Federal Accounting Standards Advisory Board

December 1, 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.

This paper continues the discussion Social Security characteristics from the October meeting. In October members raised questions about certain characteristics and/or suggested possible areas for development.

Over the past months the Staff has selected certain characteristics that may create a present obligation, in conjunction with an obligating event, prior to the point when benefit payments are due and payable. The Board is considering possible bases for concluding that such a present obligation exists in absence of legal enforceability. The Board has discussed "constructive obligations" but to date a working concept in that regard is limited to the notion that present obligations do not have to be "strictly or technically" legally enforceable. This obviates the need for projects other that the Elements/Concepts Project to discuss the scope of the not-legally-enforceable concept. The characteristics discussed below would presumably create a present obligation because they induce reasonable expectations and reliance or for other reasons the Government has no realistic alternative under current law but to settle the obligation.

With respect to the absence of legal enforceability, Staff notes that payments due from Social Security and other social insurance programs under current law are legally enforceable against administrators who might withhold them in contravention of that law. This is true generally for annual Government programs. It is also true for some long-term obligations, including public debt. Unless current law is changed the obligee has a right to

the payment when due. Staff notes that the Board is currently discussing how the notion of legally enforceability should be applied to Social Security and other programs. A characteristic concerning legally enforceable payments is presented below for the Board's consideration.

The characteristics discussed below include those from page 15 of the October staff memorandum[1] as well as other characteristics that were mentioned in the October Board discussion, i.e., permanent eligibility [see (1) below]; specific participants and benefits [see (5) below]; participants' and/or their employers are paying into the program [see (7) below]; and information about accruing benefits directly communicated to the participants [see (8) below]. Also, Staff has included a characteristic that Staff mentioned in October: future benefit payments are legally enforceable under current law [see (4) below]. The following lists characteristics discussed in this memorandum:

(1) Eligibility is permanent: Current law provides the conditions that, once met, qualify participants "permanently" to receive a benefit without further conditions being required. If further conditions are required and the likelihood of them not being met is remote, then we would not find them relevant to the notion of a present obligation.
(2) Benefit level specified in current law.
(3) A permanent funding source is made available under current law.
(4) Future benefit payments are legally enforceable under current law.
(5) The participants and benefits can be specifically identified well before the due and payable point.
(6) The participants are performing under the terms of the program. They are working in covered employment and the wages they earn therein determine the amount of their current dedicated taxes and future benefits.
(7) Participants may be viewed as exchanging current resources in the form of taxes for future benefits, an exchange or exchange-like transaction.
(8) Information about the participants' accruing benefits is directly communicated to the participants.

This paper's discussion of each characteristic ends with the question of whether the characteristic by itself would create a present obligation (in conjunction with an obligating event) prior to the point when benefit payments are due and payable; and, if not, whether it is relevant for establishing a present obligation in combination with other characteristics.

The characteristics discussed in this paper may also distinguish Social Security and, ultimately, the other social insurance programs from the programs previously submitted for

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[1] Characteristics listed on page 15 of the October staff memorandum were:

√ Program benefits, financing, etc., are provided in current law and current policy. This characteristic has been distilled to (2) above.
√ The benefits are based on work in covered employment and wages earned therein. See (6) above.
√ The participant is required to pay specific, dedicated taxes. This is included in (7) above.
√ Permanent and indefinite budget authority has been provided to use the payroll taxes without further Congressional action. See (3) above.
√ The program is not means tested. This is included in (1) above.

discussion – Medicaid, Food Stamps, SSI, TANF — as well as other federal programs. However, the focus of this paper is on whether the characteristics create an obligation that, in conjunction with an obligating event, is a “present obligation” within the meaning of a liability definition. Presumably other programs with these characteristics would meet the liability definition as well, all else being equal.

If these characteristics create a present obligation, then the next question is: what is the obligating event? This paper takes up that question in the section following the discussion of characteristics immediately below.

Staff notes that recognition and measurement issues will be considered in due course.

Regarding display, several illustrations of alternative reporting were presented at the October meeting, and some members expressed interest in considering sooner rather than later how information might be presented. The concluding section of this memorandum – preceding the appendices – presents an illustration of the relationship between possible liability measures and the Statement of Social Insurance (SOSI). Staff is planning to use this illustration for discussion purposes at the December meeting.

Characteristics

<u>Characteristic 1</u> – *<u>Eligibility is permanent</u>: Current law provides the conditions that, once met, qualify participants "permanently" to receive a benefit without further conditions being required. If further conditions are required and the likelihood of them not being met is remote, then we would not find them relevant to the notion of a present obligation.*

Several members have said eligibility should be established before a present obligation is considered.

Several members have said they would oppose accumulating benefits before eligibility is established.

The 40 quarters in covered employment (QC) requirement that render participants permanently eligible (or "**permanently insured**[*]**")** for Old-age and Survivors Insurance (OASI) and Medicare benefits appears to be similar to vesting provision of pension and stock-based compensation plans. With respect to stock-based compensation, the FASB exposure draft *Share-based* Payments (March 31, 2004) called for public entities to measure the cost of employee services received in exchange for equity instruments based on the grant-date fair value of those instruments, and to recognized the cost over the requisite service period (often the vesting period). Generally, no compensation cost would be recognized for equity instruments that do not vest.

The Social Security and Medicare programs require participants to work 40 QC to qualify for benefits. (Eligibility with fewer than 40 quarters is possible in cases of disability and for survivors. See Glossary, Appendix A, for more on **disability benefits** and **survivor benefits**.) After meeting the 40 QC condition, no additional conditions are required to be eligible to receive a payment that is due at a specified time (attainment of the designated age). This is also true for Medicare: the participant is eligible for Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) after 40 QC.[2] At 62 years of age (or 65 for Medicare) a participant with 40 QC is eligible to receive benefits.

By contrast, eligibility for Food Stamps and other "social assistance"[3] programs is not permanent and unconditional. The benefit for social assistance programs is based on conditions existing in the benefit year; specifically, the participant's means and, where applicable, medical condition.

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[*] Staff has included a glossary at Appendix A that includes definitions for certain terms from the FASAB Consolidated Glossary, the SSA Website, and other sources. Words or terms found in the glossary are in **boldface** the first time they appear in the text.

[2] See Appendix B for "Fact Sheets" for Medicare and the other programs presented in the briefing books for the August Board meeting.

[3] In this paper the term "social assistance programs" is used for convenience to represent the programs discussed previously with respect to the "Application of the Liability Definition" project – Medicaid, SSI, Food Stamps, and TANF.

Characteristics

The point at which conditions are satisfied for Social Security and other programs can be termed "threshold eligibility" and "full eligibility." The Public Sector Committee (PSC) Invitation to Comment (ITC) *Accounting for Social Policies of Governments* (*Social Policies*) term "threshold eligibility" would be applicable for instances such as 40 QC, while eligibility for an immediate annuity at 62 or for medical treatment at 65 would be labeled "full eligibility." In both cases there would be no more conditions to meet, unless one considers staying alive a program condition.

The PSC ITC *Social Policies* identifies three Options or alternative views regarding past event(s) that give rise to a present obligation in the absence of legal enforceability. Option 1, the full eligibility alternative ("Satisfy all eligibility criteria"), provided that, for "ongoing benefits subject to regular satisfaction of eligibility criteria, the maximum amount of the present obligation is the benefit that the individual is entitled to from the current point in time until the next point in time at which eligibility criteria must be satisfied." However, where validation of eligibility criteria is required only once, the present obligation would be for all future benefits to be provided to that individual as a result of that validation.

There is some debate about the extent of the Option 1 accrual. ITC paragraph 4.35 clearly states that, "where no further validation of entitlement is required, the government has a liability for both current and future amounts to be paid to the individual." But, regarding government pensions (Chapter 8), paragraph 8.13 also states that the present obligation for pensions under Option 1 is limited to the benefits receivable from the point that eligibility criteria are satisfied until the next payment date (or the date at which eligibility must be satisfied again, if this point is different). According to this view, there is no long-term liability because individuals can cease to meet eligibility criteria at any point in time due to death or failing to meet income or asset tests. Thus, the ITC Option 1 considered staying alive a condition. Also, Staff emphasizes the last phrase – i.e., failing to meet income and asset tests – because it seems to indicate that the PSC viewed means testing as significant in the consideration of liabilities.

The PSC ITC Option 2, "Satisfy threshold criteria," and Option 3, "Key participatory events," presented earlier past transactions than Option 1. [The full text of the ITC Options is provided on page 21.]

Ms. Wardlow's December memorandum notes that FASB Statement 116, *Accounting for Contributions Received and Contributions Made*, (Issue Date 6/93) defines a conditional promise to give as one that depends "on the occurrence of a specified future and uncertain event to bind the promisor" (par. 22). Statement 116 states that such promises should be recognized when the conditions are substantially met (i.e., the promise becomes unconditional). Ms. Wardlow notes that Statement 116 also indicates "a conditional promise to give is considered unconditional if the possibility that the condition will not be met is remote" (par. 22). As an example, the FASB states that the possibility that a

donee would fail to provide a required annual report to receive subsequent annual payments on a multiyear promise to give would be a remote condition. It would not preclude a liability encompassing amounts beyond the current year.

Ms. Wardlow states that the FASAB may wish to consider whether there is a parallel concept here for multiyear programs that have certain eligibility requirements beyond those initially required. For some of those requirements, the possibility that they would not be met might be remote, so that an expense and a liability would be incurred upon satisfaction of the initial eligibility requirements. In contrast, satisfaction of other requirements to renew eligibility might be more problematic, suggesting that the expense and liability be limited to the first year of eligibility.

Periodic Re-qualification

Means Testing

Some members questioned whether means testing mattered. At least two members have said they would eliminate the means test characteristic because it is unimportant.

One member's response was that means testing mattered because is it represents periodic re-qualification. One could become ineligible for such benefits whereas, in Social Security, you never become ineligible. Staff notes that under exceptional circumstances one could lose one's Social Security benefits at least temporarily, e.g., SSA will discontinue payments to those who go to jail for more than 30 days, reasoning that the state is already paying for their living expenses. [SSA Website.]

Several members said that permanent eligibility was very significant for them.

SSA explains the distinction between DI and SSI with respect to eligibility as follows:

> The Social Security Administration is responsible for two major programs that provide benefits based on disability: Social Security Disability Insurance (SSDI), which is based on prior work under Social Security, and Supplemental Security Income (SSI). Under SSI, payments are made on the basis of financial need.
>
> Social Security Disability Insurance (SSDI) is financed with Social Security taxes paid by workers, employers, and self-employed persons. To be eligible for a Social Security benefit, the worker must earn sufficient credits based on taxable work to be "insured" for Social Security purposes. Disability benefits are payable to blind or disabled workers, widow(er)s, or adults disabled since childhood, who are otherwise eligible. The amount of the monthly disability benefit is based on the Social Security earnings record of the insured worker.
>
> Supplemental Security Income (SSI) is a program financed through general revenues. SSI disability benefits are payable to adults or children who

> are disabled or blind, have limited income and resources, meet the living arrangement requirements, and are otherwise eligible. The monthly payment varies up to the maximum federal benefit rate, which may be supplemented by the State or decreased by countable income and resources. See http://www.socialsecurity.gov/notices/supplemental-security-income/text-benefits-ussi.htm… .

There was discussion at the October meeting about whether Social Security is means tested. A member asserted that some Social Security benefits were subject to income taxation at higher levels of income and that that represented means testing. Other members disagreed, saying that the income tax formula is separate. Another member mentioned that benefits are weighted toward the lower wage earner in terms of income replacement percentage.

At one time Social Security contained an annual earnings test whereby beneficiaries with higher incomes lost benefits. However, the "Senior Citizens' Freedom To Work Act of 2000" eliminated the Social Security annual earnings test [and a foreign work test] in and after the month in which a person attains full retirement age (FRA).[4] The FRA was age 65 in 2000 through 2002, but began increasing beginning with 2003. Earnings in the month of FRA attainment and after do not count towards the earnings test. Only earnings before the month of FRA count toward the earnings test. Thus, the earnings test now operates as a reduction due to early retirement.

