivers include Hawaii, Massachusetts, Montana, and Tennessee.

Benefits[69]

The TANF program provides tremendous flexibility for funding a wide variety of activities, supportive services, and benefits to accomplish the purposes of the program. The following lists identify some possible uses of Federal TANF or State MOE funds:

[69] "Appropriate Uses of Funds", HHS, at http://www.acf.dhhs.gov/programs/ofa/funds2.htm#additional.

Support for Work Activities

- Provide job search, job placement, transportation, and child care services to TANF applicants from the beginning of the TANF application period;
- Provide work experience and case management to individuals with employment barriers, such as little or no work history;
- Subsidize wages directly or through an employer. Provide subsidies to help pay for the creation of community jobs for needy parents in private, non-profit or community agencies;
- Help unemployed needy noncustodial parent by providing job skills training, re-training, job search, employment placement services, or other work-related services;
- Provide job retention services or post-employment follow-up services, such as counseling, employee assistance, or other supportive services;
- Pay refugee services providers to provide linguistically and culturally appropriate services that help refugee TANF recipients obtain employment or participate in work activities;
- Provide specialized training for supervisors or job coaches in private industry on how to work with newly hired TANF individuals who have serious barriers to employment—or reimburse employers for the time supervisors spend in such training;
- Subcontract with business organizations or associations to expand participation of employers in welfare-to-work initiatives and encourage the hiring of TANF recipients;
- Conduct a State public awareness campaign designed to inform employers about the benefits of hiring TANF recipients and encourage employers to alert the TANF office when they have job openings;

Child Care

- Transfer Federal TANF funds into the Child Care and Development Fund to support "quality activities," e.g., to help child care providers attain accreditation and increase monitoring and unannounced inspections of child care settings;
- Counsel needy parents about health, safety, educational, social, and emotional development issues to consider in selecting child care;
- Provide full-day/full-year high quality child care services for young children in needy families by expanding or extending the hours of programs with high educational and developmental standards, such as Head Start and accredited pre-kindergarten;
- Increase child care subsidy levels, especially for infant and toddler care, to expand the availability of care for needy families;
- Increase child care payment rates for child care offered during non-traditional hours in order to expand the availability of such care;

- Expand child care staff recruitment activities to increase the availability of care for needy families, especially in areas of short supply such as care for children with special needs, sick-child care, care in rural areas, and care during non-traditional work hours;
- Fund after-school and summer recreation activities that provide supervision and developmental services for children and youth while their needy parents work;

Transportation

- Provide transportation allowances to cover incidental expenses and participation-related expenses for unemployed families;
- Provide transit passes or tokens;
- Arrange with another agency to use its buses or vans or share in the costs of purchasing transportation services;
- Invest in reverse commute projects and other local initiatives to improve the existing transportation network so that needy parents can access jobs;
- Reimburse clients for mileage, auto repairs, or auto insurance to facilitate finding employment and job retention;
- Contract with a private organization or service to refurbish previously owned cars and provide the cars to TANF recipients or provide financing support that enables recipients to purchase a car;
- Subsidize costs of transporting needy children to child care;

Education and Training

- Train employed recipients, former recipients, and noncustodial parents in job-related vocational and literacy skills needed for regular, full-time employment;
- Fund education or job training activities at colleges and secondary and technical schools that promote advancement to higher paying jobs and self-sufficiency;
- Share with employers the costs of on-site education, such as ESL or literacy classes;
- Provide classes for new, unskilled, and semi-skilled workers to teach new skills or enhance existing skills in order to improve their chances of job retention and advancement;

Mental Health/Substance Abuse

- Use Federal TANF funds to provide appropriate counseling services (e.g. mental health services, anger management counseling, non-medical substance abuse counseling services) to family members with barriers to employment and self-sufficiency;