Like Social Security, Medicare is not means tested. The participant is eligible for Medicare if he or she has 40 QC, or is otherwise eligible to receive Social Security benefits on his or her earnings. If a person does not meet these requirements, he or she can still get HI by paying a monthly premium if he or she is a citizen or a lawfully admitted alien who has lived in the U.S. for at least five years.

Staff notes that government social insurance policies differ with respect to means testing. The PSC ITC *Social Policies* mentions classes of "social policy" benefit programs where some governments include means testing and some do not. The ITC cites old-age pensions and unemployment insurance as two examples.

Review of Medical Condition

DI and SSI are examples of a government program based on medical need. The SSA administers both. SSI obviously includes financial need as a condition whereas DI does not. Medical standards for disability for those 18 years old or older are the same for DI and SSI.

[4] If a participant is under FRA when he or she starts getting Social Security payments, $1 in benefits is deducted for each $2 earned above the annual limit. For 2005, that limit is $12,000; for 2004, that limit is $11,640. In the calendar year the participant attains FRA, $1 in benefits will be deducted for each $3 earned above a higher annual limit up to the month of FRA attainment. For 2005, that limit is $31,800; for 2004, that limit is $31,080.

Characteristics

DI benefits are not based on the degree or severity of the claimant's disability but rather on the amount of the claimant's lifetime earnings before his or her disability began. SSI benefits have different more generalized benefits. (See Appendix B for Fact Sheets.}

All people receiving DI and SSI disability benefits must have their medical conditions reviewed from time to time. Benefits continue unless there is strong proof that the beneficiary's condition has improved medically and that he or she is able to return to work. How often the beneficiary's medical condition is reviewed depends on how severe it is and the likelihood it will improve. The beneficiary's award notice tells him or her when to expect their first review.

If their medical condition is expected to improve within a specific time, the beneficiary's first review will be six to 18 months after he or she started getting disability benefits. If improvement in his or her medical condition is possible, his or her case will be reviewed about every three years. If his or her medical condition is unlikely to improve, his or her case will be reviewed only about once every five to seven years. The DI benefits continue until full retirement age after which the only change is that, for Social Security purposes, the benefits are called "retirement benefits" instead of disability benefits.

Staff notes that one could argue that someone that is disabled under the SSI program has the same "permanent" eligibility as someone that is disabled under DI. If that person recovers from their disability, they are no longer disabled. If the person receiving SSI is permanently disabled and is earning no income, they may be considered permanently eligible forever. However, the differences between the two programs include some of the characteristics listed below, e.g., DI participants work in covered employment to qualify for benefits; DI participants are paying dedicated taxes; DI benefit payments are related to the participants earnings in covered employment.

Question 1 – Does the fact that current law provides conditions that, once met, qualify participants permanently to receive a benefit without further conditions create a present obligation, in conjunction with an obligating event, prior to the point when benefit payments are due and payable? If not, is it relevant for establishing a present obligation in combination with other characteristics?

1 **Characteristics 2 – *The benefit level is specified in current law*.**

The Social Security program benefit levels are provided in current law. SSA obviously can and does project future benefits for participants.

Current law also provides the benefit level of "social assistance" programs from which one can determine future benefits. However, such projections are typically short term. They are based on conditions that exist in the benefit year.

Establishing benefits in law may have consequences. The Public Sector Committee ITC *Social Policies* uses the International Public Sector Accounting Standards (IPSAS)[5] definition of constructive obligations wherein obligations derive from an entity's actions where,

(a) By an established pattern of past practices, published policies or a sufficiently specific current statement, the entity has indicated to other parties that it will accept certain responsibilities; and
(b) As a result, the entity has created a valid expectation on the part of those other parties that it will discharge those responsibilities.

SFAS 146, *Accounting for Costs Associated with Exit or Disposal Activities,*[6] establishes the following criteria to determine if a one-time benefit arrangement exists:

(a) Management, having the authority to approve the action, commits to a plan of termination.
(b) The plan identifies the number of employees to be terminated, their job classifications or functions and their locations, and the expected completion date.
(c) The plan establishes the terms of the benefit arrangement, including the benefits that employees will receive upon termination (including but not limited to cash payments), in sufficient detail to enable employees to determine the type and amount of benefits they will receive if they are involuntarily terminated.
(d) Actions required to complete the plan indicate that it is unlikely that significant changes to the plan will be made or that the plan will be withdrawn.[7]

For SFAS 146, the obligating event occurs when management communicates the plan to the beneficiaries.

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[5] IPSAS follows 19 International Accounting Standards 37. Both are titled *Provisions, Contingent Liabilities and Contingent Assets*. IAS 37 is dated September 1998, while IPSAS 19 is dated October 2002. The scope of IPSAS 19 did not include "social benefit" transactions in order "to allow for further consideration of the **obligating event** and the measurement of such liabilities." See PSC ITC *Accounting for Social Policies of Governments*, par. 1.2 [Emphasis in original]
[6] June 2002.
[7] FAS146, Par. 9.

Characteristics

Ms. Wardlow notes in her staff paper for December that a federal government announcement of its intent to provide particular benefits would seem to be conceptually similar to a promise to give. Ms. Wardlow's notes that, before promises to give can be recognized in the financial statements, SFAS 116 requires "sufficient evidence in the form of verifiable documentation that a promise was made and received."

She suggests that the FASAB may wish to consider bounds similar to those established by the FASB; namely, that there be verifiable documentation of the issuance and receipt of the relevant communication, in those instances where the commitment is not included in a statute or otherwise legally based. Thus, where the commitment <u>is</u> included in a statute as in the case of Social Security, Medicare and the other social insurance programs, the statue would seem to supply sufficient evidence.

Question 2 – Does the fact that the benefit level is specified in current law create a present obligation, in conjunction with an obligating event, prior to the point when benefit payments are due and payable? If not, is it relevant for establishing a present obligation in combination with other characteristics?

<u>Characteristic 3</u> – *A <u>permanent funding source</u> is made available under current law.*

There was discussion at the October Board meeting regarding whether Social Security was on "autopilot" because of its characteristics and especially because it has permanent spending authority (or "**budget authority"**). At least one member disputed that it was possible to distinguish between Social Security (and presumably other social insurance programs) from social assistance and/or other programs (student loans were also mentioned) with respect to the spending authority. Staff asserted that social assistance programs require annual **appropriations**, while Social Security, Medicare and the other social insurance programs do not.

It was asserted at the Board meeting that the annual appropriation for some social assistance programs is driven by the **authorizing legislation**, and the annual appropriation is a matter of form that makes no substantive difference. The Food Stamp program was offered as an example. It was noted that the Food Stamp program is in a budgetary class of programs called "**appropriated entitlements**," and that expenditures for such programs are permanently established in law, like social insurance programs, by authorizing legislation.

At the October Board meeting the Staff characterized Social Security as being on autopilot in part because authorizing legislation provides the authority to collect and spend money without further Congressional action. That contrasted with other entitlements, such as Food Stamps, which require Congress to provide appropriations, usually annually, in order to pay benefits. The legislative basis for social assistance programs supports the assertion that these programs required annual appropriations.

Some confusion may exist from the fact that the annual appropriations for some appropriated entitlements allow spending flexibility during a given fiscal year. Reference has been made to Food Stamps having an appropriation of "such sums as may be necessary." While it always reflects an appropriation of an unlimited amount, such language does not reflect an appropriation of unlimited duration. Such language serves to provide an indefinite amount to make payments in a fiscal year should the specific amount appropriated for that fiscal year turn out to be insufficient. Such fiscal year appropriations are tantamount to indefinite appropriations as to amount. Staff has been advised by FASAB legal counsel that this explains why, as a matter of law, anyone entitled to benefits such as food stamps in a fiscal year will receive them. However, the programs do not have an appropriation that is either permanent or continuing beyond a fiscal year.

The need for annual appropriation act is an authorizing condition rather than a funding requirement. The FASAB has never required advanced funding for liability recognition. The appropriation is significant because it represents the

intent of Congress to structure a program either for autonomous operation or review it annually or at least at relatively short intervals.

Ms. Wardlow's December memorandum notes that Statement 116 FASB discusses the effects of "conditions" on the timing of liability recognition. A citation from Statement 116 states that uncertainty is inherent in a transfer involving a conditional promise. FASB notes that several factors affect whether a condition will be met, including whether additional funding from other sources will be necessary. Such factors make it difficult to determine reliably when, if at all, the conditional promise will become a right of the promisee and a duty of the promisor. [SFAS 116, par. 76]

Question 3 – Does having a permanent funding source available under current law create a present obligation, in conjunction with an obligating event, prior to the point when benefit payments are due and payable? If not, is it relevant for establishing a present obligation in combination with other characteristics?

Characteristic 4 – *Future benefit payments are legally enforceable absent a change in law. (Note: Current law limits future benefits to the amount available via the trust fund. This could be a measurement issue but some may view the "cap" as relevant to the question of whether a present obligation exists.)*

Payments due from Social Security and other social insurance programs under current law are legally enforceable against administrators who might withhold them in contravention of that law. This is true generally for annual Government programs. It is also true for some long-term obligations, including public debt. Unless current law is changed the obligee has a right to the payment when due.

FASAB counsel has advised that the Government is liable for past periods of eligibility where payment has not been made, such as when a beneficiary had not received payments to which he was entitled between the period of reaching eligibility and the date of his death, where his estate seeks payment.

Benefits are also legally enforceable for other programs. For example, a claimant under the Food Stamp program is entitled to benefits as provided under law, provided he or she meets the eligibility criteria. However, a legal argument with respect to the Food Stamp or other social assistance program would be limited to circumstances in the current year. One would not associate an individual's present or past work effort with a future payment.

Again referencing Ms. Wardlow's staff paper for December, she notes that, before promises to give can be recognized in the financial statements, SFAS 116 requires "sufficient evidence in the form of verifiable documentation that a promise was made and received." When a communication does not indicate clearly whether it is a promise, it is "considered an unconditional promise to give if it indicates an unconditional intention to give that is ***legally enforceable***" (par.6). [Emphasis added]

She suggests that the FASAB may wish to consider that there be verifiable documentation of the issuance and receipt of the relevant communication, in those instances where the commitment is not included in a statute or otherwise legally based. The commitment for Social Security, Medicare and the other social insurance programs is included in a statute.

Question 4 – Does the fact that future benefit payments are legally enforceable absent a change in law create a present obligation, in conjunction with an obligating event, prior to the point when benefit payments are due and payable? If not, is it relevant for establishing a present obligation in combination with other characteristics?

<u>Characteristic 5</u> – *The participants and benefits can be <u>specifically identified</u> well before the due and payable point.*

In October the Board discussed general versus specific obligations and whether it would make a difference for liability consideration whether the Government is obligated to make payments to a class of beneficiaries versus specific individuals. It was stated that the Government would have to know enough about the benefit structure and the beneficiaries to measure the liability. Most programs prepare projections for at least the relatively near term horizon. However, the identity of the specific individuals, by Social Security Number, in the population of potential beneficiaries well before the due and payable point might be important.

Of the five social insurance programs, all but Unemployment Insurance (UI) know who the participants are well before the due and payable point. Unemployment Insurance and social assistance beneficiaries are not known individually before their claims are filed. On the other hand, we know something about the potential UI population, e.g., from their employment and tax records.

For the October meeting Ms. Wardlow noted the issue regarding whether the government can incur liabilities for the provision of goods and services to the citizenry in general. She noted that the provision of goods and services is part of the government's mission, and the administration and legislators frequently announce that certain services or benefits will be provided, or that ongoing programs will be continued or expanded. She raised the issue of whether these announcements give rise to liabilities.

She noted that other standards boards are considering these issues, including the United Kingdom's Accounting Standards Board (UK-ASB) and the Public Sector Committee of the International Federation of Accountants (PSC). She noted UK-ASB's 2003 *Proposed Interpretation for Public Benefit Entities of its Statement of Principles for Financial Reporting*, where the UK-ASB classifies commitments to provide public benefits into general versus specific commitments. The interpretation defines a general commitment as "a general or policy statement of intention, that the entity stands ready to provide goods or services to certain classes of potential beneficiaries in accordance with its objectives" (par. 4.29).

The UK-ASB indicates that a general commitment would not result in a liability for the following reasons (par. 4.34, footnote omitted):

> The commitments described at (a)(i) above [i.e. general commitments] are expected to include political commitments made by governments, for example the announcement of a forthcoming new initiative to provide cash benefits to members of the public meeting certain criteria. Political commitments are different from commercial contracts. Such political commitments (whether express or implied) are political promises;

> examples are the general promise to provide health-care or education. Governments make, and amend, such promises and policies as part of their ongoing political processes to manage the economy and redistribute wealth within or between periods and generations. As such they should not be viewed as constructive commitments.

Further (par. 4.35):

> A general commitment to provide public benefits contrasts with an announcement by a profit-oriented entity where the announcement has created a valid expectation that the decision will be implemented such that the entity cannot withdraw from it, because a general commitment could be changed (or withdrawn).

On the other hand, the UK proposal also included the alternative view (par. 33) that:

> . . . some general political promises are relied upon by individuals, for example in taking financial decisions about investments for the future, and therefore in these cases a liability has been created because the outflow of economic resources cannot be avoided.

In contrast to general commitments, the UK-ASB defines a specific commitment as follows (par. 4.29):

> . . . a specific commitment, or promise, to provide specified goods or services to a beneficiary that has met any necessary criteria, such that the beneficiary is able to rely on the entity fulfilling its promise (ie the general commitment has become specific as a result of certain past events) meaning that the entity could not realistically withdraw from it.

In the UK-ASB's view, specific commitments create a liability because (par. 8 4.32):

> . . . the general commitment has become specific and there is an obligation to transfer economic benefits to an identified beneficiary or group of beneficiaries as a result of past events. In general, the definition of a liability does not require a reporting entity to know the identity of the party to whom an obligation is owed. Nevertheless, in distinguishing between general and specific commitments to provide public benefits, in order to identify the point at which a general commitment becomes specific, identification of the beneficiary is usually necessary.

Ms. Wardlow noted that the UK-ASB proposal does not explain how a general commitment becomes specific—that is, what the qualifying past events might be. Moreover, it is not explained why, in distinguishing between general and specific commitments, it is necessary to contravene one of the characteristics of a liability (in the FASB's definition as well as the UK-ASB's)—namely, that it is not necessary to know the identify of the claimant in order to conclude that an entity has a liability.

Characteristics

1 **Question 5 – Does the fact that participants and their benefits can be**
2 **specifically identified well before the due and payable point create a**
3 **present obligation, in conjunction with an obligating event, prior to the**
4 **point when benefit payments are due and payable? If not, is it relevant for**
5 **establishing a present obligation in combination with other**
6 **characteristics?**
7
8

1 **Characteristic 6 –*The participants are performing under the terms of the program.***
2 ***They are working in covered employment and the wages they earn therein***
3 ***determine the amount of their current dedicated taxes and future benefits.***
4
5 Some members asserted that Social Security benefits are based on past
6 earnings and "other factors" included in the formula for benefits. For retiree
7 benefits, it may be useful to restate that the formula is a straightforward
8 calculation based one's average indexed earnings. SSA calculates a worker's
9 **average indexed monthly earnings** (AIME) during the 35 years in which the
10 worker earned the most. If a worker has less than 35 years of earnings, SSA
11 averages in years of zero earnings to bring the number of years to 35.
12
13 SSA applies "a formula" to these earnings to arrive at the worker's basic benefit,
14 or "primary insurance amount" (PIA). The PIA depends on the *year* in which a
15 worker attains age 62, becomes disabled before age 62, or dies before attaining
16 age 62. This is the amount the worker would receive at the worker's full
17 retirement age (FRA), which, for most people, is age 65. (FRA is gradually
18 increasing.) A worker receives a different amount if he or she retires early or
19 late. Also, retirees receive an annual COLA.
20
21 The PIA is weighted toward lower wage earners. The PIA formula is the sum of
22 three separate percentages applied to three separate portions of AIME. For
23 2005 these portions are the first $627 (90%), the amount between $627 and
24 $3,779 (32%), and the amount over $3,779 (15%). These dollar amounts are
25 also called "bend points."
26
27 Most social insurance programs base non-medical benefits on work in covered
28 employment and wages earned therein. The dollar amount of Medicare benefits
29 obviously naturally tied to the treatment received.
30
31 As participants perform under the terms of social insurance programs the
32 Government's ability to avoid the payment would seem to diminish. Ms. Wardlow
33 cites in her December memorandum FASB Statement 116, par. 77, in support of
34 the notion that uncertainties about meeting a condition diminish over time.
35

> 36 Makers of conditional promises generally can avoid a future sacrifice of
> 37 assets if they provide promisees with timely notification of the cancellation
> 38 of their conditional promise. However, as time passes that ability
> 39 diminishes. Case law and public policy suggest that once a promisee has
> 40 begun efforts in reliance on a conditional promise, both parties should be
> 41 held to their promises. Promisors generally are not allowed to escape
> 42 their promises until and unless a reasonable period of time has elapsed
> 43 for the promisee to meet the condition, and promisees generally are held
> 44 to their part of the agreement, which includes meeting the condition.
> 45 However, until the specified future and uncertain event that is the subject
> 46 of the condition occurs or fails to occur, a promisee does not have an

1 unconditional right to retain the assets transferred or to demand
2 payments. [Emphasis added]
3

4 **Question 6 – Does the fact that participants are performing under the terms**
5 **of the program create a present obligation, in conjunction with an**
6 **obligating event, prior to the point when benefit payments are due and**
7 **payable? If not, is it relevant for establishing a present obligation in**
8 **combination with other characteristics?**

9

10

1 **<u>Characteristic 7</u> – *Participants may be viewed as <u>exchanging</u> current resources in***
2 ***the form of taxes for future benefits and the program is exchange or exchange-***
3 ***like.***
4
5 Characteristic 7 would isolate the exchange element in the Social Security and
6 other social insurance programs. Ms. Wardlow has noted (staff memorandum
7 dated August 14, 2004) that FASB states (SFAC 6, par. 39) that a liability or
8 obligation most commonly arises from an exchange transaction and is
9 contractual in nature—based on written or oral agreements to pay cash or to
10 provide goods or services to another entity.
11
12 In October the Board discussed why participants may view their payments into
13 the program as an exchange. It was stated that many people feel that, if you get
14 a paycheck and it says on it that money is withheld for Social Security and
15 Medicare and you are working your quarters to be a part of that system, there is
16 a connection between the payment and the benefit. On the other hand, it was
17 stated that, with respect to whether or not the government has an obligation, it
18 does not matter whether the government labels these taxes for a specific
19 program or not.
20
21 One member has said that, in his view, there are exchanges or exchange-like
22 activities taking place. This involved the question of whether the government
23 benefits from the Social Security payment above and beyond what the
24 government pays into the "fund" for the use of the payroll taxes. If there is a
25 benefit associated it, then perhaps it was getting closer to an exchange
26 transaction.
27
28 Another member liked the concept of "exchange-like" because it limits the
29 consideration to those programs where some exchange is present.
30
31 Some commentators have argued that with Social Security the employer share of
32 the tax is based on compensation expense and is thus, as a minimum, similar to
33 sales taxes in being based on exchange transactions. To others the fact that a
34 tax is imposed on, or coincident with, an exchange transaction, does not make
35 the tax itself an exchange. For them this is true whether the tax is a sales tax or
36 a payroll tax. The income tax is imposed on an exchange between the employer
37 and employee (or an exchange between the owner of capital and the borrower)
38 but the income tax is not said to be an exchange between the Government and
39 the individual.
40
41 Some argue that if employers treat the Social Security tax as compensation
42 expense for financial reporting and internal cost accounting, then the case for
43 liability recognition for Social Security is compelling in that the employer's
44 expense is accounted for as an exchange transaction. Moreover, they argue that

the employee share of the tax is a payroll deduction and is thus almost certainly accounted for as part of total employee compensation, an exchange transaction.

Furthermore they argue that employer defined benefit pension plans are designed to integrate social security benefits into the employer plan in a way that reduces the employer obligation for pension benefits dollar for dollar by social security benefits. Thus employers are implicitly treating Social Security as an obligation of the government that they expect to be paid.

Others have likened the payment of Social Security payroll taxes to buying a future stream of inflation-indexed income, not unlike purchasing inflation-indexed Treasury bonds. And, because participants know they will get this income stream, presumably they are a little more aggressive with their individual retirement accounts, 401(k) plans and their other retirement savings.[8]

Others have said the collection of taxes is irrelevant for liability recognition. Some have argued that liability recognition should not be dependent on exchange transactions and that the temptation to require that characteristic should be resisted.

For some commentators the element of exchange in the Social Security tax, if there is one, arises from the relationship between what a participant pays in and what the Government gets (the use of the participants money). SFFAS 7 defines exchange transaction based on the reciprocal, (but not necessarily equal or voluntary) exchange of consideration or value. For these commentators the Social Security exchange relationship is highly imperfect because the benefit structure is skewed toward lower income earners. The government does credit the Social Security trust fund with interest on the money paid in that is in excess of amounts paid out, but it is not as if the participant is guaranteed that he or she will get back his or her contributions plus interest. However, they argue that there is some element of a reciprocal exchange of consideration. The benefit formula does consider the amounts paid in.

One member would prefer if the specific, dedicated taxes were better tied to the fact that they are assessed on covered employment. The payroll tax is not like tax like the gasoline tax. It is based on earnings.

The Exchange Concept

Although Ms. Wardlow's December memorandum initiates the conceptual discussion of issues involving different kinds of non-exchange transactions, a brief note here seems in order.

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[8] Jonathan Clements, WSJ, "What Privatizing Social Security Would Mean for Your Retirement Plans," November 24, 2004; Page D1.

The exchange concept obviously has been applied successfully to certain Government transactions. The distinction has worked well for commercial-type events, for example, exchanges between the federal entity employer and its employees and vendors. The entity's is operating its program and incurring expenses some of which are paid in cash and some are promises of future cash payments. However, expand the scope to transactions and events beyond these and additional concepts would seem to be needed.

The absence of a profit motive in the Social Security program would seem to complicate the application of the exchange model. The model is applicable to the relationship between federal employer and employee and between federal entity and private vendor because these relationships are identical to their private sector analogues. The private sector employs people, purchases equipment, etc., as part of its ongoing profit-seeking efforts, for example, in selling insurance or making loans. There's an exchange of money for risk. This is obviously an imperfect model for the Government, which provides, for example, insurance or loans to "promote the general welfare." Some Government entities are created with the intention that they will match costs and revenue, for example, PBGC. There are few pure exchanges outside of the narrow cases mentioned above.

Arguably participants may be viewed as exchanging current resources in the form of taxes for future benefits. The current participant provides – some say is compelled to provide – taxes/cash/resources and gets a "promise" of specific future retirement/survivor and disability (and, considering Medicare, retiree healthcare) benefits. The government gets the resources to (1) liquidate the past obligations incurred in the program in conjunction with the receipt of past taxes and (2) to finance general governmental programs.

<u>Analogues</u>

The Social Security and Medicare and the other social insurance projects are similar to insurance: if the insured event does not occur, the participant gets no benefit. Some argue that Social Security and Medicare are basically collective risk-sharing mechanisms. They argue that, rather than let each person run the risk of ending up destitute or without health care in old age, these programs pool the risk. Because risk is shared, it can be managed and people can be guaranteed a minimally acceptable outcome. They argue that these programs are designed to protect people from things they have little control over – risk of illness, of macroeconomic change, of industrial obsolescence. The "insurance company's" assets are, in effect, investments in the U.S. economy.