- Use Federal TANF or State MOE funds to provide non-medical substance or alcohol abuse services, including room and board costs at residential treatment programs;
- Use State MOE funds (that have not been commingled with Federal TANF funds) to pay for medical services (e.g., for treatment of substance or alcohol abuse not paid by Medicaid) or to provide medical coverage for families that lack medical benefits (e.g., for families ineligible for transitional Medicaid or for adults whose children are served by Medicaid or CHIP);

Domestic Violence

- Use TANF or MOE funds to help victims of domestic violence relocate somewhere else in the State or outside the State where employment or safe housing has been secured;
- Collaborate with domestic violence service providers to screen and identify victims; develop safety and services plans; provide appropriate counseling, referrals and other related services; determine the need for waivers of TANF program requirements; establish procedures that will maintain confidentiality of case-record information and ensure safety; and develop appropriate staff training;

Developmental and Learning Disabilities

- Arrange for the State's vocational rehabilitation agency or similar provider to provide assessment, evaluation, assistive technology and equipment, and vocational rehabilitation services to needy individuals who have physical or mental disabilities, but would not otherwise receive services (Such services may also be important to parents or caretakers who receive SSI, while their children receive TANF.);
- Provide cash assistance during the waiting period for SSI benefits for a disabled parent or disabled child in the family;

Enhancing or Supplementing the Family Income or Assets

- Make loans to needy families to provide stable housing, secure a car, or for other reasons that are reasonably calculated to meet a purpose of the program;
- Create a State refundable Earned Income Tax Credit Program, using State MOE funds to pay for the refundable portion of the credit;
- Fund a supplemental unemployment insurance program for unemployed workers in needy families who are not eligible for benefits under the State's regular unemployment insurance program;
- Provide stipends to needy parents who combine education/training and work;
- Increase earnings disregards for employed parents and adult caretaker relatives;

- Match the contributions of TANF eligible individuals in Individual Development Accounts (IDAs) developed either under the TANF provisions or the Assets for Independence Act of 1998;
- **NOTE:** IDA benefits are not "assistance." Also, IDA benefits and assets may be disregarded in determining TANF eligibility and benefits.
- Pass through to the family (and disregard) some or all of the State's share of the assigned child support collection or pass through the full amount of the child support collection by using the State's share of the assigned child support collection for part of it and using additional State MOE funds to pay the remainder;
- Provide weatherization assistance or pay for home repairs;
- Provide rental assistance, including security deposits, application fees, and payments of back rent to prevent evictions;
- Provide a moving allowance (e.g., when a needy adult family member secures a job that is not close to the family's home);
- Inform families about the availability of the Earned Income Tax Credit and other ongoing supports for working families -- including food stamp benefits, Medicaid, and child care;

Child Welfare

- Collaborate with the child welfare agency to identify and serve children in needy families who are at risk of abuse or neglect (e.g., family counseling, vocational and educational counseling, and counseling directed at specific problems such as developmentally disabled needs);
- Provide cash assistance to needy caretaker relatives or provide appropriate supportive services (e.g., referral services, child care, transportation, and respite care) to caregiver relatives who can provide a safe place for a needy child to live and avoid his or her placement in foster care;
- Screen families who have been sanctioned under TANF for risk of child abuse or neglect and provide case management services designed to eliminate barriers to compliance;

Family Formation and Pregnancy Prevention

- Fund responsible fatherhood initiatives that will improve the capacity of needy fathers to provide financial and emotional support for their children;
- Provide parenting classes, premarital and marriage counseling, and mediation services;
- Provide counseling services or classes that focus on teen pregnancy prevention;
- Fund State or local media campaigns to encourage young people to delay parenting or to encourage fathers to play a responsible role in their children's lives;
- Change TANF eligibility rules to provide incentives for single parents to marry or for two-parent families to stay together;

Community Development

- Issue grants to local welfare planning councils for their use in addressing TANF recipient needs within a specific locale;
- Provide loans to small businesses if they agree to hire and train TANF recipients
- Fund a micro-enterprise development initiative;
- Fund Community Development Corporation (CDC) projects or community-based organizations that employ TANF clients, e.g., by covering the appropriate share of planning, development, and implementation costs;