Some have argued that Social Security is similar to Pension Benefit Guaranty Corporation or vice versa. The PBGC is a federal corporation established under the Employee Retirement Income Security Act (ERISA) of 1974. It currently guarantees payment of basic pension benefits earned by 44.4 million American workers and retirees participating in 31,200 private sector defined benefit

pension plans. PBGC receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor defined benefit pension plans and by investment income and assets from terminated plans. When pensions plans default, PBGC gets the assets as well as the liability. For 2004 PBGC reported for single-employer plans $40 billion in assets and $63.3 billion in liabilities, for a negative 23.36 billion net position, as well as $96 billion in reasonably possible contingent liabilities. (See Appendix C for the PBGC press release regarding the FY 2004 financial statements.)

On the other hand, the program is often characterized as involving transfer payments between participants: current workers (future beneficiaries) pay and current retirees/beneficiaries (past workers) receive.

Question 7 – Does the fact that participants may be viewed as exchanging current resources for future benefits in an exchange or exchange-like transaction create a for a present obligation, in conjunction with an obligating event, prior to the point when benefit payments are due and payable? If not, is it relevant for establishing a present obligation in combination with other characteristics?

Characteristic 8 – ***Information about the participants' accruing benefits is directly communicated to the participants.***

Some members said the direct communication of accruing benefits is important. Some people feel that, since participants get a sheet every year that tells them what they can expect to receive from the government and what their earnings have been and what they have paid, there is a connection between what they paid and what they get. There seemed to be some agreement that the communication increases the probability that the government cannot realistically avoid the payment.

It was asserted that the Government communicates about many programs and that there was nothing unique about Social Security doing so. The example of parents with college age students would get information about student loans, and veterans would receive communications about benefits. Several members said they do not receive any communications from the government similar to the ones they receive from Social Security.

SFAS 146, *Accounting for Costs Associated with Exit or Disposal Activities*[9]

In SFAS 146 the FASB cites the act of communication of the plan to the employees as the event for expense and liability recognition for one-time termination benefits. SFAS 146 addresses financial accounting for exit or disposal costs, including one-time termination benefits provided to current employees who are involuntarily terminated under the terms of a one-time termination benefit arrangement.

SFAS 146 states that a liability for the cost of such benefit arrangements is incurred when the definition of a liability is met, and it cites the Concepts Statement 6 definition of liability.

Under SFAS 146 the expense and liability for one-time termination benefits would be recognized when the plan is communicated to the employees.[10] If employees are entitled to receive the termination benefits regardless of when they leave, or if employees will not be retained to render service beyond the minimum retention period, a liability for the termination benefits is recognized and measured at its fair value at the communication date.[11] Otherwise, the liability is measured at the communication date and recognized ratably over the future service period.[12]

[9] June 2002.
[10] FAS146, Par. 10.
[11] FAS146, Par. 10.
[12] FAS146, Par. 11.

Characteristics

SFAS 146 explicitly indicates: "a plan by itself would be insufficient to create a present obligation."[13] This supports the notion that something more than the existence of a federal program is needed to create a constructive or equitable obligation.

Issue 8 – Does the fact that information about the participants' accruing benefits is directly communicated to the participants create a present obligation, in conjunction with an obligating event, prior to the point when benefit payments are due and payable? If not, is it relevant for establishing a present obligation in combination with other characteristics?

The following matrix compares the characteristics with Social Security, Medicare, and social assistance programs.

[13] FAS146, Par. 5.

Characteristics – Program Matrix

	OASI	DI	Medicare			Medicaid	Food Stamps	SSI	TANF (formerly Aid to Families w/ Children)
			HI Part A	SMI Part B	PDP Part D				
(1) Eligibility is permanent	√	√	√	√	√				
Means testing.	[14], [15]	See note under OASI		√ [16]		√	√	√	√
(2) Benefit level specified in current law.	√	√	√	√	√	√	√	√	√
(3) Permanent funding source (“A” = annual, “MY” = multi-year, “PI” = permanent and indefinite, “TI” = temporary and indefinite. NY = “no year”)	√	√	√	√	√	NY/ TI [17]	A[18]	NY[19]	[20]

[14] 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.

[15] 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.

[16] 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.

[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 18-199, 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.

Characteristics – Program Matrix

	OASI	DI	Medicare			Medicaid	Food Stamps	SSI	TANF (formerly Aid to Families w/ Children)
			HI Part A	SMI Part B	PDP Part D				
(4) Future payments are legally enforceable (when due)?	√	√	√	√	√	√	√	√	√
(5) The participants and benefits can be specifically identified well before the due and payable point?	√	√	√	√	√		[21]		See note under Food Stamps
(6) Participants are performing in covered employment and taxes and benefits based on wages earned therein?	√	√	√	√	√				
(7) Participants' may be viewed as exchanging resources for benefits?	√	√	√	√	√	[22]			
(8) Information about the participants' accruing benefits is directly communicated to the participants?	√	√	√	√	√				

[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.

[21] In order for some participants to receive benefits under Food Stamps and TANF, they must meet certain work requirements. In those cases, some might argue that benefits are indirectly based on work in covered employment (i.e., must work but not in an illegal business).

[22] Some Medicaid participants pay a nominal co-payment for services (as low as $1 per visit), and thus, could view themselves as exchanging resources for benefits.

Obligating Events

The obligating event alternatives that were the focal point for the discussion in October are:

(1) Full eligibility, 62 years old for Social Security.
(2) "Threshold eligibility," at 40 quarters of work in covered employment for Social Security; and
(3) Beginning of work in covered employment.

The past events are similar to the three broad alternative views of past events that give rise to a present obligation outlined in the PSC ITC *Accounting for Social Policies*:

Option 1 – Satisfy all eligibility criteria

In the absence of a legal obligation, a past event giving rise to a present obligation occurs when an individual satisfies all applicable eligibility criteria.

In the case of ongoing benefits which are subject to regular satisfaction of eligibility criteria, the maximum amount of the present obligation is the benefit that the individual is entitled to from the current point in time until the next point in time at which eligibility criteria must be satisfied.

Where validation of eligibility criteria is required only once, the present obligation is for all future benefits to be provided to that individual as a result of that validation.

Option 2 – Satisfy threshold eligibility criteria

In the absence of a legal obligation, a past event giving rise to a present obligation occurs when an individual meets the eligibility criteria for the first time (the threshold criteria). The present obligation is for all benefits to be provided to the individual in future periods regardless of whether the individual is required to satisfy eligibility criteria again in future periods.

Option 3 – Key participatory events

In the absence of a legal obligation, a past event, or series of past events, giving rise to a present obligation occurs prior to the point at which an individual meets threshold eligibility criteria (where threshold criteria are applicable).

The present obligation arises when key participatory events have occurred that lead an individual to have a reasonable expectation of eventually satisfying eligibility criteria for a benefit and, as a result, the individual has relied on that expectation over a period of time leaving the government with no realistic alternative but to settle the obligation in the future.

The present obligation is for all benefits to be provided to the individual in future periods regardless of whether the individual is required to satisfy eligibility criteria again in future periods.

Obligating Events

The following table illustrates how the program characteristics listed above might apply to the three obligating events. This table is offered for discussion purposes rather than as a final, definitive statement.

	Participant Becomes Fully eligible (62 yrs)	Participant Reaches Threshold Eligibility	Participant Begins of Work in Covered Employment
(1) Eligibility is permanent	√	√	√
(2) The benefit level specified in current law	√	√	√
(3) A permanent funding source	√	√	√
(4) Future benefit payments legally enforceable	√	√	
(5) The participants and benefits can be specifically identified well before the due and payable point.	√	√	√
(6) The participants are performing under the terms of the program.	√	√	√
(7) Participants may be viewed as exchanging current resources for future benefits	√	√	√
(8) Information about accruing benefits is directly communicated to the participants	√	√	

The program characteristics would seem to be present when all three events occur except that "permanent eligibility" and "direct communication" are absent for "beginning work in covered employment." Those beginning work are not permanent eligible and a statement of benefits is not transmitted. Communication starts with the participant's 25th birthday, which is consist with the 40 QCs or 10-year approach because the assuming year to begin covered employment is 15 years old.

At least one member has said that, whatever the final list of characteristics, all of them should be necessary to create a present obligation. Using these characteristics and requiring all of them to be present, a present obligation would exist when the "obligating event" occurs either at 40 QCs or at "full eligibility."

As an alternative to requiring that all the characteristics be present, certain ones could be required and/or each program could be required to consider "all the circumstances," with the standard providing a conceptual discussion or the parameters to be considered.

Alternative Presentations

Several illustrations of alternative reporting were presented at the October meeting. The relationship between possible financial reporting and the Statement of Social Insurance (SOSI) was mentioned at least once. The following is an illustration of how possible liability measures would relate to the SOSI. Staff is planning on using this illustration for discussion purposes at the December meeting.

(1) Future benefit payments are legal enforceability under current law.

Pro forma Statement of Social Insurance - Version B2	Attributable to past service				Attributable to future service			Aggregate imbalance
	Future outlays	Future receipts	Cumulative imbalance		Future outlays	Future receipts	Cumulative imbalance	
Trust fund balance at beginning of period - a result of past receipts & outlays	0	0	1378		0	0	0	100
Participants who have attained age 62	-900	0	-800		-10	12	2	-798
Participants who have 40QC's & have attained age 62 but have not yet retired	-1200	0	**-2000**	**A**	-100	50	-48	-2048
Participants aged 15-61 who have 40 QC's or more but have not reached retirement age	-2400	0	**-4400**	**B**	-1000	110	-938	-5338
Participants aged 15-61 who have entered covered employment but do not have 40 QC's	-3000	0	**-7400**	**C**	-4800	5000	-738	**-8138**
Future participants (under age 15 and births [and immigration] during the period [75 years] who have not yet worked	0	0	-7400		-5000	7000	1262	**-6138**
Future participants (under age 15 and births [and immigration] beyond 75 years in perpetuity	0	0	-7400		-2400	3600	2462	-4938

A: Accrual starts at retirement age
B: Accrual starts at 40 quarters coverage
C: Accrual starts at entry in covered workforce
D: SSA: Closed Group imbalance
E: SSA: Open Group imbalance

Glossary

Appropriated Entitlement

See **Direct Spending or "Mandatory" Programs.**

Appropriation

In most cases, appropriations are a form of **budget authority** provided by law that permits federal agencies to incur obligations and make payments out of the Treasury for specified purposes. An appropriation usually follows enactment of **authorizing legislation**. An appropriation act is the most common means of providing budget authority, but in some cases the authorizing legislation itself provides the budget authority.
[FASAB *Consolidated Glossary*]

Authorizing Legislation

A measure that may create or continue an agency or program as well as provide funding or authorize the subsequent enactment of **appropriations**. While the Constitution grants to Congress the power over appropriations, the authorization appropriation process is derived from House and Senate rules. The formal process consists of two sequential steps: (1) enactment of an authorization measure and (2) enactment of appropriations. A division of labor within the Congressional committee system carries out this two-step authorizing and appropriating process. However, not all federal agencies and programs, however, are funded through this authorization-appropriations process.

Agencies and programs funded through the annual appropriations process, referred to as discretionary spending, generally follow this two-step process. Funding for some agencies and programs is provided by the authorizing legislation, bypassing this two-step process. Thus, a distinctive feature of authorizing legislation is that in some cases it affords agencies the authority to collect or to spend money without first requiring the Appropriations committees to enact funding. Such spending, referred to as **direct spending or "mandatory" programs**, currently constitutes about two-thirds of all federal spending. Direct/mandatory programs are mostly formula benefit or entitlement programs with permanent spending authority that depend on eligibility criteria, benefit levels, and other factors. This category of spending includes interest the Government pays on the public debt and the spending of several major programs, such as Social Security, Medicare, unemployment insurance, and Federal employee retirement. Other direct spending (referred to as **appropriated entitlements**), such as Medicaid, is funded in appropriations acts, but authorizing legislation controls the amount appropriated.

Some authorizing legislation expires after one year, some expires after a specified number of years, and some is permanent. Also, Congress may enact appropriations for a program even though there is no specific, prior authorization for it.

[See, for example, *FY 2005 Analytical Perspectives*, p. 358, 376-7, and 330, fn. 3; and *Overview of the Authorization-Appropriations Process*, CRS Report for Congress, July 2003.]

Appendix A – Glossary

Average Indexed Monthly Earnings

The dollar amount used to calculate a worker's Social Security benefit if he or she attained age 62 or became disabled (or died) after 1978. To arrive at AIME, SSA adjust the worker's actual past earnings using an "average wage index." If he or she attained age 62 or became disabled (or died) before 1978, SSA uses Average Monthly Earnings (AME).

A certain number of years of earnings are needed to compute the average indexed monthly earnings. After SSA determines the *number* of years, SSA chooses those years with the highest indexed earnings, sums such indexed earnings, and divides the total amount by the total number of months in those years to derive the *average indexed monthly earnings.*

A worker becomes eligible for retirement benefits when he or she attains age 62. For example, a worker reaches age 65 in 2005 and therefore becomes eligible that year, SSA would divide the national average wage index for 2003 ($34,064.95) by the national average wage index for each year prior to 2003 in which the worker had earnings and multiply each such ratio by the worker's earnings. This would give the indexed earnings for each year prior to 2003. The year 2003 is significant because it is the year in which the worker reaches 60 years of age, which is the base year for the index, i.e., it equal "1." SSA considers any earnings in or after 2003 at face value, without indexing. Then SSA computes the average indexed monthly earnings.
[SSA Web site]

Budget Authority

The authority provided by Federal law to incur financial obligations that will result in immediate or future outlays. Specific forms of budget authority include:

- ✓ Appropriations -- which may be provided in appropriations acts or other laws and which permit obligations to be incurred and payments to be made;
- ✓ Borrowing authority -- which permits obligations to be incurred but requires funds to be borrowed to liquidate the obligation;
- ✓ Contract authority -- which permits obligations to be incurred but requires a subsequent appropriation or offsetting collections to liquidate the obligations; and
- ✓ Spending authority from offsetting collections -- which permits offsetting collections to be credited to an expenditure account and permits obligations and payments to be made using the offsetting collections….

Budget authority may be classified by period of availability (one year, multiple-year, or no year), by nature of the authority (current or permanent), by the manner of determining the amount available (definite or indefinite), or as gross (without reduction of offsetting collections) and net (with reductions of offsetting collections). …
[FASAB *Consolidated Glossary*]

Appendix A – Glossary

Budget Enforcement Act of 1990

The Budget Enforcement Act of 1990 (Title XIII of P.L. 101-508) was designed to constrain future budgetary actions by Congress and the President. BEA took a different tack on fiscal restraint than earlier efforts, which had focused on annual deficit targets in order to balance the budget. BEA sought to reach budget balance by limiting congressional actions. The process was designed to enforce a previously reached agreement on the size of discretionary spending and the budget neutrality of revenue and mandatory spending legislation (PAYGO). In 1993, the discretionary spending limits and the PAYGO rules were extended through fiscal year 1998; the 1997 Budget Enforcement Act (Title X of P.L. 105-33) again extended the discretionary spending caps and the PAYGO rules through 2002.
[CRS Report for Congress, July 2003.]

Delayed Retirement Credit

Social Security benefits are increased (by a certain percentage depending on a person's date of birth) if retirement is delayed beyond full retirement age (FRA). Increases based on delaying retirement no longer apply when people reach age 70, even if they continue to delay taking benefits. For example, if the participant were born in 1944 with an NRA age of 66 years and intend to retire at age 68, his or her delayed retirement credit would be 8 percent per year. The difference between his or her retirement age and NRA is 2 years, so his or her benefit would be 8 percent times 2, or 16 percent, higher than his or her primary insurance amount.
[SSA Web site]

Direct Spending or "Mandatory" Programs

The Budget Enforcement Act of 1990 (BEA) divided spending into two types– **discretionary spending** and direct spending. Although the BEA and its enforcement mechanisms expired on September 30, 2002, the BEA classifications are still being used in the budget formulation process. Discretionary spending is controlled through annual appropriations acts. Direct spending, which is more commonly referred to as mandatory spending, is controlled by permanent laws. The BEA required budget authority provided in annual appropriations acts for certain specifically identified programs to be treated as mandatory. This is because the **authorizing legislation** in these cases entitles beneficiaries to receive payment or otherwise obligates the Government to make payment, even though the payments are funded by a subsequent appropriation. Since the authorizing legislation effectively determines the amount of budget authority required, the BEA classified it as mandatory.

The BEA defined categories of discretionary spending and specified dollar limits known as *"caps"* on the amount of spending in each category. If the amount of budget authority or outlays provided in appropriations acts for a given year exceeded the cap for that category, the BEA required a procedures, called sequestration, for reducing the spending in the category. The BEA did not cap mandatory spending. Instead, it required that all laws that affected mandatory spending or receipts be enacted on a *"pay-as-you-*

go'' (PAYGO) basis. That means that if such a law increased the deficit or reduced a surplus in the budget year or any of the four following years, another law had to be enacted with an offsetting reduction in spending or increase in receipts for each year that was affected. Otherwise, a sequestration would be triggered in the fiscal year in which the deficit would be increased.
[See *FY 2005 Analytical Perspectives*, p. 378.]

Disability Insured

A worker has disability-insured status if he or she (1) has earned at least 20 credits during the last 10 years, and (2) is "**fully insured**" (see below). Exceptions apply for those under age 31 and in certain other cases.

A participant can get disability benefits if he or she:

- ✓ Is under full retirement age
- ✓ Has enough Social Security credits and
- ✓ Has a severe medical impairment (physical or mental) that's expected to prevent him or her from doing "substantial" work for a year or more, or have a condition that is expected to result in death.

[SSA Web site]

Disability Benefits, Social Security

In addition to meeting SSA's definition of disability, the claimant must have worked long enough--and recently enough--under Social Security to qualify for disability benefits.

Social Security work credits are based on the claimant's total yearly wages or self-employment income. The claimant can earn up to four credits each year.

The amount needed for a credit changes from year to year. In 2004, for example, participants earned one credit for each $900 of wages or self-employment income. In 2005, that amount increases to $920. When the he or she has earned $3,600 ($3,680 in 2005), the participant has earned his or here four credits for the year.

The number of work credits the claimant needs to qualify for disability benefits depends on the claimant's age when he or she became disabled. Generally, the claimant needs 40 credits, 20 of which were earned in the last 10 years ending with the year the claimant becomes disabled. However, younger workers may qualify with fewer credits.

Whatever his or her age, the claimant must have earned the required number of work credits within a certain period ending with the time he or she became disabled. The participant's Social Security statement shows whether he or she meets the work requirement at the time it was prepared. If the participant stops working under Social Security after the date of the Statement, he or she may not continue to meet the disability work requirement in the future.
[SSA Web site]

Discretionary Programs

See **Direct Spending or "Mandatory" Programs.**

Fully Insured

To be fully insured, a participant generally needs at least one credit for each calendar year after he or she turns 21 and the earliest of the following:

- ✓ the year before he or she attains age 62,
- ✓ the year before he or she dies, or
- ✓ the year he or she becomes disabled.

The minimum number of credits needed is 6. The maximum number needed is 40. Any year (all or part of a year) that was included in a period of disability is not included in determining the number of credits he or she needs.
[SSA Web site]

Permanently Insured

A participant is permanently insured if he or she is **fully insured** and he or she will not lose his or her fully insured status when he or she stops working in covered employment. Examples:

- ✓ He or she has earned the maximum 40 credits, so is permanently (and fully) insured.
- ✓ He or she was:
  - o Born in 1949 and worked under covered employment in 1971-77, earning a total of 28 credits.
  - o Attained age 21 in 1970.
  - o Were fully insured after earning 6 credits and continued to be fully insured through 1998 (1998 less 1970 is 28).
  - o After 1998 he or she was no longer fully insured. He or she earned only 28 credits and was never permanently insured.

[SSA Web site]

Primary Insurance Amounts

The PIA is the sum of three separate percentages of portions of average indexed monthly earnings. The portions depend on the *year* in which a worker attains age 62, becomes disabled before age 62, or dies before attaining age 62. The "bend points" of the PIA formula are the dollar amounts that govern the portions of the average indexed

monthly earnings. The bend points in the year 2005 PIA formula, $627 and $3,779, apply for workers becoming eligible in 2005.

For example, a person who had maximum-taxable earnings in each year since age 22, and who retires at age 62 in 2005, would receive a reduced benefit based on a PIA of $1,926.60. This individual would not receive the 2.7-percent COLA for December 2004, but would instead receive the COLA effective for December 2005.
[SSA Web site]

Survivor Benefits, Social Security

When a person who has worked and paid Social Security taxes dies, certain members of the family may be eligible for survivor benefits. For many survivor cases, the number of required earnings credits is based on the worker's age at the time of death. In general, younger workers need fewer earnings credits than older workers. However, no worker needs more than 40 earnings credits (10 years of work) to be fully insured for any Social Security benefit.

- ✓ A widow or widower -- full benefits at full retirement age (currently age 65), or reduced benefits as early as age 60
- ✓ A disabled widow or widower -- as early as age 50
- ✓ A widow or widower at any age if he or she takes care of the deceased's child who is under age 16 or disabled, and receiving Social Security benefits
- ✓ Unmarried children under 18, or up to age 19 if they are attending high school full time. Under certain circumstances, benefits can be paid to stepchildren, grandchildren, or adopted children.
- ✓ Children at any age who were disabled before age 22 and remain disabled.
- ✓ Dependent parents age 62 or older

A former spouse can receive benefits under the same circumstances as a widow/widower if the marriage lasted 10 years or more. Benefits paid to a surviving divorced spouse who is 60 or older will not affect the benefit rates for other survivors receiving benefits. A widow/widower cannot receive benefits if they remarry before the age of 60 (50 if disabled) unless the latter marriage ends, whether by death, divorce, or annulment. However, remarriage after age 60 (50 if disabled) will not prevent payments on a former spouse's record.

The amount of the survivors benefit is based on the earnings of the person who died. The more he or she paid into Social Security, the higher the benefits will be. The amount a survivor receives is a percentage of the deceased's basic Social Security benefit. The following provides the most typical situations:

- ✓ Widow or widower full retirement age or older-100 percent.
- ✓ Widow or widower age 60 to 64-about 71 - 94 percent.
- ✓ Widow or widower at any age with a child under age 16 - 75 percent.
- ✓ Children - 75 percent.

If a person is receiving widow/widower's benefits, they can switch to their own retirement benefits (assuming they are eligible and their retirement rate is higher than the widow/widower's rate) as early as age 62. In many cases, a widow/widower can begin receiving one benefit at a reduced rate and then switch to the other benefit at an

unreduced rate at full retirement age. However, they will not be paid both benefits - they will be paid the higher of the two benefits.

Taxes, Income on Social Security Benefits

Some people who get Social Security benefits have to pay income taxes on them. This applies to beneficiaries with other substantial income in addition to Social Security benefits (for example, wages, self-employment, interest, dividends and other taxable income reported on the tax return). 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:

- ✓ If the beneficiary files a federal tax return as an "individual" and has combined income* between $25,000 and $34,000, he or she may have to pay income tax on 50 percent of Social Security benefits. If his or her combined income is above $34,000, up to 85 percent of Social Security benefits is subject to income tax.
- ✓ If a joint return is filed, the beneficiary may have to pay taxes on 50 percent of his or her benefits if he or she and spouse have a combined income* that is between $32,000 and $44,000. If the combined income is more than $44,000, up to 85 percent of Social Security benefits is subject to income tax.

[SSA Web site]

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[23].

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[24].

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)[25].