General

- Use Federal TANF funds for activities for which the State had been specifically authorized per the State's approved AFDC plan, JOBS plan, or Supportive Services plan as of September 30, 1995, or, at State option August 21, 1996 -- e.g., foster care or juvenile justice activities;
- Use funds to purchase food stamp benefits from the U.S. Department of Agriculture for legal aliens who are not eligible for benefits under the Federal food stamp program;
- Provide outreach activities that will improve access of needy families to medical benefits provided under the Medicaid or CHIP programs;
- Contribute State MOE funds to Tribal TANF programs;
- Provide training to counselors in employee and family assistance programs about the needs of the population leaving welfare.

Funding[70]

Rather than requiring an annual appropriation, the law that created TANF provided for mandatory block grants to the states totaling $16.5 billion each year for six years. This is a flat dollar amount, not adjusted for inflation. As a result, the real value of the block grant has already fallen by more than 11 percent. The TANF law authorized the block grant through fiscal year 2002; Congress has been regularly extending this authorization for short periods at a time since then.

The 1996 law also created supplemental grants for certain states with high population growth or low block grant allocations relative to their needy population, as well as a contingency fund to help states weather a recession.

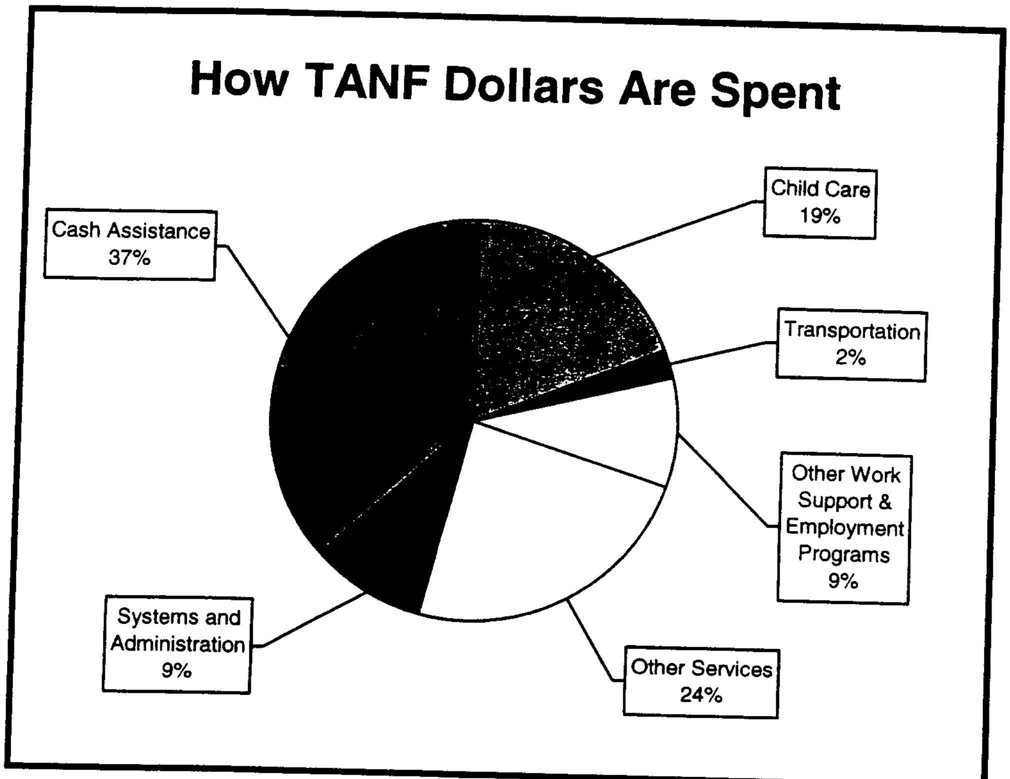
Finally, the 1996 law created two "performance bonuses." The first, known as the "high performance bonus," rewards states for meeting employment-related goals like job entry,

[70] Center on Budget and Policy Priorities "An Introduction to TANF" by Martha Coven at http://www.cbpp.org/1-22-02tanf2.htm

job retention, and wage progression. The second is a bonus for reductions in non-marital births.