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[23] 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)
[24] National Academy of Social Insurance, *Social Insurance Sourcebook,* website material, http://www.nasi.org/publications3901/publications.htm, Washington, DC.
[25] 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	15.0	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	$10.8
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. [26]

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 home health care. Cost: Most people don't have to pay a monthly payment, called a premium, for Part

[26] 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.

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[27]. 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[28].

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 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

[27] Recipients may be able to receive assistance from their states to pay for both Part A or Part B.

[28] 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.

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[29]:

- 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[30] 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[31], 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
- 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

[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 144.
[30] Beneficiaries eligible for both Medicare (Part A and/or B) and Medicaid
[31] SSI limits assets to $2,000 for individuals and $3,000 for couples.

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.[32]

How is Medicare Financed?[33]

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.

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

[32] 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.
[33] National Academy of Social Insurance, *Social Insurance Sourcebook,* website material, http://www.nasi.org/publications3901/publications.htm, Washington, DC.

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.[34] 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.

[34] 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

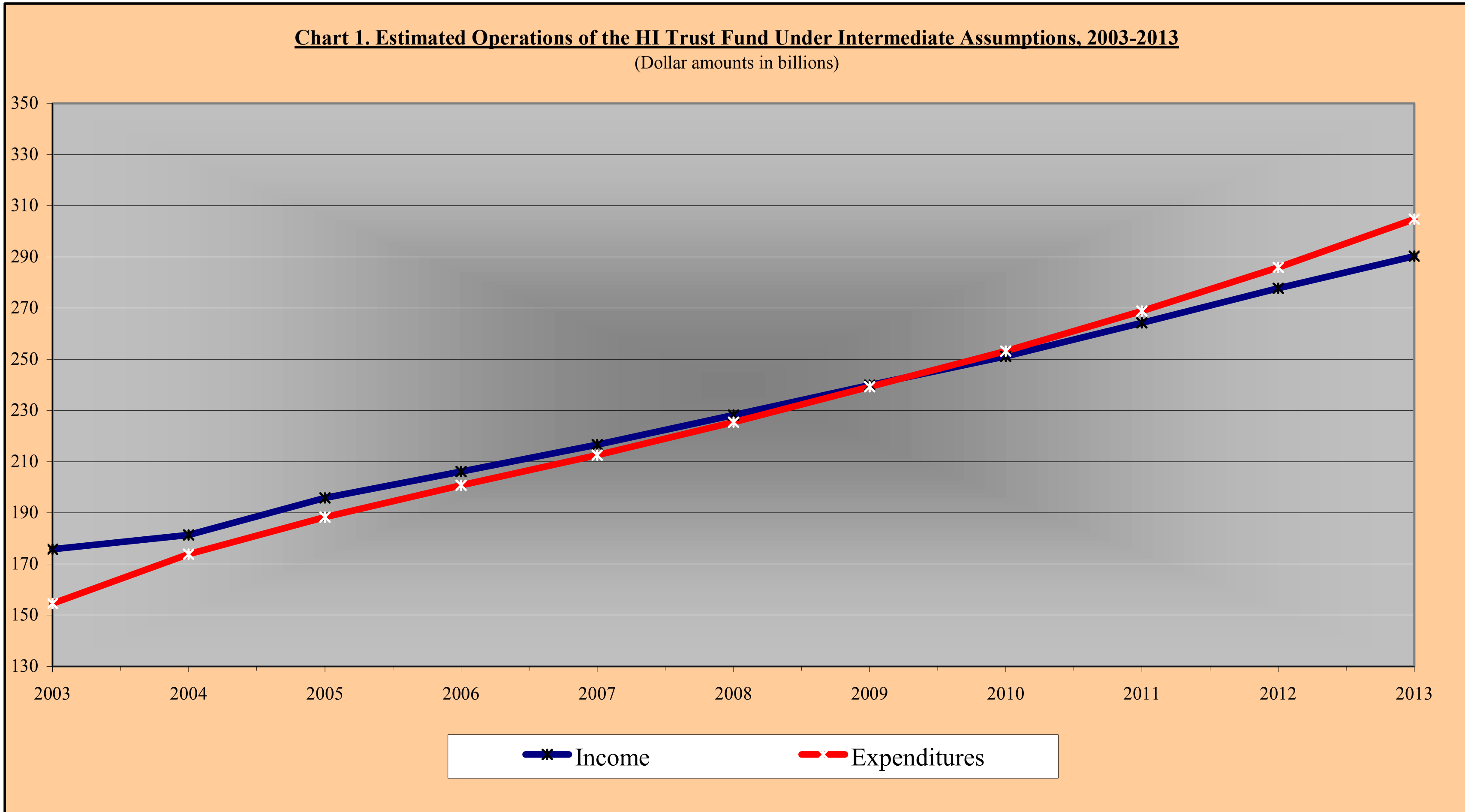
[In thousands]

Calendar year	HI Part A	SMI Part B	SMI 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	43,009	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	[3]	71,185
2030	78,794	72,060	75,063	[3]	79,063
2035	83,806	76,530	79,818	[3]	84,078
2040	86,792	79,247	82,659	[3]	87,064
2045	88,992	81,273	84,758	[3]	89,265
2050	91,230	83,449	86,884	[3]	91,504
2055	93,878	85,992	89,393	[3]	94,153
2060	97,084	88,951	92,432	[3]	97,361
2065	100,040	91,591	95,237	[3]	100,317
2070	102,924	94,240	97,971	[3]	103,200
2075	105,325	96,466	100,244	[3]	105,597
2080	107,770	98,746	102,184	[3]	108,037

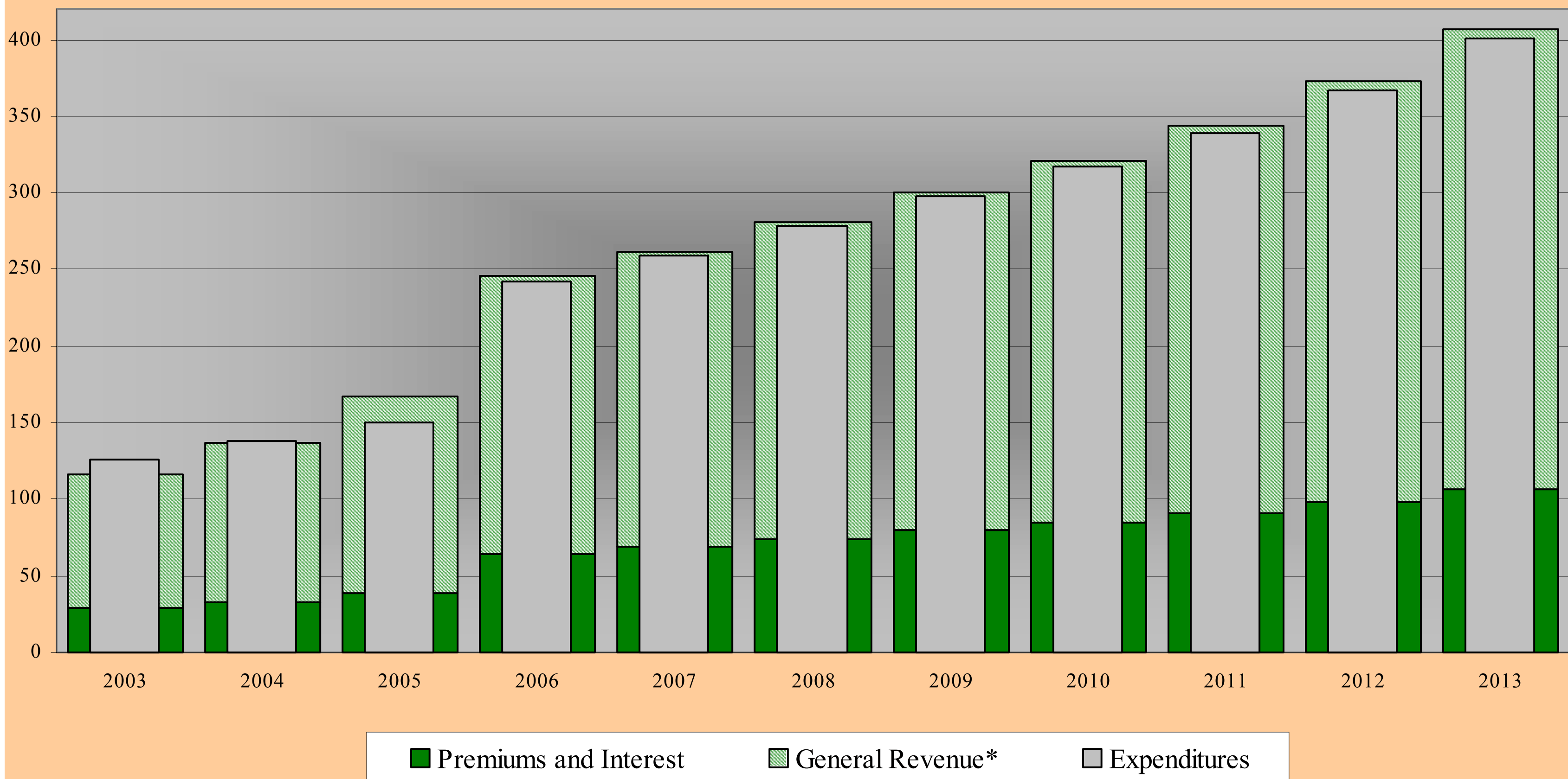
[1]Number of beneficiaries enrolled in a Medicare Advantage plan. From early 1980s to 1997 represents those enrolled in a risk HMO, and from 1998 to 2003 represents those enrolled in a Medicare+Choice plan. In order to enroll in a Medicare Advantage plan, a beneficiary must be enrolled in both Part A 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.

[35]

[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 27.

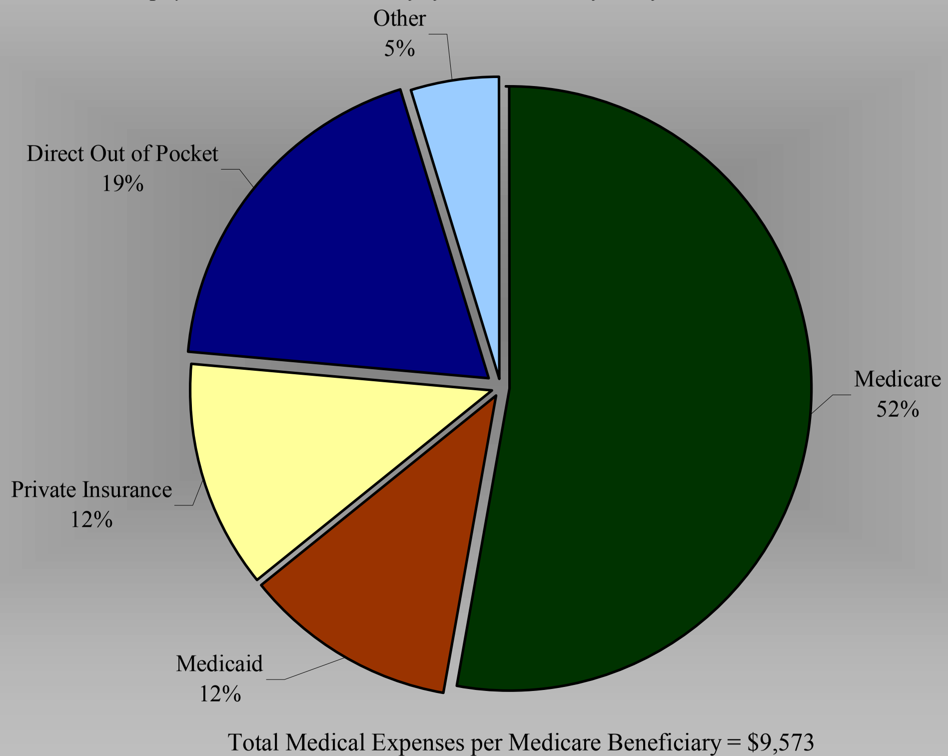


Source: Data from Medicare Board of Trustees, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* Washington, DC, March 23, 2004, page 10.



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.



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.