In order to maintain the shared federal-state responsibility that was built into the AFDC program, states must continue spending at least 75 percent of their 1994 contribution to AFDC-related programs. This is the "maintenance of effort" (MOE) requirement, and it totals roughly $10.5 billion.

States have used their TANF funds in a variety of ways, including: cash assistance (including wage supplements); child care; education and job training; transportation; and a variety of other services to help families make the transition to work. In addition, in order to receive TANF funds, states must spend some of their own dollars on programs for needy families. This is what is known as the "maintenance of effort" (MOE) requirement.



Reflects fiscal year 2002 expenditures of TANF and MOE funds (totaling $28.4 billion)

The law that created the TANF block grant authorized funding through the end of federal fiscal year 2002 (September 30, 2002). Since 2002, Congress has been working on legislation to reauthorize the block grant and make some modifications to the rules and funding levels. However, no final agreement has yet been reached on reauthorization legislation. In the meantime, TANF funding has been temporarily extended several times.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a Federal income supplement program administered by the Social Security Administration but funded by general tax revenues (not Social Security taxes):

- *It is designed to help aged, blind, and disabled people (adults and children), who have little or no income; and*
- *It provides cash to meet basic needs for food, clothing, and shelter.*

Summary

Unlike Social Security benefits, SSI benefits are not based on your prior work or a family member's prior work. SSI is financed by general funds of the U.S. Treasury--personal income taxes, corporation taxes and other taxes. Social Security taxes withheld under the Federal Insurance Contributions Act (FICA) do not fund the SSI program. In most States, SSI beneficiaries also can get Medicaid (medical assistance) to pay for hospital stays, doctor bills, prescription drugs, and other health costs. SSI beneficiaries may also be eligible for food stamp benefits in every State except California. In some states, an application for SSI benefits also serves as an application for food assistance. SSI benefits are paid on the first of the month for the entire month. To get SSI benefits, one must be disabled, blind, or at least 65 years old and have "limited" income and resources. In addition, to get SSI benefits, one must:

- be a resident of the United States;
- not be absent from the country for more than 30 days; and,
- be either a U.S. citizen or national, or in one of certain categories of eligible non–citizens.

The medical standards for disability are the same in both programs for individuals age 18 or older. There is a separate SSI definition of disability for children under age 18. Both programs pay monthly benefits. SSA administers both programs.[71]

Eligibility[72]

An individual who is:

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[71] Understanding Supplemental Security Income SSI Overview at http://www.socialsecurity.gov/notices/supplemental-security-income/text-over-ussi.htm

[72] Understanding Supplemental Security Income SSI Eligibility Requirements at http://www.socialsecurity.gov/notices/ supplemental-security-income/text-eligibility-ussi.htm

- aged (age 65 or older);
- blind; or,
- disabled.

And, who:

- has limited income;
- has limited resources;
- is a U.S. citizen or one of certain categories of aliens;
- is a resident of one of the 50 States, including the District of Columbia, and the Northern Mariana Islands;
- is not absent from the country for a full calendar month or more than 30 consecutive days;
- agrees to apply for any other cash benefits for whom he or she may be entitled; and,
- meets certain other requirements.

may be eligible to receive SSI benefits.

Limited income includes money earned from work; money received from other sources, such as Social Security, worker's compensation, unemployment benefits, Department of Veterans' Affairs, friends or relatives; and free food, clothing, or shelter.[73]

Resources include items owned such as cash; bank accounts; land; vehicles; personal property; and life insurance and are subject to the following limits:

Individual	$2,000
Couple[74]	$3,000

Examples of individuals that are **not** eligible to receive SSI include, but are not limited to:

- Fugitive felons;
- Individuals currently in prison or jail;
- Individuals who sacrifice resources in order to meet resource limitations;
- Non-citizens who fail to meet alien status; or,
- Someone who is absent from the country for more than 30 consecutive days.

It is important to note that potential recipients of SSI must also apply for all other benefits or payments for which they may be eligible such as pensions or Social Security.

[73] SSA does not count all kinds of income for SSI, but most income that it does count reduces the SSI benefit amount.
[74] A couple means two SSI-eligible persons residing together.

There is a benefit eligibility screening tool (BEST) available on the SSA web page.[75]

Benefits

The basic monthly SSI payment is the same nationwide and changes annually. For fiscal 2004, it is:

- $564 for one person; or
- $846 for a couple.

Not everyone gets the same amount. A participant who lives in a state that supplements the federal SSI payment would receive more than a participant who lives in a state that either does not supplement the federal SSI payment or supplements it at a lower rate. A participant may receive less if he or his family has other income. Also, the location of one's household and other household members can determine if one qualifies for SSI and can make a difference in the amount of the SSI payment.[76]

It is interesting to note that there is a detailed discussion of an individual's right to appeal decisions made about their eligibility for SSI in the Social Security Handbook Chapter 21, §§2192-2195.

Funding

SSI benefits are financed from the general funds of the United States Treasury. They are not paid out of the Social Security or Medicare trust funds. States that supplement the Federal benefits make these supplemental payments from State funds.[77]

There are two types of State supplementary payments: mandatory and optional. If a participant was converted to SSI from a State assistance program, the State must supplement the SSI amount. The amount of the supplement is what is necessary to provide the participant with the same level of payment he had before he was converted to SSI. These mandatory payments may be issued directly by the State or the State may elect Federal administration where the Federal Government combines the mandatory payment and the SSI payment into one payment.

In addition, any State may make an agreement with SSA to administer its supplementation program. SSA would pay the State supplementary amounts along with the basic SSI benefits. Each month, SSA charges the State an administration fee for every State supplementary payment issued during that month. For fiscal year 2004, the fee is $8.77 per payment. The rate will remain $8.77 per payment until SSA decides upon an appropriate rate for later years.[78]

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[75] BEST is located at http://best.ssa.gov/.
[76] "You May be Able to Get Supplemental Security Income" pamphlet at http://www.ssa.gov/pubs/11069.html.
[77] Social Security Handbook Chapter 21, § 2105
[78] Social Security Handbook Chapter 21, § 2106

All of the states (and DC) listed below have an agreement with SSA to pay supplementary payments on their behalf for an administrative fee:[79]

- California
- Delaware
- The District of Columbia
- Hawaii
- Iowa*
- Massachusetts
- Michigan*
- Montana
- Nevada
- New Jersey
- New York*
- Pennsylvania
- Rhode Island
- Utah
- Vermont*

* Dual administration State. Both Social Security and these States administer some State supplements.

Most States provide optional supplementary payments to SSI recipients. These payments vary from State to State and reflect differences in regional living costs. Supplementary payments may be made directly by the State or combined with the SSI payment (by mutual agreement of SSA and State agencies).[80]

The following states do not pay a supplement to people who receive SSI benefits:

- Arkansas
- Georgia
- Kansas
- Mississippi
- Tennessee
- West Virginia
- Northern Mariana Islands

[79] Understanding SSI – SSI Benefits at http://www.ssa.gov/notices/supplemental-security-income/text-benefits-ussi.htm
[80] Social Security Handbook Chapter 21, § 2181

This three-page paper was submitted by Linda Hoogeveen App, CPA, CGFM, Associate Deputy Administrator for Financial Management, Food & Nutrition Service (FNS)/USDA on July 15, 2004, for consideration by the Board.