1 Appendix 2: Private Insurance Industries
2
3 The primary purpose of insurance is to provide economic protection from
4 identified risks occurring or discovered within a specified period. Some types of
5 risks insured include death, disability, property damage, injury to others, and
6 business interruption. Insurance transactions may be characterized generally by
7 the following:[36]
8
9 • The purchaser of an insurance contract makes an initial payment or
10 deposit to the insurance enterprise in advance of the possible occurrence
11 or discovery of an insured event.
12 • When the insurance contract is made, the insurance enterprise ordinarily
13 does not know if, how much, or when amounts will be paid under the
14 contract.
15
16 In general an important issue for insurance organizations is the recognition of
17 revenue on insurance contracts. GAAP requires the classification of contracts
18 (*policies*) as short –duration and long-duration as follows:
19
20 • Short-duration contracts – revenue over the policy period in proportion to
21 coverage
22 • Long-duration contracts – revenue when premium is due from the
23 policyholder
24
25 FASB 60 requires that insurance policies be classified as either short-duration
26 contracts or long-duration contracts. In a short-duration contract, the insurance
27 carrier primarily provides insurance protection; in a long-duration contract the
28 insurance company provides services and functions in addition to insurance
29 protection, including loans secured by the insurance policy and various options
30 for the payment of policy benefits.
31 In determining whether an insurance contract is of short-duration or long-
32 duration, FASB 60 requires that the following be considered (FAS 60, par. 7):[37]
33
34 • *Short-duration contracts* The contract provides insurance protection
35 for a fixed period of short duration and enables the insurer to cancel the
36 contract or to adjust the provisions of the contract at the end of any
37 contract period, such as adjusting the amount of premiums charged or
38 coverage provided.
39
40 • *Long-duration contracts* The contract generally is not subject to
41 unilateral changes in its provisions, such as noncancelable or guaranteed

[36] Financial Accounting Standards Board, *Current Text: Industry Standards Volume II,* Norwalk, CT, 2001, In6.101.
[37] 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.[38]

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.[39]

Cash Basis[40]

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.

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

1 When adjusting journal entries are made for workpapers to convert the cash
2 basis trial balance to accrual basis, they are not posted to the book. Therefore,
3 the books of an insurance companies are on the cash basis. The insurance
4 company will keep other records, such as a *claim register*, so that information is
5 available to adjust easily to the accrual basis.
6
7 *The claims register keeps track of claims pending, paid, negotiated, and rejected,*
8 *while cash basis trial balance reflects only the claims actually paid. The claims*
9 *register is used to prepare some of the adjusting journal entries necessary for*
10 *conversion to the accrual basis.*
11

2 **Medicaid/SCHIP Fact Sheet**

4

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

13 Summary

14
15 *Medicaid.* Close to 42 million individuals were enrolled in Medicaid in 2003. Medicaid
16 covers approximately one-fourth of the Nation's children and is the largest single
17 purchaser of maternity care and nursing home/long-term care services in the United
18 States. In 2003, the elderly and those with disabilities represented approximately 30
19 percent of Medicaid beneficiaries but accounted for two-thirds of its spending. Total
20 Medicaid spending for 2005 is estimated to be around $322 billion ($182 billion Federal
21 share).[41]
22
23 Title XIX of the Social Security Act is a program that provides medical assistance for
24 certain individuals and families with low incomes and resources. The program, known as
25 Medicaid, became law in 1965 as a jointly funded cooperative venture between the
26 Federal and State governments (including the District of Columbia and U.S. Territories)
27 to assist States in the provision of adequate medical care to eligible needy persons.
28 Medicaid is the largest program providing medical and health-related services to
29 America's poorest people. Within broad national guidelines provided by the Federal
30 government, each of the States:
31
32 1. Establishes its own eligibility standards;
33 2. Determines the type, amount, duration, and scope of services;
34 3. Sets the rate of payment for services; and
35 4. Administers its own program.
36
37 Thus, the Medicaid program varies considerably from State to State, as well as within
38 each State over time. State legislatures may change Medicaid eligibility, services,
39 and/or reimbursement during the year.[42] Medicaid does not pay money directly to the
40 participants; instead, it sends payments directly to participating health care providers.
41 Depending on each state's rules, the participant may also be asked to pay a small part of
42 the cost (co-payment) for some medical services.
43
44 *State Children's Health Insurance Program (SCHIP).* SCHIP was established in 1997 to
45 make available approximately $40 billion over 10 years for States to provide health care
46 coverage to low-income, uninsured children. SCHIP gives States broad flexibility in

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

1 program design while protecting beneficiaries through Federal standards. Since the
2 beginning of the Administration, enrollment in SCHIP has grown by over 1 million
3 children, to approximately 5.3 million in 2002.[43]
4
5 Title XXI of the Social Security Act established SCHIP. Some of the states administer
6 SCHIP in combination with Medicaid while other states maintain two separate programs.
7 Due to their similarity, they will both be addressed in this paper.

8 Eligibility[44]
9
10 Individuals DO NOT need to be on welfare to receive Medicaid. The 1996 Personal
11 Responsibility and Work Opportunity Reconciliation Act (PRWORA) severed the
12 automatic link between eligibility for cash assistance for families and children and
13 Medicaid.

14 **Medicaid**

15 *Categorically Needy*
16
17 Medicaid does not provide medical assistance for all poor persons. Medicaid eligibility is
18 limited to individuals who fall into specified categories. The federal statute identifies over
19 25 different eligibility categories for which federal funds are available. These categories
20 can be classified in to one of the following broad coverage groups:
21
22 • Pregnant Women;
23 • Children and Teenagers; and,
24 • Persons who are Aged, Blind, or Disabled.
25
26 In general, citizens are encouraged to apply for Medicaid if their income is low; they have
27 few resources; and they are either pregnant, under 18 or over 65, blind, or disabled.
28 Medicaid coverage generally stops at the end of the month in which a person no longer
29 meets the criteria of any Medicaid eligibility group.

30 *Medically Needy*
31
32 Thirty-seven states also have optional “medically needy” programs. Individuals that are
33 classified as medically needy have too much money or resources to be eligible as
34 “categorically needy.”
35

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

1 *Special Groups*
2
3 In addition, there are several special groups that states can fund through the Medicaid
4 program:
5
6 • Medicare Beneficiaries – Medicaid pays Medicare premiums, deductibles, and
7 coinsurance for Qualified Medicare Beneficiaries (QMB) – individuals whose
8 income is at or below 100 percent of the Federal poverty level and whose
9 resources are at or below the standard allowed under SSI; individuals whose
10 income is greater than 100 percent but less than 120 percent of the Federal
11 poverty level; and individuals whose income is at least 120 percent but less than
12 135 percent of the Federal poverty level.
13 • Qualified Working Disabled Individuals - Medicaid can pay Medicare Part A
14 premiums for certain disabled individuals who lose Medicare coverage because
15 of work. These individuals have income below 200% of the Federal poverty level
16 and resources that are no more than twice the standard allowed under SSI.
17 • States may also improve access to employment, training and placement of
18 people with disabilities who want to work through expanded Medicaid eligibility.
19 Eligibility can be extended to working disabled people between ages 16 and 65
20 who have income and resources greater than that allowed under the SSI
21 program. States can extend eligibility even more to include working individuals
22 who become ineligible for the group described above because their medical
23 conditions improve. States may require such individuals to share in the cost of
24 their medical care.
25 • There are two eligibility groups that states may include under their Medicaid
26 plans. One is a time-limited eligibility group for women who have breast or
27 cervical cancer; the other is for people with tuberculosis (TB) who are uninsured.
28 Women with breast or cervical cancer receive all plan services; TB patients
29 receive only services related to the treatment of TB. The charts below identify the
30 states that include these groups under their Medicaid plans.
31 • 1115 MEDICAID WAIVERS - Some states have also expanded eligibility under
32 Medicaid waivers. These waivers relate to Section 1115 of the Social Security
33 Act, which provides the Secretary of Health and Human Services with broad
34 authority to authorize experimental, pilot, or demonstration project(s) that, in the
35 judgment of the Secretary, are likely to assist in promoting the general objectives
36 of Medicaid.
37 • Long Term Care - All states provide community Long Term Care services for
38 individuals who are Medicaid eligible and qualify for institutional care. Most
39 states use eligibility requirements for such individuals that are more liberal
40 than those normally used in the community.
41 • Transitional Medical Assistance (TMA) – Medicaid coverage generally stops at
42 the end of the month in which a person no longer meets the criteria of any

Medicaid eligibility group.[45] 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[46]

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.

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

1 Funding[47]

2

3 Medicaid operates as a vendor payment program. States may pay health care providers
4 directly on a fee-for-service basis, or States may pay for Medicaid services through
5 various prepayment arrangements, such as health maintenance organizations (HMOs).
6 Within Federally imposed upper limits and specific restrictions, each State for the most
7 part has broad discretion in determining the payment methodology and payment rate for
8 services. Generally, payment rates must be sufficient to enlist enough providers so that
9 covered services are available at least to the extent that comparable care and services
10 are available to the general population within that geographic area. Providers
11 participating in Medicaid must accept Medicaid payment rates as payment in full. States
12 must make additional payments to qualified hospitals that provide inpatient services to a
13 disproportionate number of Medicaid beneficiaries and/or to other low-income or
14 uninsured persons under what is known as the "disproportionate share hospital" (DSH)
15 adjustment.
16
17 States may impose nominal deductibles, coinsurance, or copayments on some Medicaid
18 beneficiaries for certain services. The following Medicaid beneficiaries, however, must
19 be excluded from cost sharing: pregnant women, children under age 18, and hospital or
20 nursing home patients who are expected to contribute most of their income to
21 institutional care. In addition, all Medicaid beneficiaries must be exempt from
22 copayments for emergency services and family planning services.
23
24 The Federal Government pays a share of the medical assistance expenditures under
25 each State's Medicaid program. That share, known as the Federal Medical Assistance
26 Percentage (FMAP), is determined annually by a formula that compares the State's
27 average per capita income level with the national income average. States with a higher
28 per capita income level are reimbursed a smaller share of their costs. By law, the FMAP
29 cannot be lower than 50 percent or higher than 83 percent. In fiscal year (FY) 2003, the
30 FMAPs varied from 50 percent in twelve States to 76.62 percent in Mississippi, and
31 averaged 56.6 percent overall. The Federal Government pays States a higher share for
32 children covered through the SCHIP program. This "enhanced" FMAP averages about
33 70 percent for all States, compared to the general Medicaid average of 56.6 percent.
34
35 The Federal Government also reimburses States for 100 percent of the cost of services
36 provided through facilities of the Indian Health Service, provides financial help to the
37 twelve States that furnish the highest number of emergency services to undocumented
38 aliens, and shares in each State's expenditures for the administration of the Medicaid
39 program. Most administrative costs are matched at 50 percent, although higher
40 percentages are paid for certain activities and functions, such as development of
41 mechanized claims processing systems.
42

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

1 Except for the SCHIP program, the Qualifying Individuals (QI) program (described later),
2 and DSH payments, Federal payments to States for medical assistance have no set limit
3 (cap). Rather, the Federal Government matches (at FMAP rates) State expenditures for
4 the mandatory services, as well as for the optional services that the individual State
5 decides to cover for eligible beneficiaries, and matches (at the appropriate administrative
6 rate) all necessary and proper administrative costs.

2

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.[48] Food stamp benefit recipients can purchase eligible food, seeds, and/or plants in authorized retail stores.