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Draft Issue Paper for FASAB:
Food Stamps Do Not Represent Potential Liabilities or Long-Term Commitments
for
Financial Statement Reporting Purposes

Prepared by US Food and Nutrition Service/FM

Background of FASAB Research Assignment

The FASAB staff is currently conducting research into program characteristics in an exercise "...to reconsider the recognition, measurement and display of liability and expense, potential new elements/statements, and all related disclosures for commitments of the federal government that could potentially result in a net outflow of resources." The FASAB Board has not approved a formal project plan, but is using the results of this preliminary data collection to determine the direction, if any, that the project will take in the application of the liability definition beyond its current parameters.

FASAB has identified the Food Stamp program (as well as TANF, Medicaid, and others) as part of its research effort. The US Food and Nutrition Service (FNS), a component of the United States Department of Agriculture (USDA), administers the Food Stamp program. This paper was prepared by the FNS staff to assist FASAB staff efforts to identify other potential liabilities and long term commitments which might be recognized or disclosed for financial reporting purposes. This paper is based on a review of existing FASAB accounting standards and concepts and the Food Stamp Act.

Food Stamp Liability Recognition

The Food Stamp program records relatively few liabilities due to the nature and timing of the payment mechanisms inherent in the EBT process that has now completely replaced food stamp coupons. On a daily basis, FNS authorizes the Treasury Department to reimburse intermediary processors, businesses who repay grocery stores for the cost of purchases made by Food Stamp households, via EBT cards. Since EBT purchases are skewed toward the beginning-of-the-month when monthly benefits are issued, there are relatively few reimbursements made at the end of each month/quarter/year. The year-end liability recorded for the Food Stamp program is therefore only a small adjustment figure, relative to the month's transactions.

Comparison of Food Stamp Program Characteristics with Other Select Programs

The Food Stamp program characteristics are dissimilar to other Federal programs where the need for disclosure of contingent liabilities and long-term commitments are generally understood, such as with social insurance programs, bank insurance programs, and the EPA Superfund. The following discusses these dissimilarities.

Social insurance future program costs (long term commitments) can generally be actuarially estimated due to the characteristics of the identifiable benefit population. Beneficiaries generally are permanently eligible from birth, remain beneficiaries until their death; and the national demographics can, within reason, provide a basis for estimating the volume of future beneficiaries. Additionally, these programs are participatory in nature since beneficiaries have paid part of the costs into "trust funds", which accumulate assets today to pay benefits in future years. Social Security beneficiaries believe strongly in their "vested interest" (whether real or not) and have valid expectations in receiving future benefits. One of the factors contributing to the valid expectations of social security beneficiaries is the Social Security Administration website which displays projected benefits, even though the estimated amounts may fluctuate up or down. In this instance, disclosing the long-term obligation related to those assets appears to be appropriate.

However, this situation bears no resemblance to the Food Stamp program. According to the Food Stamp Act, income standards of eligibility are adjusted each October 1, "and shall provide that a household shall be ineligible to participate in the Food Stamp Program if the household's income exceeds the poverty line." In other words, there is no permanent eligibility for the Food Stamp Program and, consequently, there is no valid expectation, as with social security benefits, since Food Stamp beneficiaries may change every year with the change in the poverty line. The Food Stamp Program is not a participatory program akin to social insurance programs (such as Medicare, Social Security, Railroad Retirement, etc.) in which beneficiaries have paid premiums or taxes (dedicated collections) into special funds intended to cover the benefits received.