19 Summary[49]

20

21 The purpose of the Food Stamp Program is to end hunger and improve nutrition and
22 health. The program helps low-income households buy the food they need for a
23 nutritionally adequate diet. The program is operated by State and local welfare offices,
24 and the U.S. Department of Agriculture administers the Food Stamp Program at the
25 Federal level through its Food and Nutrition Service (FNS).[50] State agencies administer
26 the program at State and local levels, including determination of eligibility and allotments,
27 and distribution of benefits. The program is in operation in the 50 States, the District of
28 Columbia, Guam and the U.S. Virgin Islands.
29
30 The Food Stamp Program helped put food on the table for some 8.2 million households
31 and 19.1 million individuals each day in fiscal year 2002 and cost $20.7 billion. It
32 provides low-income households with electronic benefits they can use like cash at most
33 grocery stores to ensure that they have access to a healthy diet. The Food Stamp
34 Program is the cornerstone of the Federal food assistance programs, and provides
35 crucial support to needy households and to those making the transition from welfare to
36 work. It provided an average of $1.52 billion a month in benefits in fiscal year 2002.
37
38 Households must meet eligibility requirements and provide information – and verification
39 -- about their household circumstances. U.S. citizens and some aliens who are admitted
40 for permanent residency may qualify. The Personal Responsibility and Work Opportunity
41 Reconciliation Act ("welfare reform act") of 1996 ended eligibility for many legal
42 immigrants, though Congress later restored benefits to many children and elderly
43 immigrants, as well as some specific groups. The welfare reform act also placed time
44 limits on benefits for unemployed, able-bodied, childless adults. Able–bodied adults
45 without dependents who are not meeting the work requirements are limited to any 3
46 months in a 36–month period.[51]
47

[48] 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.

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

[50] 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.

[51] Public Law 104-193, Sec. 408(a)(7)(A) and Sec. 824(a), August 22, 1996

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

6 Eligibility[53]
7
8 To participate in the Food Stamp Program:
9

10 • Households may have no more than $2,000 in countable resources, such as a
11 bank account ($3,000 if at least one person in the household is age 60 or older,
12 or is disabled).[54]
13 • The gross monthly income of most households must be 130 percent or less of
14 the Federal poverty guidelines ($1,654 per month for a family of three in most
15 places, effective Oct. 1, 2003 through Sept. 30, 2004).
16 • Net monthly income must be 100 percent or less of Federal poverty guidelines
17 ($1,272 per month for a household of three in most places, effective Oct. 1, 2003
18 through Sept. 30, 2004).
19 • Most able-bodied adult applicants must meet certain work requirements.
20 • All household members must provide a Social Security number or apply for one.
21
22 The Personal Responsibility and Work Opportunity Reconciliation Act of 1996
23 (PRWORA) limits the receipt of food stamps to 3 months in a 3-year period for able-
24 bodied adults without dependents (ABAWDs) who are not working, participating in, and
25 complying with the requirements of a work program for 20 hours or more each week, or
26 a workfare program. Individuals are exempt from this provision if they are:
27

28 • under 18 or over 50 years of age;
29 • responsible for the care of a child or incapacitated household member;
30 • medically certified as physically or mentally unfit for employment, pregnant; or,
31 • already exempt from the work requirements of the Food Stamp Act.
32

33 States may request a waiver of this provision for people in areas with an unemployment
34 rate above 10 percent or for those in an area with insufficient jobs. States also have
35 authority to exempt individuals using the 15% exemption authorized by the Balanced
36 Budget Act.[55]

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[52] 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)

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

[54] 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.

[55] 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.[56] 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.[57]

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).[58]

Benefits[59]

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.

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

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
2	259
3	371
4	471

5	560
6	672
7	743
8	849
Each additional member	+106

Funding

FNS pays the full cost of food stamp benefits and shares the states' administrative costs—with FNS usually paying 50 percent.[60] 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.[61] 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.[62]

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.[63] States can also earn a performance bonus for meeting certain performance criteria established by FNS relating to administration of the Food Stamp Program.[64]

[60] 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)
[61] Public Law 108–199,Jan. 23, 2004
[62] Food Stamp Act of 1977 [As Amended Through P.L. 108–199, Jan. 23, 2004] §18
[63] Food Stamp Act of 1977 [As Amended Through P.L. 108–199, Jan. 23, 2004] §16
[64] 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.[65]

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."[66]

Eligibility[67]

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

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

[67] 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[68]

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:

[68] "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[69]

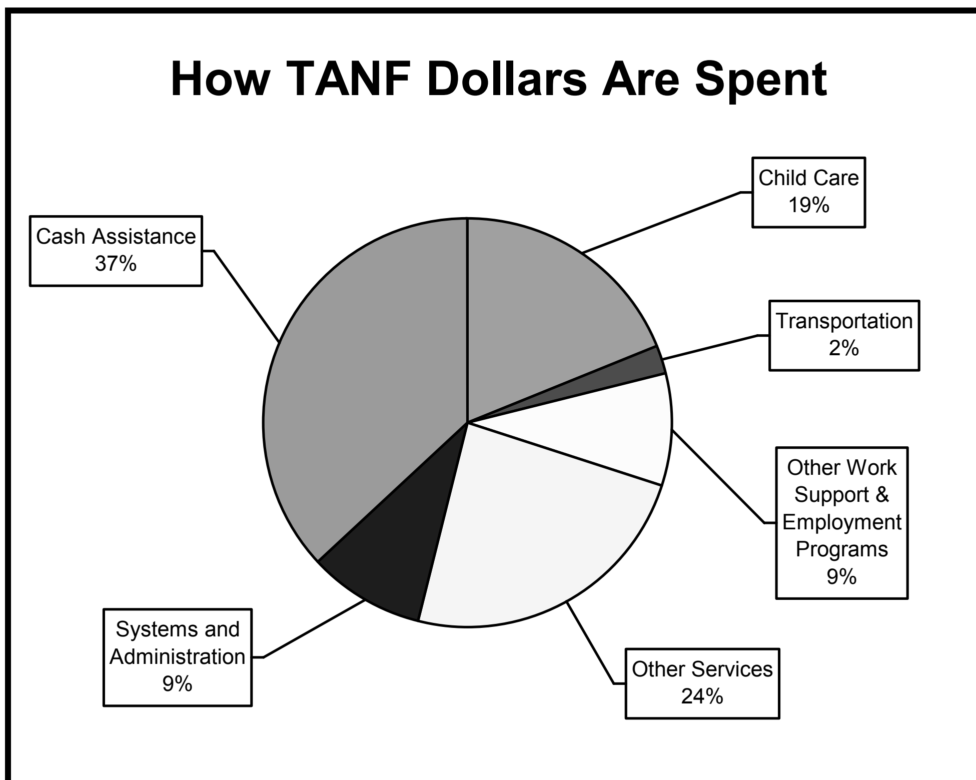
Rather than requiring an annual appropriation, the law that created TANF provided for mandatory block grants to the states totaling $16.5 billion each year for six years. This is a flat dollar amount, not adjusted for inflation. As a result, the real value of the block grant has already fallen by more 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, job retention, and wage progression. The second is a bonus for reductions in non-marital births.

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

1 In order to maintain the shared federal-state responsibility that was built into the AFDC
2 program, states must continue spending at least 75 percent of their 1994 contribution to
3 AFDC-related programs. This is the "maintenance of effort" (MOE) requirement, and it
4 totals roughly $10.5 billion.
5
6 States have used their TANF funds in a variety of ways, including: cash assistance
7 (including wage supplements); child care; education and job training; transportation; and
8 a variety of other services to help families make the transition to work. In addition, in
9 order to receive TANF funds, states must spend some of their own dollars on programs
10 for needy families. This is what is known as the "maintenance of effort" (MOE)
11 requirement.
12



13
14 **Reflects fiscal year 2002 expenditures of TANF and MOE funds (totaling $28.4 billion)**
15
16 The law that created the TANF block grant authorized funding through the end of federal
17 fiscal year 2002 (September 30, 2002). Since 2002, Congress has been working on
18 legislation to reauthorize the block grant and make some modifications to the rules and
19 funding levels. However, no final agreement has yet been reached on reauthorization
20 legislation. In the meantime, TANF funding has been temporarily extended several
21 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.[70]

Eligibility[71]

An individual who is:

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

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

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

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.[72]

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[73]	$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.

There is a benefit eligibility screening tool (BEST) available on the SSA web page.[74]

Benefits

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

[72] SSA does not count all kinds of income for SSI, but most income that it does count reduces the SSI benefit amount.
[73] A couple means two SSI-eligible persons residing together.
[74] BEST is located at http://best.ssa.gov/.

- $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.[75]

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.[76]

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.[77]

All of the states (and DC) listed below have an agreement with SSA to pay supplementary payments on their behalf for an administrative fee:[78]

- California
- Delaware
- The District of Columbia
- Hawaii

[75] "You May be Able to Get Supplemental Security Income" pamphlet at http://www.ssa.gov/pubs/11069.html.
[76] Social Security Handbook Chapter 21, § 2105
[77] Social Security Handbook Chapter 21, § 2106
[78] Understanding SSI – SSI Benefits at http://www.ssa.gov/notices/supplemental-security-income/text-benefits-ussi.htm

- 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).[79]

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] Social Security Handbook Chapter 21, § 2181

FOR IMMEDIATE RELEASE
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PBGC Public Affairs, 202-326-4040

PBGC Releases Fiscal Year 2004 Financial Results

WASHINGTON—The Pension Benefit Guaranty Corporation's insurance program for pension plans sponsored by a single employer incurred a net loss of $12.1 billion in fiscal year 2004, according to the agency's financial statements released today. The program's fiscal year-end deficit increased to $23.3 billion from $11.2 billion a year earlier. For the first time, the total number of people owed benefits by the PBGC passed 1 million and the total amount of benefits paid passed $3 billion.

"The PBGC is committed to protecting pension benefits, and with $39 billion in assets we can continue to meet our obligations for a number of years," said Executive Director Bradley D. Belt. "But with more than $62 billion in liabilities, it is imperative that Congress act expeditiously so that the problem doesn't spiral out of control. The Administration proposed an initial set of pension reforms last year, and today's report highlights the need for comprehensive reforms that ensure pension plans are better funded."

The PBGC's single-employer program insures the pensions of 34.6 million Americans in 29,600 plans. Of the $12.1 billion net loss for 2004, the two biggest factors were a $14.7 billion loss from completed and probable pension plan terminations and a $1.5 billion charge for actuarial adjustments due to a change in mortality assumptions. Partially offsetting the single-employer program's losses were premium income of $1.5 billion and investment income of $3.2 billion. Overall, including the assets of terminated plans for which PBGC became trustee during the year, the single-employer program had $39.0 billion in assets to cover $62.3 billion in liabilities as of September 30, 2004.

In addition to losses booked, the PBGC calculates "reasonably possible" exposure, an estimate of the amount of unfunded vested benefits in pension plans sponsored by companies at greater risk of default. The 2004 financial statements estimated PBGC's reasonably possible exposure at $96 billion, up from $82 billion a year earlier.

"While the economy is improving, pressures on the pension insurance program are expected to continue," Belt said. "These challenges warrant prompt action. When Congress reconvenes, the Administration will submit a comprehensive proposal that strengthens the funding rules, rationalizes premiums, enhances transparency, and provides new tools to protect the insurance fund."

The PBGC's separate insurance program for multiemployer pension plans posted a net gain of $25 million in fiscal year 2004, resulting in a fiscal year-end deficit of $236 million compared to a deficit of $261 million a year earlier. The multiemployer program covers 9.8 million participants in nearly 1,600 plans. The improvement in the program's financial condition is due largely to a decrease in loss from future financial assistance to multiemployer plans and an increase in investment income. The multiemployer program has about $1.1 billion in assets to cover $1.3 billion in liabilities.

For both programs combined, the total number of participants owed or receiving PBGC benefits in 2004 reached 1.1 million, up from 934,000 the previous year. Total benefit

payments rose to $3.0 billion from $2.5 billion. The number of underfunded plan terminations rose to 192 from 155.

The PBGC's financial statements are prepared in accordance with Generally Accepted Accounting Principles (GAAP). The financial statements for fiscal year 2004 received an unqualified audit opinion. The audit was performed by PricewaterhouseCoopers LLP under the direction and oversight of the agency's Inspector General.

PBGC is a federal corporation created under the Employee Retirement Income Security Act of 1974. It currently guarantees payment of basic pension benefits for more than 44 million American workers and retirees participating in more than 31,000 private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.