Statement of Federal Financial Accounting Concept (SFFAC) No. 1, Paragraph 136 cites contingent liabilities and unrecognized obligations and provides the example of the probable future cost of deposit insurance. However, this need for determining an amount is because banks have paid insurance premiums to Federal insurers (such as FDIC), which are held and invested for many years in anticipation of paying out claims on deposits of failed banks. An estimated amount of annual future claims helps to determine the amount of premiums to charge member banks. Again, there are no similarities to the Food Stamp Program. For example, there is no event, which triggers the right to receive, or the issuance of, food stamps. With the FDIC, the event of failure of a savings and loan institution triggers the payment of insurance to those who have placed their money in the trust of a federally insured savings and loan. Poverty is not an event; it is a state of existence and cannot be predicted or accurately determined. Any measurement of poverty verges on the subjective rather than the objective. The poverty level of a potential food stamp beneficiary is indeterminate; an existing food stamp recipient is not guaranteed of any rights to receive food stamps in the future. Many potential, qualified food stamp recipients are reluctant to apply for food stamps. Their tendency to claim food stamps (or not) is not a triggering event to any liability of the Food Stamp Program.

Statement of Federal Financial Accounting Standard (SSFAS) No. 5 *Accounting for Liabilities,* Paragraph 20, states that the existence of a past event is essential for liability recognition; and an event is a happening of financial consequences to an entity. SSFAS No. 5 provides examples of events, such as toxic waste damage and natural disasters, which have financial consequences and are considered government-acknowledged events, if the government chooses to respond them. In the case of the Food Stamp Program, no specific event has occurred which causes poverty, and thus creates the need for the federal entity to formally acknowledge financial responsibility for the cost of that event. Therefore, Food Stamps is not a program where some harm has been done that must be undone, thus creating a liability for the "undoing" such as the EPA Superfund. Superfund contingent liabilities represent a sum total; once expended, the contaminated site should be "clean." There is no such "end in sight" for Food Stamps. Cancellation of the program, should Congress deem it appropriate, is not such an event.

SSFAS No. 5 also states, "A liability for federal accounting purposes is a probable future outflow or other sacrifice of resources as a result of past transactions or events." There is no "tie" to past events with the Food Stamp Program. SSFAS No. 5 also states that federal financial reports should recognize outflows arising from nonexchange transactions that, according to current law, and applicable policy, are unpaid amounts due as of the reporting date. Paragraph 24 states that a nonexchange transaction is a one-way flow of resources or promises. However, with regards to the Food Stamp Program, the question is to whom the promise is made or amounts due. Food Stamp benefits are paid to a class of people (i.e., below the poverty line) and are based on current monthly household circumstances, which often change. Unlike social insurance programs, food stamp beneficiaries do not accrue entitlement to future benefits. Congress periodically reviews Food Stamp Program eligibility and benefits in the reauthorization process in terms of needs and budgetary resources.

Summary

A Federal program, such as the food stamp program, that is expected to be ongoing that receives no dedicated taxes and has no trust fund or similar funding mechanism is not a logical candidate for disclosures similar to those required for social insurance programs, bank insurance programs, or for "booking" contingent liabilities for past events (for example, environmental damage recorded for the EPA Superfund).

SFFAC No. 1 states, the Federal Government has a responsibility for the general welfare of the nation in perpetuity. As FASAB strives to define the federal government's liabilities and commitments that could potentially result in a net outflow of resources, we urge FASAB to keep in mind the broad context of the federal government's responsibility for the general welfare of the nation. In providing for the general welfare of the nation the federal government has substantial commitments that could and will result in a net outflow of resources in addition to those related to social programs. For example, one could argue that maintaining a strong national defense is critical to providing for the general welfare of the nation and therefore national defense should be subject to the same recognition and disclosure requirements as those applied to general welfare programs such as Food Stamps.

For the reasons cited above, we believe that the criteria for recognizing a liability or disclosing information about the commitments of the federal government that provide for the general welfare of the nation and could potentially result in a net outflow of resources be considered very carefully. We believe any effort to expand the criteria for a liability or the disclosure requirements for commitments should be undertaken only after carefully considering the cost and benefits of such requirements. Further, we believe that the Food Stamp program is not an appropriate candidate for additional financial statement disclosures of short-term or long-term liabilities or commitments.